



# Technical Assistance Consultant's Report

---

Project Number: 37402  
May 2009

## RETA 6143: Technical Assistance for Promoting Gender Equality and Women's Empowerment (Financed by the Gender and Development Cooperation Fund)

Prepared by PRIMEX

This consultant's report does not necessarily reflect the views of ADB or the Government concerned, and ADB and the Government cannot be held liable for its contents. (For project preparatory technical assistance: All the views expressed herein may not be incorporated into the proposed project's design.)

**Asian Development Bank**

**RETA 6143**  
**PROMOTING GENDER EQUALITY AND WOMEN'S EMPOWERMENT**

**SUPPORTING WOMEN AT-RISK AND VULNERABLE TO HIV/AIDS**

**Prepared by PRIMEX**

**May 2009**

ADB



# RETA 6143: SUPPORTING WOMEN AT RISK AND VULNERABLE TO HIV/AIDS IN THE PHILIPPINES (Contract No. COSO-080-081)



**FINAL REPORT**  
May 2009



IN ASSOCIATION WITH



AND



---

# RETA 6143: SUPPORTING WOMEN AT RISK AND VULNERABLE TO HIV/AIDS IN THE PHILIPPINES (Contract No. COSO-080-081)

---

***FINAL REPORT***  
***May 2009***



**PACIFIC RIM INNOVATION AND  
MANAGEMENT EXPONENTS, INC.,  
PHILIPPINES**

IN ASSOCIATION WITH



AND



## TABLE OF CONTENTS

**Page**

List of Tables	ii
List of Appendixes	ii
List of Abbreviations	iii
Executive Summary	v
<b>I. INTRODUCTION</b>	<b>1</b>
<b>II. PROJECT DESCRIPTION</b>	<b>2</b>
<b>III. PROJECT ACCOMPLISHMENTS</b>	<b>3</b>
A. Component 1: Female Spouses of Seafarers	3
B. Component 2: Female Seafarers	11
C. Component 3: Female IDUs	15
<b>IV. EVALUATION OF PROJECT DESIGN AND IMPLEMENTATION</b>	<b>21</b>
A. Relevance of Project Design and Formulation	21
B. Project Outputs	21
C. Project Schedule	23
D. Implementation Arrangements	23
E. Consultant Recruitment and Procurement	23
F. Performance of the IAs	23
G. Performance of the Consultant	23
H. Performance of ADB	23
<b>V. EVALUATION OF PROJECT PERFORMANCE</b>	<b>24</b>
A. Relevance	24
B. Effectiveness in Achieving Outcomes	24
C. Efficiency in Achieving Outputs	25
D. Preliminary Assessment of Sustainability	26
<b>V. LESSONS LEARNED</b>	<b>26</b>
A. Component 1: Female Spouses of Seafarers	26
B. Component 2: Female Filipino Seafarers	27
C. Component 3: Female IDUs	27
<b>VI. RECOMMENDATIONS AND NEXT STEPS</b>	<b>27</b>
A. Component 1: Female Spouses of Seafarers	27
B. Component 2: Female Filipino Seafarers	28
C. Component 3: Female IDUs	29
D. Overall	29
<b>REFERENCES</b>	<b>30</b>



## LIST OF TABLES

<u>Number</u>	<u>Title</u>	<u>Page</u>
1	Information on the Spouses' Organizations	4
2	Summary of Training Courses Conducted for Female Spouses of Seafarers	5
3	Knowledge and Skills Gaps Identified through TNA	7
4	Consultant's Assessment of Performance Targets and Deliverables	21
5	Coverage of Female Spouses Reached by the Project	23

## LIST OF APPENDIXES

<u>Number</u>	<u>Title</u>
1	Design and Monitoring Framework (DMF)
2	Comprehensive Training Report on the Development of Peer Educators Among Female Spouses of Seafarers
3	Training Evaluation Report of Peer Education Outreach Seminars
4	Review of Existing Behavioral Change Communication (BCC) Material and Identification of HIV Information Needs of Female Spouses of Seafarers
5	Illustrated BCC Material: <i>"Pagbangon sa Bagong Umaga: Ang Kwento ng Isang Asawang HIV+"</i>
6	Highlights of the Stakeholders' Forum on Establishing A Sexual and Reproductive Health (SRH) Referral Mechanism for Female Spouses of OFWs
7	Sexual and Reproductive Health (SRH) Directory
8	A Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Filipino Seafarers to HIV Infection and Other Reproductive Health problems
9	Gender-Specific Vulnerabilities of Females Who Inject Drugs (FIDUs) in Metro Cebu and Zamboanga City
10	Program and Policy Implications of Study on Female Injecting Drugs Users



## LIST OF ABBREVIATIONS

ACHIEVE	Action for Health Initiatives, Inc.
ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
ALAGAD	Alliance Against AIDS
AMTP	AIDS Medium Term Plan
BCC	behavior change communication
BIHMI	Brokenshire Integrated Health Ministries, Incorporated
BTL	bilateral tubal ligation
CCSV	Craftstruck Club of Seaman's Village
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHD	Center for Health Development
CHO	City Health Office
DFR	draft final report
DMF	design and monitoring framework
DMPA	depot medroxyprogesterone acetate
DOH	Department of Health
DOLE	Department of Labor and Employment
FGD	focus group discussion
FIDU	female injecting drug user
FR	final report
GAD	gender and development
GDCF	Gender and Development Cooperation Fund
GO	government organization
HDES	Human Development and Empowerment Services
HDII	Human Development Initiatives Institute
HIV	human immunodeficiency virus
IDI	in-depth interview
IDU	injecting drug user
IHBSS	Integrated HIV and AIDS Behavioral and Serologic Surveillance
ILO	International Labor Organization
IMC	ILO Maritime Convention
KABP	knowledge, attitude, behavior, and practices
KAP	knowledge, attitudes, and practices
KII	key informant interview
LGU	local government unit
MARP	most-at-risk population
MHO	Municipal Health Office
MSSSFA	Mary's Star of the Sea Seafarers' Families Association
NCDPC	National Center for Disease Prevention and Control
NEC	National Epidemiology Center
NGO	non-government organization
NTP	notice to proceed
OFW	overseas Filipino worker
PE	peer educator
PLHIV	people living with HIV
PNAC	Philippine National Aids Council
PNGOC	Philippine NGO Council on Population, Health and Welfare, Inc.
POEA	Philippine Overseas Employment Administration



PRIMEX	Pacific Rim Innovation and Management Exponents, Inc.
RAF	Remedios AIDS Foundation
RETA	regional technical assistance
RH	reproductive health
RHU	rural health unit
SRH	sexual and reproductive health
STI	sexually transmitted infection
TNA	training needs assessment
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAC	Veritas Allottees' Circle
VAWC	Anti-Violence Against Women and Children
VCT	voluntary counseling and testing
WCSV	Women's Circle of Seaman's Village
WEF	Women's Empowerment Framework







# **EXECUTIVE SUMMARY**

## EXECUTIVE SUMMARY

1. Subproject 5 of the ADB Regional Technical Assistance for Fighting HIV/AIDS in Asia and the Pacific (RETA 6321) provided technical assistance to the Philippine Department of Health (DOH), local government units (LGUs), and non-government organizations (NGOs) to strengthen the country response to HIV/AIDS, specifically for two groups considered vulnerable, viz., injecting drug users (IDUs) (Component 1) and overseas Filipino workers (OFWs) (Component 2). During the implementation of Subproject 5, several gender-related concerns emerged which had to be addressed to strengthen the gender perspective of the Project outputs.

2. In April 2008, ADB approved DOH's request for funding to enable the conduct of studies and other activities under the project, "**Supporting Women at-Risk and Vulnerable to HIV/AIDS in the Philippines.**" Funding was provided by ADB through the **Gender and Development Cooperation Fund (GDCF) established under RETA 6143**, which supports initiatives to promote gender mainstreaming in ADB operations, gender capacity development, and strategic partnerships.

3. The Project was designed to help (i) increase knowledge and awareness of vulnerable women, specifically female spouses of OFWs, on gender, sexual reproductive health (SRH), and HIV prevention in the Project areas, and (ii) develop policy recommendations for female seafarers and FIDUs in the national HIV and AIDS Program. It was expected to deliver the following outputs: (i) improved knowledge and practice of female spouses; (ii) development of a model for SRH referral for female spouses; (iii) increased knowledge and information on HIV vulnerability among female seafarers; and (iv) increased knowledge and information on female IDUs.

4. The Project worked with three groups of women considered vulnerable to HIV and AIDS, namely: female spouses of seafarers, female seafarers, and female IDUs. It was expected to deliver the following outputs: (i) improved knowledge and practice of female spouses of seafarers; (ii) model SRH referral for female spouses of seafarers; (iii) increased knowledge and information on HIV vulnerability among female seafarers; (iv) increased knowledge and information on HIV vulnerability among female IDUs; and (v) Policy Brief on issues concerning FIDUs. The Project's accomplishments per target output are summarized below.

5. **Output 1: Improved Knowledge and Practice of Female Spouses of Seafarers.** Three spouses' groups in Cavite province, Davao City, and Metro Manila participated in weekend capacity building activities designed to train them to serve as peer educators on HIV and AIDS, gender, sexuality, and SRH. The 21 peer educators have reached out to 110 peers: Cavite (65) and Davao (45). Post-test results revealed an increase in the knowledge and awareness of the female spouses on HIV and AIDS. The Project also accomplished the production of an IEC/BCC material on HIV and AIDS for female spouses, "*Pagbangon sa Bagong Umaga,*" in comics format.

6. **Output 2: Development of a Model for SRH Referral for Female Spouses.** As agreed during the stakeholders' forums held in Dasmariñas, Cavite and Davao City, a directory of SRH service providers was developed and distributed to the female spouses in lieu of establishing a model for SRH referral.

7. **Output 3: Increased Knowledge and Information on HIV Vulnerability among Female Seafarers.** A "*Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Filipino Seafarers to HIV Infection and other Reproductive Health Problems*" was conducted among 43 female seafarers. The study was a pioneering effort to describe and analyze, in a comprehensive way, the gender dimensions of the risks and vulnerabilities, especially to HIV infection, of female seafarers. It was carried out mainly to identify appropriate actions that will help prevent the spread of HIV among them, to their sexual partners and children, within their occupational group, and in society at large.



8. **Output 4: Increased Knowledge and Information on Gender-specific Vulnerabilities of FIDUs.** A “Qualitative Study on Gender-specific Vulnerabilities of Female IDUs in Metro Cebu and Zamboanga City” was carried out among a total of 37 women in Metro Cebu and Zamboanga City. The study examined issues and concerns that confront women who inject drugs for non-medical/non-prescribed purposes and assessed the social and historical roots of problems to enable the identification of potential areas for policy revision and harm reduction operational guidelines.

9. **Output 5: Policy Brief on Issues Concerning Female IDUs.** A discussion paper was developed on issues concerning FIDUs, which presented the program implications of the findings of the above qualitative study on FIDUs and recommended some policy actions. The information can be used in guiding harm reduction programs and in working towards providing a client-friendly provision of services, especially for FIDUs.

10. The Project outputs *vis-à-vis* performance/target indicators based on the Project design and monitoring framework (DMF) are shown in the table below.

Outputs	Performance Indicators/Targets	Remarks
<b>Output 1</b> Improved knowledge and practice of female spouses	<ul style="list-style-type: none"> <li>At least 80 female spouses/partners of seafarers trained as peer educators – <b>Partly achieved</b></li> <li>At least 30% of female spouses/partners able to negotiate regular condom use with their partners</li> </ul>	<ul style="list-style-type: none"> <li>21 female spouses trained to be peer educators (Cavite, 7; Davao, 14) reached out to 110 peers: Cavite (65) and Davao (45).</li> <li>90 seminar participants attended various community-based awareness raising activities: Cavite (26), Davao City (50), and Metro Manila (15).</li> <li>72 spouses attended gender, SRH, and HIV seminars in Cavite (16), Davao City (40), and Metro Manila (16).</li> <li>Condom use: No conclusive quantitative data that can measure whether the target of 30% was reached, but qualitative feedback from peer educators and peer outreach participants indicate spouses' willingness to use condoms and encourage and teach their fellow spouses to use condoms.</li> <li>Review of Existing Behavioral Change Communication (BCC) Material and Identification of HIV Information Needs of Female Spouses of Seafarers completed.</li> <li>BCC material developed in comics format and 2,000 copies produced for distribution.</li> </ul>
<b>Output 2</b> A model for SRH referral for female spouses developed	<ul style="list-style-type: none"> <li>Approved MOU on referral network for female spouses in two cities: Davao and Dasmariñas – <b>Not pursued</b></li> <li>At least two health centers in each project site are involved</li> <li>At least 30% of women reached by the project have been referred for SRH services</li> </ul>	<ul style="list-style-type: none"> <li>Initial mapping of SRH service providers conducted and directory of service providers for distribution to female spouses in Cavite and Davao.</li> <li>At the Final Dissemination Forum, CHDs (Davao and Cavite) committed to convene the stakeholders and local partners to resume the discussion on the referral system.</li> </ul>
<b>Output 3</b> Increased knowledge and information on HIV vulnerability among female seafarers	<ul style="list-style-type: none"> <li>Approved study - <b>Done</b></li> <li>Draft recommendations on gender-specific HIV vulnerability among female seafarers for consideration of the national HIV/AIDS program and policies discussed and agreed upon</li> </ul>	<ul style="list-style-type: none"> <li>Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Filipino Seafarers to HIV Infection and other Reproductive Health Problems completed and presented at two dissemination forums among various stakeholders including DOH.</li> </ul>
<b>Output 4</b> Increased knowledge and information on female IDUs	<ul style="list-style-type: none"> <li>Approved study - <b>Done</b></li> <li>Draft recommendations on specific issues related to female IDUs for consideration of operational guidelines on harm reduction discussed and agreed upon</li> </ul>	<ul style="list-style-type: none"> <li>Study on Gender-Specific Vulnerabilities of Females Who Inject Drugs (FIDUS) in Metro Cebu and Zamboanga City completed and included recommendations on specific issues related to FIDUs</li> </ul>
<b>Output 5</b> Policy brief on issues concerning female IDUs		<ul style="list-style-type: none"> <li>Policy Brief on Program and Policy Implications of Study on Female Injecting Drug Users prepared.</li> </ul>



11. The Project is considered relevant to the needs of the country, particularly in the scaling up of HIV and AIDS prevention interventions for vulnerable populations, both at the structural and individual levels. The Project responded to a call to raise awareness and build capacity of a particular segment of the female OFW population deemed vulnerable to HIV, thereby enabling them to make decisions and take actions that promote safer sexual behaviors. The study on female seafarers is a pioneering study, which not only addresses HIV and AIDS issues among this group, but also gender and SRH issues. Its results will inform policy and program interventions specific to female seafarers. At the final dissemination forum, ILO expressed interest to pursue the discussions on female seafarers as part of the process of ratification of the International Maritime Convention of 2006, particularly in refining the Convention further by the integration of gender issues and perspectives. The research on FIDUs is another pioneering effort as it is the first qualitative and exploratory study on this group of women and their specific behaviors, issues, realities, and needs. The study is accompanied by a Policy Brief, which details policy and programmatic directions that can be taken in order to address various issues and concerns faced by the FIDUs.

12. The Project outcomes and outputs have been substantially achieved, although the female spouses component fell short of meeting its quantitative targets. Various challenges were faced by the Consultant during the implementation of the TA. These included the difficulty in organizing training and capacity building activities involving the seafarers' spouses, who had other domestic activities and other commitments to attend to at the same time that the Project activities were planned. As their domestic responsibilities, especially when their seafarer spouses were due to return home from their overseas jobs, had to be prioritized, training schedules had to be reset at very short notice to accommodate the female spouses' household obligations.

13. There are possibilities for continuing and sustaining the initiatives that have been started by the TA. As a direct follow-up to this TA, both the trained peer educators in Davao and Cavite plan to continue conducting echo seminars, which include integrating HIV awareness seminars in their existing outreach activities among other female spouses and linking up with other organizations and service providers in their areas to address some of their SRH needs.

14. Following are some of the recommendations and agreements reached at the Project's Final Dissemination Forum attended by DOH, PNAC, UNAIDS, POEA, ADB, associations of seafarers' wives, crewing/manning agencies and maritime schools, and the Consultant:

(i) Policy

- PNAC to carry out an inventory of relevant studies and disseminate the data systematically
- Create a team of experts to come up with one-page briefs for policy makers
- Integrate recommendations in AMTP 5
- Identify the women-at-risk and their locations
- Come up with strategies on how to disseminate the information to other sectors

(ii) Programs

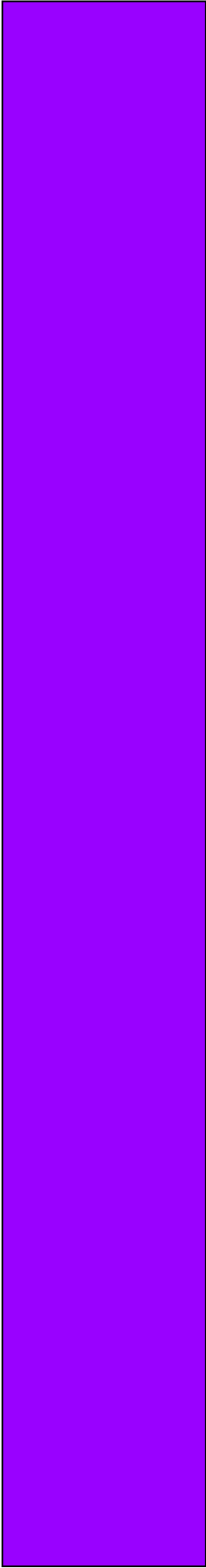
- Renew discussion on SRH with CHD offices
- Partner with PAMI for information dissemination on HIV and AIDS
- Include men in empowerment activities – DOH to specify the role of other sectors/groups
- Pass data to NEC for recording in the Registry
- Invite guidance counselors of maritime schools to a seminar on HIV to disseminate information
- Involve the DOH-CHDs in monitoring and advocacy efforts



(iii) Activities

- PRIMEX to provide pdf version of IEC material (comics) to other agencies/schools
- OWWA and crewing agencies to address family concerns of seafarers, e.g., activities on communication
- DOLE to enroll the association of seamen's wives with SWAPI
- Female spouses to partner with DOH-CHDs
- Build a core of advocates within the manning agencies
- Present the FIDU study to faith-based groups or those involved in the sector
- PRIMEX to make the studies accessible online through DOH, ADB, and PRIMEX websites





**MAIN TEXT**

## I. INTRODUCTION

1. The Asian Development Bank (ADB) approved for financing, on a grant basis by the **Gender and Development Cooperation Fund (GDCF)**, the **Regional Technical Assistance for Promoting Gender Equality and Women's Empowerment (RETA 6143)**, to support initiatives to promote gender mainstreaming in ADB operations, gender capacity development, and strategic partnerships. In April 2008, ADB<sup>1</sup> approved a **Department of Health (DOH) Proposal for Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines** for funding through RETA 6143. The proposed Project was intended to support gender-related concerns which emerged during the implementation of RETA 6321, Subproject 5, which was then under implementation.

2. As a backgrounder, Subproject 5 of RETA 6321 provided technical assistance to DOH, through the **National Center for Disease Prevention and Control (NCDPC)**,<sup>2</sup> to strengthen the Philippine response to HIV and AIDS, specifically for two highly vulnerable groups: injecting drug users (IDUs) and overseas Filipino workers (OFWs). During its implementation of Subproject 5, several gender-related concerns surfaced, which DOH wanted addressed to strengthen the gender perspective of the Project outputs. In **Component 1**, which dealt with IDUs, it was considered important to study the condition of women who inject drugs and to explore the implications of injecting drug use on gender relations between male IDUs and their female partners or between female IDUs (FIDUs) and their male partners. As prior research has shown that about 10% of IDUs are female, including sex workers, it was deemed necessary to obtain an in-depth understanding of the situation of FIDUs for gender-responsive harm reduction (HR) policies and guidelines to be developed.

3. In **Component 2**, which dealt with OFWs, female OFWs were not considered a specific target group in the studies, except in the case of the female spouses of seafarers. Thus, data were not generated on HIV and sexual and reproductive health (SRH) risks among female seafarers, an emerging population among seafarers. At present, no information on the vulnerability to HIV and SRH among female seafarers is available. Hence, the need to undertake a qualitative assessment of their specific vulnerabilities to HIV and SRH to provide gender-specific inputs and information and communication strategies and services tailored for female seafarers in HIV and AIDS programs and policies. Another gap that became evident in Component 2 was the lack of direct community interventions following the conduct of the studies in Phase I. One group of research respondents, the female spouses of seafarers, expressed the need of their community to participate in, and benefit from, an HIV awareness and prevention program, especially since seafarer spouses are vulnerable to HIV and most female spouses are unaware of gender and SRH issues.

4. To carry out the Project, ADB engaged the services of **Pacific Rim Innovation and Management Exponents, Inc. (PRIMEX)**, the consulting firm implementing RETA 6321, Subproject 5, through a consultancy contract signed on 23 May 2008.<sup>3</sup>

5. This Final Report (FR) presents the overall accomplishments of the GDCF-funded TA and the assessment of its performance and impacts, highlights the insights gained and lessons learned in the course of TA implementation, and makes recommendations to ensure the sustainability of TA benefits.

<sup>1</sup> ADB was the TA Executing Agency (EA), with Ms. Barbara Lochmann, Senior Social Sector Specialist, ADB Social Sectors Division (SESS), responsible for managing TA implementation.

<sup>2</sup> Dr. Yolanda E. Oliveros, Director IV, provided oversight supervision of DOH's involvement in TA implementation. DOH counterparts included Dr. Gerard Belimac and Dr. Ethel Dano of NASPCP.

<sup>3</sup> The Consultant Team was composed of the following specialists: Ms. Ma. Lourdes S. Marin, Team Leader; Dr. Maria Fiscalina Amadora-Nolasco and Ms. Sonia T. Tongco, FIDU Study Principal Investigator and Research Assistant, respectively; Mr. Pedrito B. dela Cruz, Policy Advisor on Harm Reduction; Dr. Carolyn I. Sobritchea and Ms. Raquel T. Ignacio, Principal Investigator and Research Assistant, respectively, Female Seafarer Study; Dr. Ma. Theresa U. Batangan, Behavior Change Communication (BCC) Specialist; Mr. Danton Remoto, BCC Writer; Mr. Nestor Escara, BCC Illustrator; and Ms. Josefina Ma. Ferriols-Pavico, Project Coordinator. Ms. Elvira C. Ablaza, President and CEO of PRIMEX, provided oversight, edited the Consultant's reports, and participated in major TA workshops and tripartite meetings.



## II. PROJECT DESCRIPTION

6. The **overall goal** of the Project was to prevent the spread of HIV infection and reduce the risk of sexually transmitted infections (STIs) in women and their partners. Its **purpose** was to (i) increase knowledge and awareness of HIV/AIDS among women at-risk in the Project area, and (ii) develop policy recommendations for female seafarers and FIDUs in the national HIV and AIDS Program.

7. The Project consisted of **three components**, each one dealing with a highly vulnerable group of women, namely:

- **Component 1, or the Female Spouses of Seafarers (FSS) Component**, which entailed the (i) conduct of training for, and awareness-raising activities among, female spouses of seafarers on their HIV vulnerability and SRH needs and (ii) establishment of an SRH referral mechanism for female spouses of seafarers;
- **Component 2, or the Female Seafarers (FS) Component**, which mainly involved the conduct of a qualitative study on female seafarers to identify their gender-related risks and vulnerabilities and propose recommendations to enhance the gender responsiveness of current policies, programs, and services for female seafarers; and
- **Component 3, or the Female Injecting Drug Users (FIDU) Component**, which conducted in-depth case studies of FIDUs and developed a policy brief on improving policy and programming for female IDUs.

8. The TA was implemented based on the design and monitoring framework (DMF) shown in Appendix 1. However, during the course of TA implementation, certain modifications to the DMF had to be made. The *first modification* was agreed upon during the tripartite meeting among ADB, DOH, and the Consultant on 10 July 2008. It was decided that instead of submitting to DOH and PNAC (Philippine National AIDS Council) policy recommendations to address HIV vulnerabilities and risks of female seafarers and female IDUs in the national HIV and AIDS Program, *only a policy brief will be prepared as a concrete output of the FIDU component (Output 5)* since the IDU Component in RETA 6321, Subproject 5 was unable to include needle and syringe distribution in the harm reduction pilot project and just focused on behavior change.

9. The *second modification* involved a change in the target number of 80 female spouses of seafarers trained to be Peer Educators (PEs) after a series of orientation meetings with the spouses' organizations. The multifaceted roles of female spouses posed a challenge for a majority of them, so that only a few could commit to the rigors of the training and the demand for their time away from their families, and further complicated by the scheduling of training during their husbands' home leave. With the concurrence of the heads of the spouses' associations, the performance target of 80 female spouses trained as PEs was adjusted to *10 PEs, 40 seminar participants, and 80 peer outreach participants at each site (i.e., Davao and Cavite)*.

10. A *third modification* involved the referral mechanism discussed at the stakeholders' forums conducted in Davao and Cavite. In view of time and resource constraints, it was agreed that, in lieu of setting up an SRH referral mechanism, which would require further discussions with the service providers before it could be established, *a mapping of existing and available SRH services and service providers will be undertaken, and the information compiled into a directory to be sent to organizations of female spouses and service providers*.





### III. PROJECT ACCOMPLISHMENTS

#### A. Component 1: Female Spouses of Seafarers

11. **This component was designed to produce two outputs:** (i) improved knowledge and practice of female spouses; and (ii) development of a model for SRH referral for female spouses. However, as mentioned above (para. 10), the second output was modified such that, instead of producing a model SRH referral, a directory of SRH service providers was produced for Davao and Cavite.

##### 1. Output 1: Improved Knowledge and Practices of Female Spouses of Seafarers

12. The Project improved the knowledge and practices of female spouses of seafarers through the (i) training of spouses as PEs, (ii) conduct of community-based training and awareness raising activities, and (iii) development of a behavior change communication (BCC) material for distribution to spouses' association, NGOs, LGUs, and DOH regional offices (Centers for Health Development [CHDs]). The specific activities that were carried out under this Component include the following: (i) orientation meetings and training needs assessment (TNA) at each site; (ii) training seminars to increase female spouses' knowledge and awareness of gender and SRH issues and to enhance their skills related to SRH, e.g., safer sex communication skills, condom use, life skills; (iii) training of trainers (TOT) to build the capacity of leaders and PEs among female spouses of seafarers; (iv) peer education activities, such as echo seminars for female spouses, to sustain the education activities; and (v) review and replication of existing BCC materials on SRH and HIV.

13. Most of the women who trained under the Project have given up their careers to be full-time mothers and homemakers. Some have held on to their careers, while others have their own home businesses or domestic livelihood ventures. Whether they are working full-time as housewives or as career women, there are challenges in involving them in political and social activities. Moreover, when their seafarer-husband is home after a tour of duty, their schedule revolves around him. The Consultant recognized this limitation and, thus, adjusted the training schedule around their availability.

##### a. Orientation Meetings and TNA on HIV/AIDS Prevention and SRH

14. **Orientation Meetings.** In the first quarter of the Project, networking visits with, and a TNA of, the members of spouses' associations were carried out at the two Project sites: Davao City and Dasmariñas, Cavite. Both groups of spouses affirmed the need to acquire a deeper knowledge on SRH issues, HIV and AIDS prevention, and safer sex negotiation. However, they expressed their concern that the target of 40 trained PEs at each site would be difficult to attain. A third group of spouses from Metro Manila was eventually included. Hence, the adjustment in the target numbers per site (Table 1).

#### HIV Situation and Female Spouses of Seafarers

Overseas Filipino workers (OFWs) have figured significantly in the *National HIV Registry* as a result of passive surveillance. Their having to undergo HIV testing, as a requirement for overseas employment, facilitates detection of HIV cases among the population.

As of December 2008, they comprised 33% of all cases, with seafarers comprising a significant proportion of these cases. There are also cases of female spouses of seafarers who are infected, but they are not categorized or identified specifically as such since they fall under the general category of local female transmissions.

#### Number of Female Spouses of Seafarers Reached by the Project

##### Spouses trained as PEs:

Modified target: 10 spouses per site or total of 20

Accomplished: 21 spouses (105%): Cavite, 7; Davao, 14

##### Seminar participants:

Modified target: 40 participants per site or total of 80

Accomplished: 90 seminar participants (113%):  
Cavite, 25; Davao, 50; Manila, 15

Total number of spouses reached by the Project: 72

##### Peer outreach participants:

Modified target: 80 participants per site or 160 total

Accomplished: 110 outreach participants (69%):  
Cavite (65), Davao (45)



**Table 1: Information on the Spouses' Organizations**

Site	Spouses' Organization	Focal Person
Dasmariñas, Cavite	Craftstruck Club of Seaman's Village (CCSV) (later named the Women's Circle of Seaman's Village [WCSV])	Prof. Socorro Moralina, President
Davao City	Mary Star of the Sea Seafarers' Families Association (MaSSSFA)	Dr. Elizabeth Malonzo, Professor, Brokenshire College, Davao City.
	Veritas Allottees' Circle (VAC)	Ms. Cecilia Bahan, Davao City Chapter
Manila	Veritas Allottees' Circle (VAC)	Prof. Prescilla Vallarta, Pamantasasn ng Lunsod ng Maynila, Manila

15. **TNA and FGDs.** In Davao City, an FGD with the members of MaSSSFA was held on 12 July 2008 to generate information on the training expectations and needs of the spouses. In Cavite, the CCSV responded to TNA forms administered on 14 August 2008 during an FGD conducted in Tagaytay City. Both groups of spouses affirmed the need to acquire a deeper knowledge on SRH issues, HIV and AIDS prevention, and safer sex negotiation. Three main topics were discussed in the FGD: (i) issues as female spouses; (ii) knowledge on HIV and AIDS; and (iii) training background on migration and HIV and AIDS.

16. **Issues faced by female spouses of seafarers.** The participants talked about their (i) vulnerability to HIV and STIs; (ii) economic dependency on the husband's income, which impacts on their sexual relationship; and (iii) problems that occur between them and their in-laws, especially concerning the control of allotment. They emphasized the need for faithfulness on the part of their husband, but they acknowledged that they have no control over his sexual behavior once he is abroad.

17. **Knowledge on HIV and AIDS.** The participants said that they discuss HIV and AIDS with their husbands. They are aware of the difference between HIV and AIDS and that the virus weakens the immune system. They have also heard of sexually transmitted infections (STIs) such as warts, gonorrhea, and syphilis. To prevent HIV transmission, they mentioned abstinence and condom use. However, they had a lot of misconceptions about HIV, e.g., that it is transmitted through sweat or saliva or that a negative HIV test result means they are protected or safe. Their husbands undergo HIV testing because it is mandatory in their job, but the female spouses themselves do not go for testing.

18. **Training background on migration and HIV and AIDS.** A number of the spouses have already attended seminars and workshops conducted by ACHIEVE on HIV and SRH issues, but majority of the participants had not attended any seminars on these topics. They expressed the need to know more about specific issues so that they can also share and discuss them with their husbands. In particular, they mentioned that they wanted the following topics to be included in the trainings: (i) RH issues; (ii) legal issues, i.e., rights of wives vis-à-vis the "other woman"; (iii) prevention of physical abuse; and (iv) economic empowerment.

#### **b. Training Seminars**

19. To prepare the spouses to be PEs, two training courses were conducted in the two Project sites. The strategy was to (i) build their knowledge on HIV, STIs, gender sensitivity, and the legal basis for gender and development issues; (ii) empower them on safer sex communication; and (iii) enhance their appreciation of their own sexuality. All those who reached the peer education stage had attended at least one foundation training course, expressed commitment to be PEs, and demonstrated good communication skills. Information on the training courses conducted is summarized in Table 2, and the full report on the capacity building activities of the female spouses is in Appendix 2.



Table 2: Summary of Training Courses Conducted for Female Spouses of Seafarers

Women's Group	Title of Training Course	Date	Venue	Topics	No. of Seminar Participants
CCSV, Cavite	HIV Prevention for Female Spouses of Seafarers	6 September 2008	Women and Ecology Wholeness Farm, Mendez, Cavite	<ul style="list-style-type: none"> <li>• Reproductive Health</li> <li>• HIV Situationer</li> <li>• HIV101</li> <li>• STIs</li> <li>• Safer Sex</li> <li>• Condom Use Demonstration</li> <li>• Testimony on Vulnerability</li> </ul>	14
	Gender Training for Female Spouses of Seafarers	4 October 2008	Women and Ecology Wholeness Farm, Mendez, Cavite	<ul style="list-style-type: none"> <li>• Sex, Gender, and Sexuality</li> <li>• Gender Equality and Women Empowerment Framework</li> <li>• Action Planning to Promote Gender Equality and Equity</li> </ul>	11
	Peer Educator's Training (TOT)	21-23 November 2008	Hotel Kimberly, Tagaytay City	<ul style="list-style-type: none"> <li>• Answering questions of participants</li> <li>• Core Messages for PEs</li> <li>• Condom Demonstration</li> <li>• Safer Sex Activities</li> <li>• Risk Continuum</li> <li>• Fun Games</li> <li>• Initial Assignments</li> <li>• Individual Lecture Demo</li> </ul>	7
Davao: • MASSSFA • VAC	Reproductive Health Awareness Seminar / Workshop	11-12 September 2008	Microtel Inn and Suites, Davao City.	<ul style="list-style-type: none"> <li>• Basic Gender Concepts</li> <li>• Manifestations of Gender Bias</li> <li>• RA 9262 – Violence Against Women and Children (VAWC)</li> <li>• Gender Equality and Women Empowerment Framework</li> <li>• Concept of Power</li> <li>• Reproductive Tract Infections</li> <li>• Body Image and Health</li> <li>• HIV 101</li> </ul>	25 MaSSSFA (22); VAC (3)
	Skills Training on Sexual and Reproductive Health for Female Spouses of Seafarers	17-18 October 2008	Eden Nature Park and Resort, Davao	<ul style="list-style-type: none"> <li>• Communication Skills</li> <li>• Safer Sex Communication</li> <li>• Condom Use Demonstration</li> <li>• Rights and Responsibilities of Allottees</li> <li>• Sexuality</li> <li>• Testimony on vulnerability</li> </ul>	25 MaSSSFA (22); VAC (3)
	Peer Educator's Training (TOT)	14-16 November 2008	Hotel Elena, Davao City	<ul style="list-style-type: none"> <li>• Answering questions</li> <li>• Core Messages for PEs</li> <li>• Condom Demonstration</li> <li>• Safer sex activities</li> <li>• Risk Continuum</li> <li>• Initial Assignments</li> <li>• Individual Lecture Demo</li> </ul>	14 MaSSSFA (11); VAC (3)
VAC, Metro Manila		22 November 2008	Veritas Training Center, Manila	<ul style="list-style-type: none"> <li>• HIV 101</li> <li>• HIV Situationer</li> <li>• Wildfire</li> <li>• Testimony on Vulnerability</li> <li>• Condom Use Demo</li> </ul>	15

20. In these sessions, the female spouses were jolted to realize how vulnerable they are to HIV when invited HIV-positive spouses gave testimonies about how they contracted the virus from their husbands, and how they are coping either as a couple (both HIV-positive) or as a widow. Some of their significant realizations were related to equality and equity, power and decision-making, sex, and gender, namely:



- The lesson on **equity and equality** made them realize that they have to decide on “*what they really want — equality or equity.*” In the words of another participant, “*Equality recognizes equal treatment of men and women, but equity takes into consideration the differences between men and women and what needs to be in place to produce an outcome that is equitable.*”
- The lesson on **power and decision-making** made them realize the difference between “power over” and “power within,” and that power over does not necessarily mean triumph over gender issues.
- The lesson on **sex and gender** made them realize that as wives, they need to have equal rights.
- The discussion on **RA 9262** made it clear that marital rape is a criminal offense, and that a marital rape law exists.
- The participants agreed to strategize on how to request crewing agencies to integrate Gender Sensitivity Training for Male Seafarers and how to **negotiate for safer sex with their partners**. A day after the training, a participant sent a text message to a trainer to report success in applying a condom on her husband without his knowing it by applying a technique learned during the workshop.

### c. Training of Trainers (TOT)

21. To build the capacity of leaders and PEs among female spouses of seafarers, the Project **conducted PEs’ training for 21 female spouses of seafarers**: 7 from CCSV, Cavite; 11 from MASSSFA, Davao; and 3 from VAC, Davao. The training included a review of the core content of peer education sessions, viz., basic HIV and AIDS (HIV 101) and vulnerability of female spouses to HIV and condom use. The learning methods included group work exercises, actual lecture demonstration by all participants (which was videotaped for immediate viewing and feedback), and demonstration on condom use. The TOT was facilitated by Mr. Joselito de Mesa with inputs from Ms. Malu Marin.

22. To qualify for the peer education training course, the participants should meet the following criteria:

- must be a female spouses of seafarers;
- committed to participate as a volunteer peer educator;
- possesses good communication skills; and
- has participated in previous training seminars of the Project.

23. From 14-16 November 2008, the peer education course was conducted at the Hotel Elena in Davao City for MASSSFA and VAC spouses. On 21-23 November 2008, the PEs’ training-workshop was held at the Hotel Kimberly in Tagaytay City for CCSV of Dasmariñas, Cavite. The design of the PEs’ training was based on a prior TNA carried out by the Training Team, which identified the participant’s knowledge and skills gaps (Table 3).



**Table 3: Knowledge and Skills Gaps Identified through the TNA**

What knowledge would you like to be clarified on?	<ul style="list-style-type: none"> <li>• In-depth understanding of HIV/AIDS</li> <li>• How to empower women</li> <li>• Process on how to effectively echo what we learn</li> <li>• Statistics on HIV and AIDS</li> <li>• Medical information</li> <li>• More information on how to prevent being infected by HIV</li> </ul>
What questions or issues might be difficult for you to answer?	<ul style="list-style-type: none"> <li>• How do we handle peers who are positive?</li> <li>• How can we affect them in a positive way?</li> <li>• How will we know if the person is infected without being tested or did not go through HIV Test</li> </ul>
What skills do you want to develop for this topic?	<ul style="list-style-type: none"> <li>• How to become an effective educator/facilitator – effective process or approach</li> <li>• Report writing</li> </ul>
What issues do you think might be difficult for you to discuss or handle?	<ul style="list-style-type: none"> <li>• Gender issues</li> </ul>
What questions from participants might be difficult for you to answer?	<ul style="list-style-type: none"> <li>• What is our clear stand on this issue?</li> <li>• How are we going to handle these ourselves?</li> <li>• How can we totally eradicate HIV?</li> <li>• Medical terms for HIV/AIDS symptoms</li> </ul>
What skills as PEs do you want to develop?	<ul style="list-style-type: none"> <li>• Public speaking, how to become an effective educator</li> <li>• Talking clearly and slowly</li> <li>• Knowledge on the issue</li> </ul>

24. The peer education training workshops enabled the participants to (i) deepen their knowledge on HIV and AIDS, safer sex, and other gender and sexuality-related issues; (ii) develop their skills on how to become effective PEs on HIV and AIDS prevention; and (iii) formulate action plans for the conduct of the peer education activities. Above all, the training enabled the women to build and enhance their self-confidence and sense of self-worth. Being able to productively engage and respond to an important issue facing female spouses of seafarers has also enabled their respective organizations to strengthen solidarity and support within their community.

#### d. Peer Education Activities

25. **CCSV, Cavite.** As a result of their engagement with the Project, the female spouses of CCSV formally formed their Team of Trainors as the Women's Circle of Seaman's Village (WCSV). This was launched on the occasion of the World AIDS Day celebrations on 1 December 2008. The WCSV spouses, who now have a "*deeper mission to raise awareness of [their] peers on their vulnerabilities to HIV,*" also conducted their first echo seminar.

26. The PEs conducted three echo training seminars and were able to reach out to a total of 65 peers: 21 participants at the 1 December 2008 seminar, 19 trainees on 6 December 2008, and 25 trainees on 24 January 2009. During the first two sessions, they targeted peers within their village; on the third session, they reached out to peers in other villages.

27. The Cavite spouses came up with their own day-long module and called it, "*Let's be Safe: HIV Awareness for Female Spouses of Seafarers.*" The morning session consisted of a (i) pre-test to determine the entry level of knowledge of participants on HIV and AIDS; (ii) Project overview to introduce the Project and the process of developing the core group of PEs; and (iii) HIV 101 to provide basic information on HIV and AIDS, including the modes of transmission of HIV, prevention methods, and important core messages. The afternoon session focused on "Safer Sex," which included a condom demonstration. Workshop-type group discussions and an open forum helped process the feelings and attitudes of the participants towards the use of condoms and other related issues. Towards the end of the



seminar, each participant was requested to accomplish the post-test and evaluation form. The PEs processed any misconceptions or unclear concepts that were still lingering in the minds of the participants based on their post-test responses.

28. **MaSSSFA and VAC, Davao City.** On 17 December 2008, the PEs of MaSSSFA and VAC Davao teamed up and kicked off their first echo seminar. A total of 20 participants attended the seminar. They adopted the program designed by WCSV, but innovated their own games and ice breakers. The whole day program included an input on basic HIV and AIDS issues, safer sex practices, and condom demo. At the end of the seminar, post-test and evaluation of the seminar were carried out. However, the pre-test/post-test was done through an exercise, rather than individually filled forms. The training was videotaped to enable the Consultant Team to provide feedback on their performance as PEs.

29. On 17 January 2009, the Davao PEs conducted their second and last echo training under the Project, and reached out to a total of 25 spouses. The training sessions ran for one whole day and involved a new batch of PEs who were not involved in the first echo seminar. They invited not just MaSSSFA members but also other spouses from various communities in Davao City. Upon completion of the seminar, the PEs convened to hear feedback from the RETA Team Leader on their performance. Specific comments were made on their good points as well as weak points, i.e., areas for improvement, which included mastery of content; more appropriate exercises; and timing and overall conduct of the sessions. The peer education outreach seminars is documented in a comprehensive training evaluation report based on the pretest/posttest performance and evaluation forms in Appendix 3.

30. In all three areas, the peer education activities enabled the trained PEs to practice their skills in organizing and conducting HIV and AIDS seminars for their peers. This has also raised their profile in the community as an organization committed to improve the lives of their female spouse-peers. The conduct of these seminars has also resulted in more spouses discussing sensitive issues (such as sex, sexuality, and gender dynamics between husband and wife), obtaining the correct information on HIV and AIDS, and learning the proper way to use condoms.

#### e. Review and Replication of Existing BCC Materials on SRH and HIV

31. In August 2008, two FGDs involving female spouses from CCSV (9) and VAC (12) were held to solicit information from the spouses on the kinds of BCC material that would appeal to them in terms of content, design, and type. The two FGDs covered the following topics: (i) notions of SRH and HIV; (ii) SRH needs of spouses; (iii) advocacy/information dissemination campaigns on HIV and AIDS; and (iv) evaluation of *"Taking Control: Life Skills Manual for Female Spouses of Migrant Workers,"* a manual produced by ACHIEVE for female spouses of OFWs.

32. The results of the FGDs showed that the participants had varying perceptions of SRH based on their age group and life cycle stage. The younger group referred to SRH in relation to physical health and disease, while the older group related the concept to sexuality and rights. The participants are aware of HIV and AIDS, but their knowledge is limited to transmission. They had questions on the origin of HIV and the other modes of transmission, treatment, and prevention. Both groups wanted to know more about HIV. For those who have benefited from IEC materials on HIV, the effects of increased knowledge have only influenced their behavior intent, but have not translated into specific safer sexual behaviors. Both groups found the manual very useful, and they were able to relate to its content. However, they recommended that it be packaged in a more popular and shorter version for easier dissemination.

33. **Conclusions Drawn from the Review.** In November 2008, the BCC Specialist submitted a full report entitled, *Review of Existing Behavioral Change Communication (BCC) Material and Identification of HIV Information Needs of Female Spouses of Seafarers*, containing the assessment and recommendations on possible storylines, core messages, layout, and type (Appendix 4). The review of BCC materials used the revised framework, based on the Theory of Reasoned Action and Personal



Behavior (TRAPB)<sup>4</sup> developed by Fishbein and Azjen (cited in McKee *et al.*, 2000), to draw the following conclusions:

- The current attitude of the FGD participants towards HIV prevention is positive and is characterized by increased recognition of their vulnerability given the perceived sexual behaviors of seafarers overseas. However, there is still denial in terms of the possibility of their partners engaging in extra-relational sexual behaviors (as they persist in believing that their partners are sexually faithful), which serves as a hindrance to fully recognizing the sexual and reproductive risks they need to face. This is further sustained by cultural expectations and discourses of “trust” and “sincerity” in intimate relationships, which shapes the norms of the husband-wife interaction.
- Furthermore, the FGD participants do not recognize that they have control over the maintenance of their SRH and needs. Though they can engage in autosexual behaviors to address their sexual needs when their partners are not physically present, they surrender this right when their husbands are around. They seldom negotiate when it comes to sex and are expected to remain available to their partners every time. Culturally defined gender roles and power relationships between males and females serve as contexts for this. Thus, though the behavioral intent of avoiding possible HIV infection is present, this is never translated into the desired behaviors (i.e., practice of safer sex) with one’s husband.

34. **Development of BCC Material.** As the spouses are inclined to prefer an illustrated pamphlet or comics-type material, a BCC writer, who specializes in producing IEC materials on HIV prevention, was tapped to write the storyline. Other relevant texts (e.g., basic information on HIV and AIDS) were adopted from an earlier pamphlet of ACHIEVE for seafarers. Given the abovementioned conclusions in the BCC report and the ACHIEVE-produced BCC material, *Ang Pagbabalik ni Leo*, the BCC writer developed the storyline for the new material using the comic book approach. A BCC illustrator then translated the text into comics form.

35. In addressing the needs of female participants for materials that will promote SRH awareness and HIV/AIDS prevention, the writer took note of the findings and recommendations from the BCC report, such as messages, media, characters, storylines, etc., as suggested by the female spouses. The story, *“Pagbangon sa Bagong Umaga: Ang Kwento ng Isang Asawang HIV+,”* is about a female spouse who gets diagnosed with HIV and discovers her husband’s HIV status in the process. It shows how she coped with the situation, rose above the difficult circumstances, and regained control of her life. The comic book, included as Appendix 5, tackled and demonstrated situations of vulnerability of female spouses and linked these with existing realities that seafarers face while at sea. It also placed the realities of female spouses within the context of current HIV awareness, i.e., low knowledge and awareness on the issues and practice of unsafe behaviors.

36. In the final dissemination forum conducted for this TA, representatives from manning agencies, maritime schools, spouses’ associations, and other NGOs recommended that the comic book be distributed in various drop-off points such as manning agencies, Social Hygiene Clinics (SHCs), SRH service providers in the Project sites, and maritime schools, among others. The content of the material has also been reviewed by NASPCP and recommended for printing and dissemination.

<sup>4</sup> TRAPB stipulates that a particular behavior is a product of one’s personal attitude, subjective norm, perceived behavioral control, and behavioral intent, as well as cultural factors that impact or sustain the abovementioned elements of behavior change.



## 2. Output 2: Development of a Model for SRH Referral for Female Spouses

37. The Project aimed to establish a local SRH referral mechanism for female spouses of seafarers to facilitate their access to SRH services in their localities. In the TA DMF, the performance targets include the following: (i) an approved Memorandum of Understanding (MOU) on a referral network for female spouses in two sites: Davao and Dasmariñas; (ii) at least two health centers in each Project site; and (iii) at least 30% of women reached by the Project referred for SRH services. Such services include gynecological examinations, HIV testing, and treatment of sexually transmitted infections (STIs). It is assumed, though, that women are confident in utilizing SRH services; however, the risk is that these services, at the local level, may not always be available and affordable.

38. **Coordination Meetings with LGUs.** The preparations and coordination for this activity were undertaken simultaneously with the preparations for the training of female spouses in Dasmariñas, Cavite and in Davao City. In the months of September and October, the Consultant Team conducted courtesy visits to the concerned LGU partners (viz., Mayor's office, City Health Office [CHO], SHC, and Center for Health Development [CHD]-Davao) and (i) presented an overview of the Project, (ii) discussed the rationale for establishing an SRH referral system for the target clientele, and (iii) arranged for a common date for the conduct of the Stakeholders' Forum as well as a list of possible stakeholder invitees to the forum. On 10 September 2008, the Team Leader and the Project Coordinator paid courtesy calls on the Office of the Davao City Mayor, the CHD-Region XI, and the Amosup Seaman's Hospital. On 22 October 2008, the Project Team visited the Office of the Mayor of Dasmariñas, Cavite, the Rural Health Unit (RHU-I), and the Provincial Local AIDS Task Force in Trece Martires, Cavite. The Project was invited by the Local HIV Coordinator to attend the meeting of the Local AIDS Task Force held at the Session Hall of the Provincial Capitol in Trece Martires, Cavite on 5 November 2008. The Consultant Team was asked to make a presentation on the Project and invite the meeting participants to the Stakeholders' Forum.

39. **Stakeholders' Forum.** A forum with stakeholders was conducted in Davao City and Dasmariñas, Cavite, respectively. The Project Team made presentations on the Overview of the Project and the results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers (from RETA 6321). The latter study has shown that female spouses of seafarers, although economically secure, are more vulnerable to the risky practices of their spouses leading to STI and HIV. The Forum provided a venue for discussing the mechanics and processes of the establishment of the referral system especially with regard to STI/HIV prevention. During the open forum, the SRH service providers provided information on the services that they were currently providing. At the end of the meeting, a focal person from among the female spouses of seafarers gave their reactions to the presentations. The proceedings of the stakeholders' forums in the two locations are included as Appendix 6.

40. On 16 October 2008, a Stakeholders' Forum for SRH and HIV and AIDS Service Providers was conducted at the Oasis Garden Resort and Restaurant, Davao City with 19 participants representing government offices (DOH-CHD XI, Davao CHO, OWWA XI), NGO (ALAGAD), private hospital (BIHMI), and organizations of female spouses (MaSSSFA and VAC). On 18 November 2008, the Stakeholders' Forum was conducted at the David's Tea House in Dasmariñas, Cavite. The Forum was attended by 23 participants representing government offices (DOH-CHD IV-A, RHU I/II, Local AIDS Council, Office of the Mayor), private hospitals, and the female spouses from CCSV. The Forum mapped out the needs of the female spouses for health services *vis-à-vis* the health and non-health services available from the service providers present.

41. Participants in both stakeholders' forums discussed the idea of an SRH referral mechanism and shared their existing SRH programs and services. *However, in lieu of a referral mechanism, which would still require further discussion with the service providers, it was decided that a mapping of existing and available SRH services and service providers be undertaken.* In Davao, the participants said that there is an existing referral system specific to HIV and AIDS-related services, which could also be utilized for SRH-related services, such as treatment for STI and HIV. Other referral systems, such as those dealing





with issues related to violence against women, also have a referral system in place. These include law enforcers, hospitals and medical services, the courts, and counseling centers. The participants agreed that once the mapping is done, it will be compiled into a directory and sent to organizations of female spouses and service providers (Appendix 7). The Davao CHO and the Dasmariñas, Cavite Municipal Health Office (MHO) both committed to address SRH concerns of female spouses in their areas.

## B. Component 2: Female Seafarers

### Output 3: Increased Knowledge and Information on HIV Vulnerability among Female Seafarers

42. A “*Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Seafarers to HIV Infection and Other Reproductive Health Problems*” was carried out to describe and analyze, in a more comprehensive way, the gender dimensions of female seafarers’ risks and vulnerabilities, especially to HIV infection. The study was carried out mainly to identify appropriate actions that will help prevent the spread of HIV among the female seafarers to their sexual partners and children, within their occupational group, and in the larger society. The specific objectives of the research were:

- to identify the risks and vulnerabilities of female seafarers to reproductive health problems, especially to HIV infection, according to work designation, education, family background, and knowledge, attitude, behavior, and practices (KABP) about RH and HIV and AIDS;
- To determine the extent of their access to SRH services and information;
- To identify the gender-related barriers and opportunities to promote reproductive health and safer sex practices among the females in the seafaring industry; and
- To recommend measures to enhance the gender-responsiveness of current policies, education, and advocacy programs and services for seafarers and other migrant workers of the government, the private sector, the associations of seafarers, and NGOs.

**HIV Situation and Female Filipino Seafarers**  
The Philippines is one of the leading sources of sea-based workers in the world. In 2007, a total of 266,553 seafarers were deployed, constituting 25% of the total deployment of OFWs. POEA data indicate that only 3% of the 230,022 seafarers deployed in 2006 were females. However, they already constituted 15.5% of all those employed in passenger and cruise vessels. Of the 6,436 females in the seafaring industry in 2006, 5% were non-officers, while less than 1% (25) were officers, mainly in cargo vessels. The majority (93%) were deployed in passenger or cruise vessels, mainly as bar and restaurant waitresses, crew stewards, casino dealers, and massage attendants.

43. The study involved secondary data gathering, literature review, development of research tools, and primary data gathering through four FGDs, nine in-depth interviews (IDIs), and five KIIs with policy makers and program managers of institutions directly involved in promoting the welfare of workers in the maritime industry. The data gathered were used to examine the causes and manifestations of risks and vulnerabilities of female seafarers to reproductive health problems, particularly HIV infection. Thirty-six respondents (34 females and 2 males) participated in the study. Most of the women are single and belong to the early and middle reproductive age groups (20-40 years old), and have reached tertiary or college level of education. Very few (six from non-passenger ships and one from a passenger ship) hold technical or managerial positions. Less than one-third (15) had either a year or less than a year of maritime work during their last contract, while seven identified themselves as “first timers.” Only 10 of the women have worked on board cargo and passenger ships for more than five years. The findings of the study are summarized below, and the full report is in Appendix 8.

44. **Sociocultural and Economic Contexts of Female Seafaring.** Understanding the social, cultural, and economic contexts of female seafaring is important in developing measures, particularly policies and programs that can prevent labor abuses and eliminate their risks to reproductive health problems and sexual abuses.



45. **Reasons for Becoming a Female Seafarer.** When asked about their motivations or reasons for becoming a seafarer, the answers of many FGD and IDI participants had to do with a strong desire, especially of the married ones, to augment their income so that they can improve the economic condition and quality of life of their respective families. Those who are single spoke of their responsibility, as surrogate parents, to send their siblings to school. Others, meanwhile, mentioned the need to give financial support to aging parents or poor relatives. The married women seafarers were particularly aware of the need for them to help augment the income of their husband, even if doing so meant being away from their young and growing children. It is worth noting that some of the women who had seafarer fathers and brothers discouraged them from getting into the same occupation.

46. **Life in the Academy.** Being a female in a maritime school does not generally confer any special treatment or attention. Since very few women have, in fact, enrolled in maritime courses over the years, the curricular requirements are the same and applied uniformly to both sexes. Although some schools have instituted policies to help the female students deal with their RH concerns, like being exempted from physical drills during their menstrual period, some of the study participants said that they did not avail of such privilege. They studied and performed all the curricular requirements just as hard as their male peers. As aptly put by one of the female cadets, "*lahat ng ginagawa ng lalaki, ginagawa namin.*" (We do everything that was required of our male classmates.) The other female participants, however, said that they availed of such privilege or "special treatment" and insisted that "even if they enrolled in a male-centered educational institution, they were still female and entitled to behave like one."

47. **Notions of Femininity and Masculinity.** This study probed into the ideas about sexuality and femininity that the female seafarers acquired in early life. The Study Team wanted to find out whether such beliefs and norms can explain their current perceptions, attitudes, and behavior about gender relations. It is interesting to note that the nine case study participants who answered this question gave very similar responses. Nearly all came from families that hardly talked about sexuality-related topics and issues. They claimed to have been brought up in traditional ways, "*where women should not talk openly and actively acquire information about sexual matters.*" Most of what they presently know about sexuality and reproductive health were acquired later in life from peers, through the media, and sparingly, from the classroom. Some stereotyped beliefs about gender identities and roles acquired in early life seem to have influenced the manner by which female seafarers deal with everyday life at sea.

48. **Perceptions of Labor Conditions and Nature of Relationships among Ship Personnel.** The perceptions of the women who participated in this study about the condition of their work at sea varied according to the nature of their job. Those who worked as cabin stewardesses of cruise vessels found their work to be so tiring and tedious since they usually work for more than 12 hours daily. The female cadets of cargo vessels, on the other hand, described their work as both physically and emotionally demanding. They have to strictly conform to daily work routines, regardless of being female, while having to deal emotionally with an all-male company. So as not to invite unwanted romantic or sexual attention from the male crew members, some female cadets said that they have to "dress, talk, and behave" like men. Alcohol drinking is a regular form of pastime, especially among male crew members. The FGD participants said that some women participate in these "drinking sessions," which are sometimes done in male cabins. These are occasions when female seafarers risk being raped or sexually harassed.

49. **Other Gender Issues.** Numerous gender issues were mentioned by both the ship officers and ratings who participated in the research. They claimed that the generally masculine or male-centered nature of work on board cargo and passenger vessels make it extremely difficult for women to perform their work. Among female ship officers, the most serious problem is their lack of female company on board cargo vessels. It is the usual practice at present to have just one or two female cadets in a cargo vessel consisting of some 30 personnel. This practice or arrangement exposes women to the dangers of rape, sexual harassment, and sexual assault. They have to behave in a masculine manner in order to deflect the sexual advances of male crew members. The lack of gender-sensitive provisions in most international policy guidelines for maritime service, including the *Maritime Labour Convention of 2006*, is



a major barrier, some argued, to protecting women seafarers from safety and security issues brought about by their biological needs and social characteristics.

50. However, the other research participants insisted that there are adequate policies on board that now protect female workers from rape and sexual harassment. There are procedures and mechanisms now imposed, especially by Western or Europe-based principals, to ensure the prevention and speedy resolution of gender-related issues like sexual harassment and sexual assault. Other FGD participants also underscored the importance of self-discipline and determination not to engage in risky sexual behavior or not to predispose oneself to situations that will make them vulnerable to romantic or sexual assault. Others carry a tear gas mace spray whenever they are out of their cabin while others lock their cabins at night and devise and install an alarm system in their cabin door.

51. **Unmet Reproductive Health Needs.** Majority of the FGD participants complained about the lack of regular access to reproductive health information and services. In terms of health and medical services, they mentioned the following issues:

- Difficulty in communicating with the medical personnel due to language barriers. Some said that *“there are no Filipino doctors on board to understand our health concerns.”* Others claimed that, sometimes, the doctors prescribe the wrong medicine.
- Health and medical service providers do not give reproductive health information like how to prevent pregnancy, when to go for STI tests, or what to do when one has painful menstruation.
- The clinic on board passenger vessels is open for a limited period of time only during the day.
- Tests and medication for STIs and other RH problems are not provided by some principals.
- Only condoms are given for free to the crew members. In some ships, the women are given only one packet of contraceptive pills. They have to purchase the rest. In other ships, however, either no pills are given for free, or all pills are free.

52. **Extent of Awareness about Reproductive Health Matters.** It is disturbing to note, for instance, that when asked some questions to assess their extent of knowledge about human sexuality, very few participants were able to give correct answers. Many were not aware of the ovulation cycle or when it is safe or unsafe for a woman to have sexual intercourse. Others did not know the causes and symptoms of STIs or how they can be prevented. Perhaps because most of the FGD and IDI participants are relatively young and new in the seafaring industry, many had very limited knowledge about STIs, including HIV and AIDS. While some said that they really did not know much about the nature and cause of HIV infection, others linked the disease to *“having sexual intercourse with women in prostitution,” “having multiple sexual partners,” “not using condom,”* and *“not being hygienic.”* A few described the symptoms of HIV infection as *“losing weight, feeling weak, and getting easily tired.”*

53. Adherence to beliefs like washing oneself thoroughly after having sex to prevent HIV infection underscores the need to step up current efforts to improve the access of female seafarers to RH information and services. Nonetheless, some of the women also claimed that the best measures against STIs are monogamy, fidelity, and *“self-control.”* Others mentioned praying, masturbation, *“phone sex with husband,”* and frequent communication with loved ones back home as ways to cope with sexual urges and to prevent having sexual relations with a crew mate. The thought of taking a blood test again for contract renewal purposes, is what keeps the others from engaging in unsafe sexual practices. The research participants mentioned the following sources of information about STIs and HIV: (i) school; (ii) pre-departure orientation and IEC materials given by manning agencies and principals; and (iii) on-board seminars given by the ship doctor.



54. **Factors that Predispose and Protect Women Seafarers from HIV Infection.** Other than the risk of being possibly raped or subjected to forced sexual relations on board, another factor that predisposes women to HIV infection is the attitude of some to accept the “polygamous” nature of males and the inevitability of being attracted to a co-worker, presumably due to the “nature of life at sea. Female seafarers, in fact, generally take a pragmatic view of sexuality and reproductive health issues. Many consider it “normal” and inevitable that crew members will get romantically and sexually involved with each other regardless of their civil status. What they usually do, they said, is just to admonish their partner to observe safer sex. However, there are women who do not like the use of condom and are, therefore, at greater risk of contracting STIs, especially HIV. Nonetheless, some said that they try to minimize the risk by having regular medical check-ups, including HIV blood testing. However, the women do not subject themselves to voluntary testing. The medical check-up they go through is one of the requirements before going on board.

55. **Policy and Institutional Initiatives to Promote Gender Responsiveness of the Maritime Industry.** In addition to the collection of qualitative data on the risks and vulnerabilities of female seafarers to HIV infection, the Study Team interviewed key personnel, such as those from the International Maritime Organization (IMO) and the Maritime Training Council (MTC), who are charged with policy development and enforcement in the shipping industry. This was meant to assess the extent to which these organizations have helped and promoted the safety and security of female seafarers. The Study also looked at the *International Maritime Convention of 2006 and Related International Instruments for the Protection of Seafarers*. The occurrence of various discriminatory practices against women workers shown by this study underscores the need for a comprehensive gender analysis of the Convention. The conditions of employment, for example, must include guidelines that can prevent the occurrence of gender-based abuses and violations. The provisions that define the enforcement mechanisms at all levels must be strengthened to include gender-sensitive guidelines on the investigation and management of cases like rape, gang rape, and sexual harassment.

56. The results of this research indicate the presence **in the shipping industry of many gender issues that make women more vulnerable to abuse and RH problems**, compared to their peers in land-based work. Work-related gender biases, such as the lack of a toilet for females in cargo vessels and the “gender neutral” language of labor, safety, and security policies all ignore the special needs of women due to their different biological functions and characteristics.

57. The study found that while some principals or ship owners have very strict rules that govern the interpersonal relations between passengers (in cruise vessels) and ship personnel, and among the crew members themselves, there are also those which hardly enforce rules of the code of employee conduct. In most cases, health and medical benefits are not sensitive to the reproductive health needs of women. Some manning agencies and principals do not provide regular services for pregnancy tests and STI testing and treatment. There is a wide variation, as well, in the current capacity of principals and manning agencies to raise the awareness of seafarers about HIV and AIDS. While some have institutionalized HIV and AIDS prevention and control programs, others have not done so. What this observation implies is that the risk and vulnerability of female seafarers to RH problems, therefore, vary greatly depending on the policies and practices observed by the principals and manning agencies which hire them.

58. This research validates the findings of earlier studies (PRIMEX-ACHIEVE-RAF, 2008; ACHIEVE, 2005; Sunas et al., n.d.) about the presence in the seafaring industry of individuals, females and males, who both practice and do not practice safer sex, who are able and unable to protect themselves from reproductive health risks and vulnerabilities. Development interventions must, therefore, seriously account for such differences and diversities. Homogenized or the “one size fits all” interventions, be they policy, program, or services for HIV prevention and control, will likely fail to deliver the desired results.

59. *The most significant finding of this study is the presence of many policies and practices with the shipping industry, in both the cargo and passenger vessels, that ignore, if not condone, the gender biases*



*and discriminatory practices*. It is important that these issues be addressed immediately given the increasing number of women employed in passenger or cargo vessels. The vulnerability of women to HIV infection, as this study has shown, is brought about by the male-centered nature of the shipping industry that fosters, among others, discriminatory practices and conditions that put them at risk of being sexually abused.

60. The **specific recommendations** of the research participants and the Study Team are as follows:

- Strengthen current advocacy efforts to promote the gender-responsiveness of existing diplomatic agreements (e.g., through IMO) and international covenants (e.g., through ILO). This will entail a comprehensive gender analysis of the *Maritime Labour Convention of 2006* to identify the gender gaps and possible amendments. There is also a need to ensure the equal access of female seafarers to income and health and medical benefits now enjoyed by land-based female workers, as enshrined in international human rights instruments like the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, which has been ratified by 184 countries.
- Review and improve existing training, education, and advocacy materials to account for the additional risks and vulnerabilities of women seafarers.
- Strengthen the capacity of women's organizations within the maritime industry to effectively promote the labor and reproductive health rights of female workers in the maritime industry. There are a number of women's groups within the maritime industry.
- Conduct more intensive research to examine in greater detail the existing international maritime labor and safety/security conventions and agreements as well as local policies for possible discriminatory provisions.
- Conduct a comprehensive assessment of the impacts of the HIV prevention training modules that have been integrated into the curriculum of maritime schools.
- Strengthen the capacity of oversight and regulatory offices to monitor the performance of manning agencies and training institutions. There is a need for stricter enforcement of rules that would protect women from rape, sexual harassment, and other forms of abuse.

### C. Component 3: Female IDUs

#### 1. Output 4: Increased Knowledge and Information on Female IDUs

61. A qualitative study was conducted on the gender-specific vulnerabilities of FIDUs in Metro Cebu and Zamboanga City to (i) examine issues and concerns that confront women who inject drugs for non-medical/non-prescribed purposes, (ii) assess the social and historical roots of problems, and (iii) identify potential areas for policy revision and harm reduction operational guidelines. The study involved the conduct of one-on-one interviews with 17 women (15 in Metro Cebu; 2 in Zamboanga City) and two FGDs with 20 women participants in Zamboanga City. The key findings and recommendations of this study are summarized below, and the full report is in Appendix 9.

62. **Injecting Drug Use.** Combining the results of the case studies and FGDs, the study showed that many of the FIDUs started using drugs at an early age, i.e., when they were in high school, primarily as a result of peer influence and curiosity. The others traced their first use of drugs to difficult situations within the family, e.g., marital conflict between parents, violence, maltreatment, and sexual abuse, and as a result of a relationship with a drug-using partner or an IDU boyfriend. While the Metro Cebu participants can be considered regular users of injectable drugs (median: 4x/day), responses obtained from the Zamboanga women varied (case study: 1-2x/day; FGD: once a month or everytime there is a special event).



63. The study showed that injecting drug use in women is not limited to sex workers. This could mean that the general population is at risk of exposure to HIV, particularly when these women engage in unprotected sex and sharing of needles, although sex workers, as well as those who engage in sex for drugs, would be at greater risk of acquiring the infection.

#### HIV Situation and Female Injecting Drug Users

In late 2005, two IDUs were found positive for HIV through the IHBSS. That finding, coupled with high levels of needle sharing and sexual risk behavior, led to renewed efforts to prevent HIV among the IDU population. There have only been spotty and intermittent efforts in this field. Currently, seven persons are recorded in the Registry as having been infected through injecting drug use, the first such case attributed to IDU since 1997. The latest IHBSS conducted in August and September 2007 showed high levels of high-risk behavior, including multiple sexual partners, high levels of unprotected sex and low levels of condom use, sharing of unclean needles among IDUs, and low perceptions of HIV risk among the most-at-risk populations (MARPs). Other MARPs, such as sex workers and men having sex with men (MSM), also reported levels of injecting drug use far above the rest of the population. There were no additional HIV-positives found during this round of surveillance, and sample sizes were generally thought to be adequate.

**Female IDUs represent about 10% to 15% of the IDU population in the Philippines.** Despite this relatively low proportion of women among the IDU population, they are disproportionately at risk to HIV infection because many of the women IDU respondents (in both the IHBSS and FGDs conducted in Zamboanga City) are also engaged in sex work. Much of the research on HIV in the Philippines (AIDS awareness, knowledge of the correct ways of HIV prevention, condom use, occurrence of signs and symptoms of STI, health-seeking behaviors, exposure to HIV intervention programs, sources of information on AIDS, incidence of drug use, and needle-sharing and cleaning practices) do not take into account gender differences, thus, the need to specifically clarify and address issues arising among women who inject drugs.

64. While some women resort to drug combinations, Nubain (Nalbuphine Hydrochloride, usually 0.2-0.3ml/episode) is the most commonly used injectable drug in both sites. The predominance of moving into injectables as a second and higher stage of drug use is due to its perceived stronger effect, lower cost, and accessibility in converging points. In this study, there is hardly any difference between sex workers and non-sex workers insofar as injecting and sexual practices are concerned, i.e., needle-sharing is high, and condom use is low.

65. Most of the women-participants are aware that one can have hepatitis, HIV, and AIDS from injecting drugs, and they know that they can protect themselves against these diseases if they do not engage in needle sharing or if they use a new needle. Yet, the data on needle sharing showed that they are sometimes engaged in this behavior, an indication that women's knowledge of injecting risks are not always translated into actual practice, particularly when they are at the height of injecting drugs. Evidently, many of the FIDUs have heard of and/or availed of services offered by government and NGOs, including a faith-based organization. However, three of the women in the Metro Cebu sample claimed that they have not availed of the services, which include HIV information, syringe and condom distribution, and HIV and AIDS testing. In Zamboanga City, the services include counseling and treatment for STI, HIV information, condom distribution, and STI and HIV and AIDS testing.

66. It seems that FIDUs who have availed of STI/HIV and AIDS prevention services are more likely to be aware of the risks of injecting drugs. However, some of the perceived risks may not be directly related to HIV (e.g., malaria, arthritis, and tuberculosis), but could be the consequence of an unhealthy lifestyle. Interestingly, there are three women in Metro Cebu who have not attended any meeting/discussion on HIV and AIDS and who have not availed of any of the prevention services offered by organizations, despite the fact that earlier data presented illustrate that most of them buy drugs and inject usually in a group at the "center."

67. The women in Metro Cebu appear to be marginalized in outreach programs, and their lack of knowledge of the correct cleaning method may be a result of interventions, which are directed mainly at male IDUs. Lack of knowledge among women regarding condoms as an HIV and hepatitis preventive measure is evident in this study, as well as lack of negotiating power in condom use. In both Metro Cebu and Zamboanga City, the reasons cited for non-use of condom during sex include: (i) its being bothersome and a disturbance to partners; (ii) partner practicing withdrawal; (iii) at the height of having sex, particularly if both are drunk; (iv) unaware that condom must be used during sex; (v) husband's



decision; (vi) own decision; (vii) using pills, no need for condom; (viii) partner is sterile; (ix) boyfriend's decision – condom use an indication of a lack of trust; and (x) boyfriend does not have AIDS. Drug use and sex are in clear association; early sex has an influence on one's decision to engage in drugs, and, conversely, early drug use has an influence on one's decision to engage in sex. There are also women who engaged in sex and drugs at roughly the same age. The popular practice of injecting drugs is done in groups, i.e., mixed heterosexual male-heterosexual female-lesbian-gay group, all female group, mixed male-female group, apparently for the following reasons: to save on the cost of drugs, peer pressure, the need to maintain smooth interpersonal relationship with friends, perceived socio-psychological effect of group sessions, i.e., mutual support mechanism, and because some women are not quite adept at injecting on themselves (apparently believing that men are "better injectors").

68. FIDUs in Metro Cebu and Zamboanga City understand the significance of HIV and AIDS prevention programs. In responding to what intervention programs were needed by FIDUs, needle distribution (15) obtained the highest frequency of mentions among FIDUs in Metro Cebu, followed by HIV and drug information (10), and condom distribution (4). One mention was obtained for bleach and water distribution, and another one for family support.

69. In Metro Cebu, those who have been exposed to interventions are appreciative of the services (HIV information, condom distribution) provided by the CHO and an NGO. The others appreciate the services of a faith-based organization, viz., condom distribution; HIV and AIDS information; vitamin and medicine/antibiotic distribution for lung problems, tuberculosis, and other illnesses; and other social support services. In Zamboanga City, services availed from the CHO and the NGO, Human Development and Empowerment Services (HDES), are well appreciated. On the whole, the women in Cebu cite a need for the following programs: needle distribution, condom distribution, and HIV and AIDS and drug information. The Zamboanga women also point to HIV and AIDS and drug information and condom distribution, but a stronger emphasis is placed on livelihood programs.

70. The women appear to realize that the use of drugs is perceived by society to be associated with "loose morals" – the same association that society places on involvement in sex. While there are women in this study who have been affected by society's labeling, a few of them also claim that they "do not care" about what other people say about their injecting behavior, as they have become "immune" to the reactions of others. What seems to be important to them is that they are able to inject drugs. Their responses obliquely refer to society's norms on the role of women as central to the family. Denigrating remarks make women think they are social outcasts. The lack of power in the real world and uncertainties about the future add to the stigma and discrimination faced by women IDUs, and these appear to have an influence on their decisions about drug use, and even early sex. This study also illustrates their awareness of society's less discriminating judgment when it comes to men who use/inject drugs. Age-appropriate and gender-specific policies are needed to bring about an enabling environment for women IDUs, both in Metro Cebu and Zamboanga City.

71. **Condom Use.** The availability of condoms was not probed deeply by the FIDU study. However, given DOH's current position *vis-à-vis* reproductive health, which has resulted in unspent resources for commodities, condoms are not as readily available now in public primary health care facilities as they were before. In the case studies, the effort of a church worker to distribute condoms was well appreciated by FIDUs, indicating that the choice of people doing the outreach makes a difference in the acceptance and utilization of the services by the target community. In the absence of strong government support, condom promotion and distribution should be pursued by other development partners, with FIDUs as among the priority target segments. As much as possible, *distributing condoms to FIDUs must not be done in a mechanical fashion, but must exhibit nurturance and gender sensitivity and encourage responsibility taking.* The planning and implementation of condom promotion and distribution provides a good opportunity for the participation of FIDUs.



Findings	Recommendations
<ul style="list-style-type: none"> <li>• Two-thirds of FIDUs are currently engaged or had been engaged in the sex trade.</li> <li>• Women who are forced to work in entertainment clubs (e.g., as GROs) are prone to become drug users because of the influence of co-workers and clients.</li> <li>• Unprotected sex is predominant in FIDUs in general                             <ul style="list-style-type: none"> <li>○ Low and inconsistent condom use with primary partner</li> <li>○ Inconsistent condom use with commercial sex clients or casual sexual partner</li> </ul> </li> </ul> <p><b>Causes:</b></p> <ul style="list-style-type: none"> <li>• Weak appreciation of the value of condom as a means of protection from infection</li> <li>• Lack of ability of FIDUs to negotiate with their spouses or sexual partners – even among those whose husbands are IDUs, there is fear that negotiating for condom use will breed mistrust.</li> </ul>	<ul style="list-style-type: none"> <li>• FIDUs' helplessness in negotiating for condom use is rooted in gender roles and, therefore, must be addressed using gender lens and tools that foster gender awareness, challenge them to have greater control over their health and body, and motivates them to have a fresher look at themselves.</li> <li>• Condom distribution to FIDUs must exhibit nurturance and gender sensitivity and encourage responsibility-taking.</li> <li>• Planning and implementation of condom promotion and distribution must be used as an entry point for the participation of FIDUs.</li> </ul>

72. **Voluntary Counseling and Testing (VCT).** There is a body of evidence from other countries, which points to the fact that most people who test positive immediately modify their behavior, thus reducing the risk of infection for others. Testing negative also tends to encourage people to adopt safer practices. Considering the traditional gender role of women as nurturers and providers of care, there is an excellent opportunity that is being missed here – the opportunity of influencing a segment that has a multiplier value for HIV prevention. *There is, therefore, a need to work towards making the value of VCT and testing for hepatitis known to FIDUs and to ensure that these services are available to them. Equally important, information about when to go for VCT<sup>5</sup> has to be disseminated to FIDUs.*

Findings	Recommendations
<ul style="list-style-type: none"> <li>• Despite their seemingly high awareness of their risk behavior and the diseases it could bring, more than half of FIDUs have not undergone testing for HIV, much less for Hepatitis.</li> <li>• Those who have not undergone HIV testing are engaged or had been engaged in commercial sex work (except for one), and almost all of them have or had a spouse or sexual partner who also injects.</li> <li>• These findings are indicative of two things, both of which show that risk reduction programs have not effectively reached FIDUs:                             <ul style="list-style-type: none"> <li>○ helplessness, defeatism or lack of control that FIDUs feel towards their health</li> <li>○ lack of adequate and appropriate services that can encourage FIDUs to submit themselves to VCT</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Interface between commercial sex and injecting drug use needs to be addressed. Probing for injecting behavior among sex workers maximizes risk reduction efforts.</li> <li>• Make the value of VCT and testing for hepatitis known to FIDUs, and ensure that these services are available to them. Information about when and where to go for VCT has to be disseminated to FIDUs.</li> </ul>

73. **Drug Abuse Prevention.** In trying to tackle the IDU problem by making it manageable, one inevitably swings to the perspective of preventing drug abuse. Doing this through a well-targeted information, communication, and education (IEC) and peer counseling program requires taking a closer look at the factors that induce people to get into drugs, including injecting substance. Peer influence should be factored into efforts towards demand reduction through the introduction or strengthening of peer facilitators' programs in schools, work places (e.g., entertainment establishments), and the community.

<sup>5</sup> When to go for HIV testing: If you are sexually active (or have been within the last 10 years) and (i) you have had unsafe sex with multiple partners; (ii) you are uncertain of the HIV status of your partner; (iii) you are uncertain if your partner is faithful; (iv) you have been the victim of sexual abuse; (v) you have contracted a sexually transmitted infection within the last 10 years; or (vi) you or your partner have used intravenous drugs and shared needles within the last 10 years.





Findings	Recommendations
<ul style="list-style-type: none"> <li>• Various factors drive women into drug use:                             <ul style="list-style-type: none"> <li>○ peer influence;</li> <li>○ the need to forget about problems in the family or a traumatic life experience, or the miserable situation they are in;</li> <li>○ influence of sexual partner, spouse of commercial sex client who is an IDU; and</li> <li>○ influence of a family member/s who is/are into drug use</li> </ul> </li> <li>• Early age of initiation into drug use (median age of 16) and the early age at first sex (17 years old in 2007 IHBS, Zamboanga; 15 years old in this study)</li> <li>• Median age for injecting debut is about 2-3 years after first episode of drug use by another route.</li> </ul>	<ul style="list-style-type: none"> <li>• Factors for the initiation of women into drug use, including injecting drug use, should be treated as guideposts to an audience-focused IEC and counseling that can serve the ends of reducing drug use among females and males.</li> <li>• The early age of initiation into drug use and the early age at first sex imply that programs on life skills and sexuality education in both schools and communities within and near the IDU hubs are worth exploring.</li> <li>• Given that the median age for injecting debut is about 2-3 years after the first episode of drug use by another route, it is also important to prioritize drug users who have just started to experiment, regardless of their age.</li> <li>• It is necessary to train local social welfare and health workers in providing care to families with several members who are into drug use.</li> </ul>

74. **Referral to Drug Dependence Treatment.** Motivating FIDUs to submit themselves to treatment for drug dependence requires program workers with strong counseling skills. The training of IDU program workers who perform counseling functions should consider the distinct characteristics and situations of IDUs compared to other drug users and, among IDUs, the distinct characteristics brought about by gender. With strong counseling skills, programs will be better able to influence IDUs, especially FIDUs, to seek treatment.

Findings	Recommendations
<p>Compared to users of non-injective ATS substances like shabu, IDUs may be a more intractable segment to convince for drug dependence treatment for several reasons:</p> <ul style="list-style-type: none"> <li>• Psychic incentives like camaraderie or bonding in sharing the same service needle and in drawing substance from the same ampoule, and the “eroticism” in the act on injecting;</li> <li>• The effect of the substance on their physical and mental health may not be as strongly corrosive as non-injecting ATS, thus lulling them into complacency.</li> </ul>	<ul style="list-style-type: none"> <li>• Motivating FIDUs to submit themselves to treatment for drug dependence requires workers with strong counseling skills.</li> <li>• Training of IDU program workers should consider the distinct characteristics of IDUs compared to other drug users and, among IDUs, the distinct characteristics brought about by gender.</li> </ul>

75. **Towards a Client-friendly Provision of Services for FIDUs.** The policy brief touched on the following factors to be considered in determining the most appropriate delivery of services and messages, among others: gender-responsive services, civil status and IDU status of spouse or live-in partner, age and duration of injecting drug use, commercial sex work, ethnicity and religion, and family.

76. **Gender.** Risk reduction programs, including the provision of services in the referral system, should have a gender lens. Program workers must keep in mind that compared to male IDUs, FIDUs are more exposed to risks and are inhibited from utilizing health care services because of fear of stigma and discrimination.

77. **Civil Status and IDU Status of Spouse or Live-in Partner.** It is noteworthy that marriage counseling was identified as one of the services needed by married women who are into injecting drug use. Health programs, in general, tend to overlook the psychosocial needs of married women or those who are in a live-in relationship. The same holds for harm reduction programs that have only recently taken a closer look on the gender dimensions of drug use.



78. **Age and Duration of Injecting Drug Use.** Older FIDUs have different material, health care, and psychosocial needs compared to younger FIDUs. The years that FIDUs had been injecting also affect their world view and predisposition towards risk reduction practices and quitting. *Program workers who recognize these nuances are more able to take advantage of opportunities for encouraging health-seeking behavior among FIDUs.* Studies should also be done on younger females or on those who are just starting out as a way of identifying vulnerability factors.

79. **Commercial Sex Work.** Two-thirds of FIDUs in the case studies are currently engaged or had been engaged in the sex trade, thus exposing them, their spouses or sexual partners, and their peers or partners with whom they share needles to greater risks. *Harm reduction interventions, especially needle and condom distribution, should therefore be prioritized for this highly vulnerable subgroup.*

80. **Ethnicity and Religion.** Program workers in a multi-ethnic community should be aware of culture-based inequities between men and women as well as religious orientations and beliefs that inhibit women from accessing health services. There are cultures that attach harsher punishments to erring women, more than men, which can further drive FIDUs underground and difficult to reach by risk reduction interventions. Program models that tap local and indigenous leaders, so that harm reduction programs can effectively reach IDUs, should be harnessed when aiming for a greater coverage of FIDUs.

81. **Family.** FIDUs who come from families that have a member or members (father or mother, brother, sister, spouse) who are also into drug use also require special attention. Skillful counseling, referral for treatment of drug dependence, and livelihood support are essential for giving them a reason to hope and nurture their self-esteem, and need to be made available. While FIDUs in this situation may prove to be difficult cases, program workers should see in this sub-segment an opportunity to generate a positive spillover effect to family members who are drug users through the effective provision of services to FIDUs in this situation.

## 5. Output 5: Development of a Policy Brief

82. The importance of deliberately targeting FIDUs for risk reduction, its rate enhancing value in improving overall harm reduction efforts, and its contribution to the national response to HIV and AIDS cannot be emphasized enough. Women are vulnerable to HIV, while men are at risk. Most women are vulnerable because they have limited opportunity to protect themselves; many men are at risk because they refuse to do so – often deliberately, it seems. Not only will most women with the virus fall ill with AIDS, many will pass the virus to their newborn children, and most will also take on the burden of caring for other family members with the disease. The foregoing discussions underscore the urgency for the following policy-related actions (see Appendix 10 for full paper).

83. **Mainstreaming Gender into Harm Reduction Programs and Services in the Referral Chain.** Integrating gender into harm reduction programs and related services that contribute to risk reduction requires institutional capabilities that entail human resources and training. It also requires redefining or clarifying coordinative relationships between field agencies implementing vital support programs (e.g., reproductive health, livelihood, adult education) for IDUs and marginalized women. Monitoring how mainstreaming is being enforced and evaluating its results are also important.

84. **Review of the *Dangerous Drugs Act of 2002*.** Scaling up harm reduction so that it effectively reaches FIDUs will not be possible with a legal environment that criminalizes carrying of drug paraphernalia by outreach workers. The gender dimension of injecting drug use, the vulnerabilities of FIDUs, and the potential of injecting drug use in driving the epidemic in the country in the future can serve as sound bytes to convince decision makers and influential women in the legislature to take action now and amend *The Dangerous Drugs Act of 2002*.



#### IV. EVALUATION OF PROJECT DESIGN AND IMPLEMENTATION

##### A. Relevance of Project Design and Formulation

85. The Project was well-timed and coincided with the implementation of RETA 6321, Subproject 5. It was designed in response to a request from DOH to address the gender-related gaps that emerged during the implementation of RETA 6321 Subproject 5. It was envisioned to play a crucial role in supporting HIV prevention and harm reduction work among three identified HIV-vulnerable groups of women in the country.

##### B. Project Outputs

86. The Project outputs *vis-à-vis* performance/target indicators based on the Project DMF are shown in Table 4 below. The last column reflects the Consultant's assessment of the performance targets and deliverables for each component. The outputs are described in detail in the following sections.

**Table 4: Consultant's Assessment of Performance Targets and Deliverables**

Outputs	Performance Indicators/Targets	Remarks
<b>Output 1</b> Improved knowledge and practice of female spouses	<ul style="list-style-type: none"> <li>At least 80 female spouses/partners of seafarers trained as peer educators – <b>Partly achieved</b></li> <li>At least 30% of female spouses/partners able to negotiate regular condom use with their partners</li> </ul>	<ul style="list-style-type: none"> <li>The performance target for this output was reset after consultations with the spouses and disaggregated as follows: 10 peer educators, 40 seminar participants, and 80 peer outreach participants per site (Cavite and Davao).</li> <li><b>Peer educators:</b> A total of <b>21</b> female spouses were trained to be peer educators: Cavite (7) and Davao (14).</li> <li><b>Seminar participants:</b> <b>91</b> seminar participants attended the various community-based awareness raising activities disaggregated by location: Cavite (26), Davao City (50), and Metro Manila (15).</li> <li><b>72 spouses</b> attended gender, SRH, and HIV seminars in Cavite (16), Davao City (40), and Metro Manila (16).</li> <li><b>Peer outreach participants:</b> The 21 peer educators have reached out to <b>110</b> peers: Cavite (65) and Davao (45).</li> <li><b>Condom use:</b> Not all the women gave responses about condom use during the post-training assessment with the peer educators. Thus, there are no conclusive quantitative data that can measure whether the target of 30% was reached. However, qualitative feedback obtained from the peer educators and the peer outreach participants indicate that many of the spouses are willing to use condoms and encourage and teach their fellow spouses to use condoms.</li> <li>A "Review of Existing Behavioral Change Communication (BCC) Material and Identification of HIV Information Needs of Female Spouses of Seafarers" was conducted, and the full report submitted.</li> <li><b>BCC material</b> was developed in comics format and 2,000 copies have been produced for distribution.</li> </ul>



Outputs	Performance Indicators/Targets	Remarks
<b>Output 2</b> A model for SRH referral for female spouses developed	<ul style="list-style-type: none"> <li>Approved Memorandum of Understanding on referral network for female spouses in two cities: Davao and Dasmariñas – <b>Not pursued</b></li> <li>At least two health centers in each project site are involved</li> <li>At least 30% of women reached by the project have been referred for SRH services</li> </ul>	<ul style="list-style-type: none"> <li>At the stakeholders' forums held in both sites, it was expressed that further discussions need to be pursued with the service providers to accomplish the establishment of an SRH referral system. The local stakeholders agreed to undertake an initial mapping of SRH service providers to come up with a directory for distribution to female spouses.</li> <li>The directory of SRH service providers for Cavite and Davao spouses has been prepared.</li> <li>At the final Dissemination Forum for the TA, the CHDs (Davao and Cavite) committed to convene the stakeholders and local partners to resume the discussion on the referral system.</li> </ul>
<b>Output 3</b> Increased knowledge and information on HIV vulnerability among female seafarers	<ul style="list-style-type: none"> <li>Approved study - <b>Done</b></li> <li>Draft recommendations on gender-specific HIV vulnerability among female seafarers for consideration of the national HIV/AIDS program and policies discussed and agreed upon</li> </ul>	<ul style="list-style-type: none"> <li>The Study, "A Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Filipino Seafarers to HIV Infection and other Reproductive Health Problems," has been completed.</li> <li>The study was presented in two dissemination fora among various stakeholders including the DOH. The comments given during these fora have been taken into consideration in the finalization of the report. During the tripartite meeting, it was agreed that the Project will just suggest ways on how to improve the implementation of existing relevant policies, including providing inputs on how to operationalize them.</li> </ul>
<b>Output 4</b> Increased knowledge and information on female IDUs	<ul style="list-style-type: none"> <li>Approved study - <b>Done</b></li> <li>Draft recommendations on specific issues related to female IDUs for consideration of operational guidelines on harm reduction discussed and agreed upon</li> </ul>	<ul style="list-style-type: none"> <li>The study, "Gender-Specific Vulnerabilities of Females Who Inject Drugs (FIDUS) in Metro Cebu and Zamboanga City," has been completed.</li> <li>A total of 37 women were involved in the research: 17 women (15 in Metro Cebu; 2 in Zamboanga City) were interviewed individually, and 20 women participated in two FGDs in Zamboanga City.</li> </ul>
<b>Output 5</b> Policy brief on issues concerning female IDUs		<ul style="list-style-type: none"> <li>The Policy Brief, "Program and Policy Implications of Study on Female Injecting Drug Users," has been accomplished.</li> </ul>

87. For the component on female spouses of seafarers, the TA trained 21 PEs, or 105% of the target (Table 5). A series of weekend capacity building activities was conducted to provide the foundation knowledge on HIV and AIDS, gender, sexuality, and SRH. These seminars had a cumulative attendance of 90 participants, who were represented by 72 individuals, some of whom completed the series to qualify for the peer education training. After being trained as PEs, the core group (21 spouses) conducted three outreach sessions attended by 110 individuals, or an achievement of 69% of target. The peer-led activities were conducted during the busy months of December and January, when most of the spouses had various Christmas holiday activities at the homefront, and for some, this was compounded by the husbands being on home leave.



**Table 5: Coverage of Female Spouses Reached by the Project**

Parameter	Target	Modified Target	Actual Number	% Accomplishment
PEs	80	20	21	105%
Seminar participants		80	90	113%
Spouses involved			72	
Outreach peer participants		160	110	69%

### C. Project Schedule

88. The Project was implemented for eight months, from May 2008 until January 2009. The TA completion date was extended to 31 March 2009 to accommodate the conduct of the Dissemination Forum on 20 March 2009, upon the request of DOH, and then again to 31 May 2009 to enable the preparation of the Final Report after two revisions of the Draft Final Report.

### D. Implementation Arrangements

89. ADB's Southeast Asia Social Sectors Division (SESS) was the executing agency for this TA. SESS worked in close cooperation with RSDD to ensure complementation of the TA activities with other ongoing RETA 6143 activities. DOH was the TA implementing agency through NCDPC. Dr. Yolanda E. Oliveros, Director IV, provided oversight supervision for DOH involvement in TA implementation. DOH counterparts included Dr. Gerard Belimac and Dr. Ethel Daño.

### E. Consultant Recruitment and Procurement

90. A consulting firm (PRIMEX in association with ACHIEVE, Inc. and Remedios AIDS Foundation) was engaged by ADB, through single source selection, in accordance with its *Guidelines on the Use of Consultants*, to provide both technical and project management services during TA implementation. Subcontracts were also issued by PRIMEX to organizations and individuals for the conduct of various studies, review of BCC materials, development of IEC materials, and development of capacity building modules, particularly the TOT modules for the PEs.

### F. Performance of the IAs

91. The IA (DOH-NCDPC) participated in key events and milestones of RETA 6143. At the first tripartite meeting, DOH suggested that, as certain outputs indicated in the DMF would be difficult to meet, modifications had to be set in place. DOH also helped in the organization of the stakeholders forums by issuing letters of introduction for the Consultant Team to the LGUs and letters of invitation to the stakeholders. During the Stakeholders Forum in Cavite, a representative from PNAC secretariat was present together with a representative from DOH CHD IV-A. During the Final dissemination Forum, DOH representatives led by Director Oliveros, were also present.

### G. Performance of the Consultant

92. The satisfactory performance of the Consultant was acknowledged by DOH, ADB, and other stakeholders at the Final Dissemination Forum. The Project Coordinator was invited by the Local AIDS Council of Trece Martires to present an overview of the RETA and expound on the activities of the female spouses whom they plan to eventually tap as resource persons for their activities with their peers.

### H. Performance of ADB

93. ADB provided the necessary leadership and supervision over the Consultant, which resulted in a satisfactory delivery of the outputs. ADB worked closely with the Team during key milestone events and provided guidance and suggestions on progress reports submitted.



## V. EVALUATION OF PROJECT PERFORMANCE

### A. Relevance

#### 1. Component 1: Female Spouses of Seafarers

94. Because of the continuing incidence of HIV among seafarers and female spouses of seafarers in the country, there is a need to scale up interventions among this vulnerable population. Undertaking an intervention project with female spouses addresses not only migration and HIV issues, but gender and HIV issues as well. The current discussions related to the second phase of the *AIDS Medium Term Plan (AMTP) IV (2009-2010)* calls for the scaling up of interventions for vulnerable populations, both at the structural as well as the individual level. This Project responded to such a call as it directly sought to raise awareness and build capacity of the female population of an OFW sector considered vulnerable to HIV in enabling them to make decisions and actions that promote safer sexual behaviors.

#### 2. Component 2: Female Seafarers

95. This component produced a pioneering study, which not only addresses HIV and AIDS issues among female seafarers, but also gender and SRH. No in-depth study, whether qualitative or quantitative, has been done on Filipino female seafarers, which looked at their specific conditions, needs, and issues as women working aboard foreign vessels. This study is envisaged to inform policy and program interventions specific to female seafarers. In the dissemination forum of this study, ILO expressed interest to pursue the discussions on female seafarers as part of the Philippine ratification process of the *2006 ILO International Maritime Convention (IMC)*. In particular, they were interested to use the recommendations of the study to further refine the IMC, especially with regard to integrating gender issues and perspectives.

#### 3. Component 3: Female IDUs

96. While FIDUs comprise a small segment of the total population of IDUs (estimated at 10%), this study fills a current gap, i.e., the dearth of data related to gender issues and injecting drug use. Current interventions are adjudged to be gender-blind, that is, there are no specific interventions that consider the differential impact of drug use on female and male injectors. This research is pioneering, as it is the first qualitative and exploratory study on FIDUs, their specific behaviors, issues, realities and needs. The study is accompanied by a Policy Brief, which details policy and programmatic directions that can be taken in order to address the various issues and concerns faced by FIDUs.

### B. Effectiveness in Achieving Outcomes

97. As per the DOH Proposal, the expected outcomes of this Project are (i) increased knowledge and awareness of female seafarers' spouses on SRH and HIV in the Project areas and (ii) policy recommendations developed for female seafarers and women IDUs in the national HIV and AIDS Program.

98. These outcomes have been achieved by the Project, although the component on spouses fell a little short in terms of meeting quantitative targets. In both Cavite and Davao City, a total of 72 women were reached in terms of knowledge and awareness-raising activities on SRH and HIV issues. Of these, 21 women have emerged as PEs who were able to reach out to 110 peers. The two qualitative studies conducted under the Project produced policy recommendations which are envisaged as inputs into the second phase of AMTP 4 and the AMTP 5 (for 2011 and beyond).



## C. Efficiency in Achieving Outputs

### 1. Component 1: Female Spouses of Seafarers

99. Community partnership is an essential facet of this Project. Collaboration with local partners (in this case, associations of female spouses, manning and crewing agencies, and local NGOs) was crucial to the attainment of Project objectives. It also meant that the Consultant Team recognized the various contexts and realities of its local partners, especially in designing and deciding the mode of partnership and the timeframe required. While the Consultant Team was aware of the tight schedule of activities and was determined to deliver the outputs as scheduled, decisions over activities and the requisite schedules had to be made jointly with the local partner. Thus, while the original training schedule was supposed to commence in August 2008, the Consultant Team had to adjust and push the scheduled activities a month later, upon the request of the spouses' associations who had prior activities already planned. As the activities of this Project were sequential in nature, that entailed moving back the subsequent activities, reaching the month of December. The Consultant Team faced the challenge of convincing the partner organizations to fast-track the activities or schedule them even though it would be difficult to mobilize participants.

100. Just like the training activities, the schedule for the development of the BCC material was also pushed back because of the request of the spouses for additional time to review the material. This meant that the assessment report could not be generated as per the original schedule. Thus, the production schedule also had to be pushed back by another month. Another setback in this component was the sudden unavailability of the writer who was initially tapped to develop the storyline. However, through the recommendation of ACHIEVE, the Consultant immediately identified a replacement writer who proceeded to accomplish this output.

101. The role of the DOH-NCDPC is crucial in initiating and seeing through local health-related initiatives and in providing guidance and directives to their local counterparts, i.e., CHD. In this Project, the NCDPC-DOH could have made possible the establishment of the referral system within the time frame of the project, had they been present at the Stakeholders' Forum in both sites.

### 2. Component 2: Research on Female Seafarers

102. The data gathering activities for the study on female Filipino seafarers encountered some initial delays because of the difficulty in getting respondents among female seafarers, particularly those in the officer position. To address this problem, the research team made some modifications on the research design, including changing some of the criteria for participant selection. The research also utilized some of the data generated by ACHIEVE in its GFATM-funded operations research project on seafarers and HIV. The team also modified some parts of the methodology, e.g., doing KIIs instead of FGDs with key informants. As in the case of the community-based activities, this component also relied on the cooperation of the manning/crewing agencies, as they were the ones who could facilitate the participation of the respondents in the FGDs and interviews. The research was completed in time for the conduct of the first dissemination forum.

### 3. Component 3: Research on Female IDUs

103. The issue of drug use is a very sensitive issue. While the research aimed to present a more varied profile of FIDUs (i.e., include respondents from various age groups, classes, occupations, etc.), the research team had a hard time convincing professionals and women with upper income brackets to participate.

104. In Zamboanga City, there were no problems encountered, given HDES' preparedness for the activity. A problem encountered in the course of fieldwork in Metro Cebu was the difficulty in getting non-



sex worker women IDUs to participate in the study. It took the study team a considerable amount of time to convince non-sex workers, particularly students and professionals, because they were afraid that participating in the study might jeopardize their work, relationship with family and others, and reputation as a professional or student. In short, they did not want their identity exposed. Interview appointments were postponed several times, and some were eventually cancelled and replacements had to be sought.

#### **D. Preliminary Assessment of Sustainability**

105. The trained PE spouses in Cavite and Davao have expressed interest to continue undertaking peer education activities with members of their respective associations, although on a smaller scale. The echo seminars they conducted also became opportunities for them to reach out to spouses who were not yet members of their group, thus enabling them to expand their membership and reach. They have expressed interest to link with other organizations and service providers in their areas in order to address some of their SRH needs. The stakeholders' forums organized by the TA facilitated the introduction of the spouses' groups and their linkage to existing service providers. The potential sustainability of TA interventions for the female spouses lies in the strength of the spouses' groups which are already organized. Even without the TA, these groups exist as autonomous organizations, with their own set of activities and projects, and have a mechanism to integrate HIV prevention education into their activities.

### **VI. LESSONS LEARNED**

106. In many HIV prevention programs, it is ironic that gender issues often remain unaddressed and unchallenged. The fact remains that HIV infections often occur because of gender norms and stereotypes that define and regulate male and female sexual behaviors. By generating evidence through the conduct of studies and appropriate interventions, this TA has contributed in raising these issues and broadening the perspective on HIV vulnerability affecting sectors that are often invisible in various HIV prevention responses, i.e., female spouses of migrant workers, female IDUs, and female seafarers. How this evidence translates concretely into policies and programs, is ultimately within the ambit of concerned authorities, namely, DOH, PNAC, concerned LGUs, and DOLE, among others.

#### **A. Component 1: Female Spouses of Seafarers**

107. Undertaking community-based interventions requires sufficient understanding of the dynamics, stages of development, and functioning of community partners. It also entails building trust and sustaining relationships and partnerships that have been built. Furthermore, it requires open communication so that expectations with regard to deliverables and outputs are clarified and agreed upon. It is also crucial to define "ownership" of the Project because in the end, it will be the local organizations, who will be undertaking the day-to-day functioning of the project. It then entails that any consultant who wishes to engage communities and community-based organizations must respect the autonomy of these organizations in the conduct of their activities, alongside the project activities. In other words, consultants cannot impose their deadlines or compel their community partners to acquiesce to their schedules in order to adjust or accommodate the consultant's timeframe.

108. Capacity-building activities are seldom effective if they are done on a one-off basis. There is a need to sustain the conduct of such initiatives, and with the TA ending in January 2009, it was crucial to identify possibilities for continuity. Learning from lessons in the implementation of similar HIV education activities with female spouses by ACHIEVE, Inc., capacity building activities can continue even after the TA has ended, provided that resources are mobilized.

109. Another important learning, which is now emerging as a practice (and a rule) among civil society groups, is the involvement of people living with HIV in various aspects of the Project. In this Project, the involvement of HIV+ female spouses of seafarers/OFWs was one of the most-appreciated sessions in the training activities.





110. In the case of the referral system, one cannot underscore the crucial role of national institutions/agencies in providing policy and program guidance to their local counterparts. This ensures that the strategies and priorities decided on by DOH-NCDPC get translated locally and are acted upon by LGUs. Unfortunately, for this TA, such guidance and sense of urgency was not present, perhaps due to the overstretched engagements of the personnel assigned to this TA.

### **B. Component 2: Female Filipino Seafarers**

111. Because female seafarers are just an emerging population among female OFWs, the research team faced various challenges such as the lack of existing or baseline data and difficulty in engaging female seafarers as respondents in the research. Thus, it is crucial to build partnerships with institutions that have a direct bearing on female seafarers, i.e., manning agencies and maritime schools. Fortunately for this Project, such relationships have been established through RETA 6321.

112. The research on female seafarers not only focused on HIV and AIDS, it also covered a whole range of issues, including SRH, gender in the maritime sector, and labor rights issues. The findings can, thus, be utilized by a broader range of stakeholders, including those from the maritime sector and international agencies working on maritime issues.

### **C. Component 3: Female IDUs**

113. Data obtained from the qualitative study indicate that much still needs to be done to effect positive behavior change among FIDUs in Cebu and Zamboanga City. Considering that a study of this nature is sensitive and many potential participants were reluctant to be interviewed, establishing rapport with a key informant, herself an FIDU, was essential. A review of inputs and transcripts of interviews must be conducted to substantiate narrative reports, and careful editing of the final report to ensure reliability and readability, and protect against biases, value judgments, and misinterpretations.

114. Generating information on people who are regarded as engaging in “illegal or criminal” activities needs to be done with utmost sensitivity. Likewise, the utilization of this report needs to be carefully monitored. It is important to stress that the report must be utilized for what it is intended, i.e., to integrate gender issues in harm reduction responses and address specific concerns of FIDUs, and not to get more information about FIDUs, their locations, and drug use habits for purposes of surveillance and prosecution.

## **VII. RECOMMENDATIONS AND NEXT STEPS**

### **A. Component 1: Female Spouses of Seafarers**

115. **HIV Prevention Activities.** The thrust of the *Fourth AIDS Medium Term Plan (AMTP IV)* is to scale up HIV prevention among migrants and their families. In line with this, there is a need to identify opportunities where HIV education for female spouses of migrant workers can be undertaken. This includes institution- and community-based mechanisms where HIV education can be integrated.

116. For institution-based efforts, the government, through the health-related agencies (such as PNAC or DOH) or through the migration-related agencies (such as DOLE or POEA), can engage manning agencies to integrate or include social and health awareness activities, such as HIV education or SRH education for female spouses. Most agencies have already organized their female spouses, and it is a matter of integrating SRH and HIV-related education and awareness-raising in their work. For community-based efforts, it is important for LGUs to coordinate with local associations of female spouses for HIV prevention education, as well as for referrals and linkages with service providers. Certain areas can be prioritized for this initiative, e.g., areas where there are current interventions for migrant workers and their families under Rounds 3, 5, and 6 of the GFATM AIDS project.



117. As a direct follow-up to this TA, it is important for the spouses associations engaged in this TA to be able to sustain their initiatives. Both WCSV and MaSSSFA are interested to continue conducting the echo seminars, which include integrating HIV education in their regular meetings and gatherings, as well as linking with other service providers to address their SRH needs. The MaSSSFA spouses also plan to continue partnering with ACHIEVE and with the locally-based trainers to address their information and capacity building needs. They are also planning to involve their seafarer husbands in some of their forthcoming outreach activities. The PEs of WCSV plan to partner with PRIMEX to reach out to more female spouses from other crewing agencies using their Let's Be Safe program. Preliminary meetings have been arranged by PRIMEX with some shipping agencies that have responded positively in scheduling the peer education trainings in their family-centered agenda.

118. At the Dissemination Forum, representatives from DOH regional offices (CHDs IV-A and XI) expressed their willingness to partner with the female spouses to sustain their peer outreach activities. It was recommended that the spouses also enroll their organizations with the Seaman Wives Association of the Philippines Inc (SWAPI). OWWA and the crewing agencies present at the dissemination forum agreed to look into strategies to address the family concerns of the seafarers, particularly activities to strengthen or enhance communication between husband and wife.

119. **BCC Material.** At the final dissemination forum, the participants from the maritime sector, spouses' organizations, and academe, had recommended the dissemination of the BCC material developed under the TA. The comics, which was developed based on recommendations of the spouses' associations consulted, had been reproduced, and the initial target recipients of this publication are the female spouses associations who were partners in this Project, namely, MaSSSFA, CCSV, and VAC. Copies of the material should also be given to service providers (government and NGO) where these spouses go for their health needs. Further distribution can be done at the intervention sites of the GFATM project, especially in areas where there are HIV prevention initiatives for migrant workers and their families. Lastly, some copies should also be distributed to leading manning agencies. Upon completion of the distribution, the said material can be assessed before any plan for further replication or reprinting is undertaken, so that possible enhancements or improvements can still be made. During the Final Dissemination Forum, DOH raised no objection to the content of the comics and has plans to upload it on its website.

120. **Referral Mechanism for SRH.** The directory of service providers needs to be disseminated to the concerned agencies and service providers, from government, NGO, and private sector so that they can identify areas of commonality and complementation. It is highly recommended that the DOH, through the NASPCP, undertake proactive action in seeing through the establishment of this referral mechanism. Because of the devolved nature of social and health services, it is important for DOH to work closely with the LGU and the Center for Health Development (CHD), in making this happen. Follow-ups can then be subsequently made with the CHO and MHO on next steps and it is envisaged that the advocacy efforts will be initiated/facilitated by the spouses associations in these areas.

## **B. Component 2: Female Filipino Seafarers**

121. This report will be submitted to DOLE, DOH, and PNAC for their reference in developing the AMTP IV Operational Plan component on migrant workers and their families, covering the period 2009-2010. It can also guide these agencies in developing appropriate and relevant policy and program interventions that will address the needs of female seafarers, particularly in the area of gender issues, SRH, and HIV and AIDS. This can be done in partnership with manning and crewing agencies who are directly involved in deploying female seafarers.

122. Another possible next step is the enhancement of the curriculum of maritime schools to reflect realities and issues of female seafarers. The Maritime Training Council (MTC) and the Commission on Higher Education (CHED) should be capacitated on gender in maritime issues so that they will be able to sufficiently oversee and monitor the integration of gender issues in the maritime schools.



123. As this is a new area of inquiry, and with other gender issues that surfaced in the research, the DOLE can also utilize this as reference for the current discussions leading up to the ratification of the *2006 ILO International Maritime Convention*. This study will provide evidence on the need to integrate gender-responsive provisions in future revisions of the Convention, given the current analysis that it is gender-neutral and does not have specific provisions addressing the needs and concerns of female seafarers. The ILO can be tapped to spearhead these discussions as they have already expressed interest in receiving the final report of this study, following the initial dissemination forum.

### **C. Component 3: Female IDUs**

124. As a pioneering study on FIDUs, this report can be utilized by policy makers and various service providers addressing issues of IDUs and HIV and AIDS. In particular, the two research sites, Cebu City and Zamboanga City, can benefit from the new data and analysis that was provided by the research. It is ideal that a local dissemination forum is undertaken, and that can be done under the auspices of the City Government through the Local AIDS Council. The LACs, in partnership with the researchers and the agencies involved (e.g., HDES for Zamboanga City), can discuss how to take the recommendations forward as most of these are based on the local context and situation of FIDUs.

125. Other initiatives related to IDUs and HIV, such as those undertaken under the GFATM project, can also benefit from using the findings of the study. In the dissemination forum held last 15 January 2008, one of these NGOs implementing GFATM activities for IDUs (i.e., PNGOC), already made a commitment to begin addressing the specific needs of FIDUs in their intervention projects in Cebu and Zamboanga City.

### **D. Overall**

126. The studies, IEC materials, and other knowledge products developed through the study will be made accessible online through the DOH, ADB, and PRIMEX websites.



## REFERENCES

- Action for Health Initiatives (ACHIEVE), Inc. 2003. *Taking Control*. Life Skills Guidebook for Female Spouses of Migrant Workers.
- \_\_\_\_\_. 2005. *Health at Stake: Access to Health of Overseas Filipino Workers*. Quezon City, Philippines.
- Bridge, E. 2002. "Gender and HIV/AIDS: Spotlighting Inequality." In Brief, Issue 11, September 2002.
- De Onis, M., E.A. Frongillo, and M. Blössner. 2000. "Is Malnutrition Declining? An Analysis of Changes in Level of Malnutrition since 1980." *Bulletin of the World Health Organization*, 78 (10): 1225.
- Department of Health – National Epidemiology Center (DOH-NEC). May 2008. *Philippine HIV and AIDS Registry*. [http://www.doh.gov.ph/files/NEC\\_HIV\\_May-AIDSreg2008.pdf](http://www.doh.gov.ph/files/NEC_HIV_May-AIDSreg2008.pdf)
- Development Gateway. <http://hiv.developmentgateway.org/>.
- Guinan, M.E. and L. Leviton. 1995. "Prevention of HIV Infection in Women: Overcoming Barriers." *Journal of American Medical Women's Association*.
- International Labour Organization (ILO). 2006. *The ILO's Maritime Labour Convention*. Also available at [http://www.ilo.org/global/What\\_we\\_do/InternationalLabourStandards/lang--en/index.htm](http://www.ilo.org/global/What_we_do/InternationalLabourStandards/lang--en/index.htm) (accessed 10 December 2008).
- International Maritime Organization (IMO). "Introduction to IMO." Also available online: [http://www.imo.org/About/mainframe.asp?topic\\_id=3](http://www.imo.org/About/mainframe.asp?topic_id=3)
- \_\_\_\_\_. *Technical Co-operation: IMO's Response to the 2005 World Summit*.
- International Transport Workers' Federation (ITF). 2003. *Women: Facing a Coalition of Resistance*. Available online at <http://www.itfseafarers.org/resistance.cfm>.
- Knodel, J., W. Im-Em, and C. Saengtienchai. 2000. "The Impacts of HIV/AIDS on Older Populations in Developing Countries: Some Observations Based on the Thai Case." *Journal of Family Issues*, 21(6):777-805.
- Marin, M.L.S., A.T. Quesada, and C.I. Sobritchea. 2004. *For Good: Life Stories of Filipino Migrant Workers Living with HIV/AIDS*. Quezon City: Action for Health Initiatives (ACHIEVE), Inc./CARAM-Philippines, 2004.
- McKee, N., E. Mannocourt, C. Saik, C. Yoan, and R. Carnegie. 2000. *Involving People, Evolving Behavior*. New York:UNICEF.
- National Commission on the Role of Filipino Women. 2002. *Gender Mainstreaming and Institutionalization in the Budgeting Process*. Manila.
- \_\_\_\_\_. 2001. *Framework Plan for Women, 2001-2003*. Manila.
- National Statistics Office (NSO). 2007. One in Three Overseas Filipino Workers (OFWs) is a Laborer or Unskilled Worker: Results from the 2006 Survey on Overseas Filipinos. Accessible at <http://www.census.gov.ph/data/pressrelease/2007/of06tx.html>
- Panos Institute. 1998. AIDS and Men: Old Problem, New Angle. Panos HIV/AIDS Briefing No. 6. December 1998.



Philippine National Aids Council (PNAC). 2008. Follow-up to the Declaration of Commitment on HIV and AIDS United Nations General Assembly Special Session (UNGASS). *Country Report of the Philippines (January 2006 to December 2007)*. Philippine National AIDS Council with support from the UN Theme Group on HIV and AIDS.

\_\_\_\_\_. 2005. *4<sup>th</sup> Medium Term Plan, 2005-2010*. Manila, Philippines.

Philippine Overseas Employment Administration (POEA). 2008. *2007 Overseas Employment Statistics*. Also available at <http://www.poea.gov.ph/stats/stats2007.pdf>. Accessed January 27, 2009.

\_\_\_\_\_. 2007. *OFW Global Presence, 2006*. A Compendium of Overseas Employment Statistics 2006. Also accessible at <http://www.poea.gov.ph/stats/2006Stats.pdf>

\_\_\_\_\_. 2006. *OFW Global Presence: A Compendium of Overseas Employment Statistics, 2006*. Also available at <http://poea.gov.ph/2006Stats>.

Piotrow, P., D. Kincaid, J. Rimon, and R. Ward. 1997. *Health Education: Lessons from Family Planning and Reproductive Health*. Johns Hopkins School of Public Health, Center for Communication Programs, USA.

PRIMEX in association with ACHIEVE, Inc. and Remedios AIDS Foundation. 2008. "Study on Knowledge, Attitudes, and Practices (KAP) of Seafarers and their Links to HIV Risks and Vulnerability." Report submitted to the Asian Development Bank under Regional Technical Assistance for Fighting HIV/AIDS in Asia and the Pacific (RETA 6321) – Subproject 5: Strengthening Country Response to HIV and AIDS among High-risk Groups. Manila Philippines.

Remedios AIDS Foundation. 2004. *Directory of Non-Government Organizations*. Manila, Philippines.

Sobritchea, C. and M.T. Ujano-Batangan. 2004. *Communicating Reproductive Health to the Youth: Good Practices by Philippine NGOs*. Demographic Research and Development Foundation, Inc. in cooperation with the David and Lucille Packard Foundation.

Sobritchea, C.I. and F. Tadiar. 2004. *Review of Philippine Policies and Programs on Migration and HIV/AIDS*. Commissioned by the Southeast Asian Ministers of Education Organization Regional Tropical Medicine and Public Health Network (SEAMEO TROPMED), the BACKUP (Initiative-GTZ), the Philippine National AIDS Council, and the Department of Health.

Sobritchea, C.I., M.T.U. Batangan, and R.G. Talampas. 2008. *A Qualitative Study of the Risks and Vulnerabilities of Filipino Seafarers to HIV and an Assessment of Current Intervention Policies and Programs*. (Draft Report). ACHIEVE, Inc. and GFATM.

Sobritchea, C.I. 2006. *Feminist Interrogations of the HIV and AIDS Phenomena in Asia*. Institute of Gender Studies, Ochanomizu University, Tokyo, Japan.

\_\_\_\_\_. "Gender and the Prevention and Control of HIV/AIDS in the Philippines." Paper read at the ISEAS Forum on Gender Issues and HIV/AIDS: Trends and Practices in Southeast Asia, 5 December 2005, Institute of Southeast Asian Studies, Singapore.

Sunas, L.P., R.J. Mateo, J. Lopez, J.R. Navarro, and C. Lim-Quizon, n.d. *The Vulnerabilities of Filipino Seafarers to HIV/STIs*. USAID, WHO, and the Field Epidemiology Training Program (FETP). Manila, Philippines.

Tan, M. . 1998. *Sex and Sexuality*. University Center for Women's Studies, University of the Philippines, and United Nations Population Fund, Women's Health Research Consortium Project



- Tan, M., M.T. Ujano-Batangan, and H. Cabado-Espanola. 2001. *Love and Desire: Young Filipinos and Sexual Risks*. University of the Philippines Center for Women's Studies, Quezon City, Philippines.
- TESDA Women's Center. 2005. *A Study of Employment Opportunities for Women in TWC's 12 Trade Areas*. Manila. JICA Philippines.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). 2008. *Report on the Global AIDS Epidemic*. Also available at [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008Global\\_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008Global_report.asp). (Accessed 23 January 2009)
- \_\_\_\_\_. 2000. *A Report on the Global HIV/AIDS Epidemic*.
- \_\_\_\_\_. n.d. "Women and Their Vulnerability." *Women, Gender and HIV/AIDS in East and Southeast Asia*. Bangkok, Thailand.
- United Nations Development Fund for Women (UNIFEM) n.d. *Women, Gender and HIV/AIDS in East and Southeast Asia*. East and Southeast Regional Office.
- United Nations Development Programme (UNDP). 2003. *Human Development Report, 2003: Millennium Development Goals: A Compact Among Nations to End Human Poverty*. New York: Oxford University Press. 203 p.
- United Nations Economic Social Commission for Asia and the Pacific (UN/ESCAP). "Gender and HIV/AIDS in Asia and the Pacific Region." Gender and Development Discussion Paper, Series No. 18. Emerging Social Issues Division.
- United Nations Population Fund (UNFPA). 2005. *State of the World Population 2005, Child Marriage Fact Sheet*.
- United Nations General Assembly Special Session on HIV/AIDS (UNGASS). 2001. "S-26/2. Declaration of Commitment on HIV/AIDS," Twenty-sixth Special Session, Agenda item 8. 2 August 2001.
- Welbourn, A. 2006. "Women with HIV/AIDS: Commonwealth Casualties." *The Commonwealth Health Ministers Reference Book, 2006*. Also available at [http://www.icw.org/tiki-view\\_articles.php](http://www.icw.org/tiki-view_articles.php).
- World Health Organization (WHO) Department of Gender and Women's Health. 2003. "Gender and HIV/AIDS." *Gender and Health*. Also available at [http://www.who.int/gender/documents/en/HIV\\_AIDS.pdf](http://www.who.int/gender/documents/en/HIV_AIDS.pdf)
- WHO, UNAIDS, United Nations Office on Drugs and Crime (UNODC). 2004. *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*.
- Ybanez, R.F., S. Bugna, D. Sanga, C.I. Sobritchea, M.S. Marin. 2000. *Labor Migration and HIV/AIDS: Vulnerability of Filipino Migrant Workers*. Kalayaan Inc. and CARAM-ASIA, 74 p. Also available at <http://www.caramasia.org/reports/Labor%20Migration%20&%20HIV-AIDS.pdf>





# **APPENDIXES**

**Appendix 1:**  
**DESIGN AND MONITORING FRAMEWORK (DMF)**



DESIGN AND MONITORING FRAMEWORK (DMF)

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p><b>Impact</b> Prevention of the spread of HIV infection and reduction of the risk of sexually transmitted infections (STIs) in women and their partners</p>	<p>Maintain &lt;1% HIV prevalence among most-at-risk and vulnerable groups.</p>	<ul style="list-style-type: none"> <li>NEDA</li> <li>DOH, IHBSS, HIV Registry</li> </ul>	<p><b>Assumption</b></p> <ul style="list-style-type: none"> <li>Government policies and budget will continue to support HIV/AIDS and gender programs</li> </ul> <p><b>Risk</b></p> <ul style="list-style-type: none"> <li>Local government does not maintain levels of expenditure on HIV/AIDS prevention.</li> </ul>
<p><b>Outcome</b> Increased knowledge and awareness of HIV/AIDS at-risk women on gender, SRH, and HIV prevention in the Project areas</p> <p>Developed policy recommendations for female seafarers and women IDUs in the national HIV and AIDS Program</p>	<ul style="list-style-type: none"> <li>At least 70% of women spouses/partners of seafarers correctly identify ways of preventing sexual transmission of HIV</li> <li>At least 60% of women spouses/partners of seafarers reached by the project have access to SRH referral</li> <li>Produced and submitted to PNAC and DOH policy recommendations addressing HIV vulnerabilities and risks of female seafarers and female IDUs</li> </ul>	<ul style="list-style-type: none"> <li>Baseline survey</li> <li>FGDs</li> <li>Project reports</li> <li>Final survey</li> </ul> <ul style="list-style-type: none"> <li>Survey recommendations</li> <li>Documentation from policy discussions and survey dissemination forums</li> </ul>	<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>Women participate in training and use services.</li> <li>A supportive local political environment exists.</li> </ul> <p><b>Risk</b></p> <ul style="list-style-type: none"> <li>There may be changes in leadership and priorities at the local level.</li> </ul>
<p><b>Outputs</b></p> <p><b>Output 1</b> Improved knowledge and practice of female spouses</p>	<ul style="list-style-type: none"> <li>At least 80 female spouses/partners of seafarers trained as peer educators</li> <li>At least 30% of female spouses/partners able to negotiate regular condom use with their partners</li> </ul>	<ul style="list-style-type: none"> <li>Baseline / final survey</li> <li>Project reports</li> </ul>	<p><b>Assumption</b></p> <ul style="list-style-type: none"> <li>Women are able to work as peer educators in the communities.</li> </ul> <p><b>Risk</b></p> <ul style="list-style-type: none"> <li>Volunteer system of peer educators may not be sustainable.</li> </ul>
<p><b>Output 2</b> Developed a model for SRH referral for female spouses</p>	<ul style="list-style-type: none"> <li>Approved Memorandum of Understanding on referral network for female spouses in two cities: Davao and Dasmariñas</li> <li>At least two health centers in each project site are involved</li> <li>At least 30% of women reached by the project have been referred for SRH services.</li> </ul>		<p><b>Assumption</b></p> <ul style="list-style-type: none"> <li>Women are confident in utilizing SRH services.</li> </ul> <p><b>Risk</b></p> <ul style="list-style-type: none"> <li>Referral services at the local level may not be affordable.</li> </ul>
<p><b>Output 3</b> Increased knowledge and information on HIV vulnerability among female seafarers</p>	<ul style="list-style-type: none"> <li>Approved study</li> <li>Draft recommendations on gender-specific HIV vulnerability among female seafarers for consideration of the national HIV/AIDS program and policies discussed and agreed upon</li> </ul>		



Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p><b>Output 4</b> Increased knowledge and information on female IDUs</p>	<ul style="list-style-type: none"> <li>• Approved study</li> <li>• Draft recommendations on specific issues related to female IDUs for consideration of operational guidelines on harm reduction discussed and agreed upon</li> </ul>		
<p><b>Activities with Milestones:</b></p> <ol style="list-style-type: none"> <li><b>1. Community-based Education and Awareness Raising on Gender, HIV and AIDS and SRH Issues</b> <ol style="list-style-type: none"> <li>1.1 Orientation meeting and needs assessment in each site to determine the training needs of participants;</li> <li>1.2 Training seminars aimed at increasing female spouses' knowledge and awareness of gender issues and SRH issues and enhancing their skills related to their SRH, e.g., safer sex communication skills, condom use, life skills;</li> <li>1.3 Training of trainers (TOT) to build the capacity of leaders and peer educators among female spouses of seafarers;</li> <li>1.4 Peer education activities such as echo seminars for female spouses.</li> </ol> </li> <li><b>2. SRH Referral Mechanism for Female Spouse/Partners of Seafarers</b> <ol style="list-style-type: none"> <li>2.1 Workshops to identify referral mechanism</li> <li>2.2 Stakeholders' forum in Davao City and Cavite with local government officials, SRH service providers, NGOs and female spouses of seafarers.</li> </ol> </li> <li><b>3. Qualitative Study on HIV Vulnerability and SRH Issues of Female Seafarers</b> <ol style="list-style-type: none"> <li>3.1 In-depth interviews and focus group discussions with female seafarers</li> <li>3.2 Interviews with key informant, stakeholders including relevant government agencies, manning agencies, training centers, the association of female seafarers.</li> <li>3.3 Study on female seafarers, including draft recommendations for HIV/AIDS program and policies</li> </ol> </li> <li><b>4. Qualitative study on Gender-specific vulnerabilities of Female Injecting Drug Users</b> <ol style="list-style-type: none"> <li>4.1 Focus group discussions with female IDUs</li> <li>4.2 Case Studies of female IDUs</li> <li>4.3 Study on FIDUs including recommendations for operational guidelines for harm reduction</li> </ol> </li> </ol>			<p><b>Inputs:</b>                      GDCF: \$148,500                      Training, workshops: \$66,000                      Studies and surveys: \$20,800                      National consultants: \$43,566                      Miscellaneous administration and support costs: \$7,100</p>



**Appendix 2:**  
**COMPREHENSIVE TRAINING REPORT ON THE  
DEVELOPMENT OF PEER EDUCATORS AMONG  
FEMALE SPOUSES OF SEAFARERS**

## COMPREHENSIVE TRAINING REPORT ON THE DEVELOPMENT OF PEER EDUCATORS AMONG FEMALE SPOUSES OF SEAFARERS<sup>1</sup>

### A. Introduction

1. The ADB Regional Technical Assistance **Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines** (RETA 6143), an ADB-assisted Project of the Department of Health (DOH), aimed, among others, to increase knowledge and awareness of female spouses of seafarers on the following: (i) their vulnerability to HIV and AIDS, (ii) gender, (iii) sexual and reproductive health (SRH), and (iv) HIV prevention. The Project was managed, on behalf of ADB, by PRIMEX, in association with Action for Health Initiatives (ACHIEVE) Inc. and Remedios AIDS Foundation (RAF). In the months between September to November 2008, female spouses of seafarers in two Project areas, Cavite and Davao, underwent a series of training courses as part of the package of interventions for community-based education and awareness on Gender, HIV and AIDS, and Sexual and Reproductive Health (SRH) issues. It was envisaged that the series of training courses will prepare these women to be peer educators who can echo the information to other female spouses of seafarers.

2. **The silent force that keeps the economy alive.** Ever so often, our OFWs and seafarers are credited for being the new heroes of the country. Their dollar remittances account for a significant percentage of the country's improving economy. But take a closer look, behind that successful ship captain or cargo crew is a wife taking care of his family, making sure that all is well in the domestic scene. The silent role of the female spouse of a seafarer is invisible and unrecognized in the country's development, yet she faces the risks and vulnerabilities of being affected with HIV. Despite the Pre-departure Orientation Seminars (PDOS) that the seafarers attend prior to boarding the boat for their new assignment, the information needs to be supported by having the female spouse also informed on their vulnerabilities. If before, the PDOS message to seafarers was ABC (abstain, be faithful, and consistent condom use), a more comprehensive take home message for the seafarers and their female partners is **SAVE: S** - Safer Practices; **A** - Access to treatment; **V** - Voluntary counseling and testing; and **E** – Empowerment.

### B. Profile of Participants

3. The women trained under the Project are female spouses of seafarers. Most of them have given up their careers to be full-time mothers and homemakers. Some have held on to their careers, while others have their own home businesses, or some form of domestic livelihood. Despite their being home-based, there are challenges in bringing them together at a specific common day. Their preferred day for attending these activities is Saturday. However, when their spouse is home, after a tour of duty, their lives are in suspended animation. They focus all their attention on their spouse and family. The Project organizers respect this limitation and thus, adjust the training schedule around their availability.

4. The Project reached out to 71 women from three groups of female spouses from Cavite, Davao, and Metro Manila: (i) Craftstruck Club of Seaman's Village (CCSV) in Dasmariñas, Cavite (16 pax); (ii) Mary Star of the Sea Seafarers' Families Association (MSSSFA) in Davao City (37); and Veritas Allottees' Circle (VAC) Davao (3) and Metro Manila (15) chapters. Fifteen women were able to complete the two foundation training courses: eight from Cavite, and seven from Davao. Of those who became peer educators, five out of seven PEs in Cavite completed the foundation training courses, while only four out of the fourteen PEs in Davao completed the trainings. The roster of participants is included as Annex A.

<sup>1</sup> The Consultants would like to acknowledge the documentation efforts of (i) Ms. Irene Chia for preparing the documentation reports for the Cavite and Davao training events and (ii) Ms. Leslie Arididon of ACHIEVE for the documentation report for the Veritas Training in Metro Manila.



**C. Conduct of Training Workshops**

5. To prepare the spouses to be peer educators, two training courses were conducted in the two Project sites. The strategy was to (i) build their knowledge on HIV, STIs, gender sensitivity, legal basis for gender and development issues, as well as (ii) empower them on safer sex communication, and appreciation of their own sexuality. All those who reached the peer education stage had attended at least one foundation training course, expressed commitment to be peer educators, and demonstrated good communication skills. Table A2.1 below summarizes the various training courses conducted, as well as the dates, venues, topics tackled, and number of participants. The program of activities for the various training courses are included as Annex B.

**Table A2.1. Training Courses and Number of Participants**

Women's Group	Title of Training Course	Date	Venue	Topics	No. of Pax
<b>CAVITE GROUP:</b>  Craftstruck Club of Seaman's Village	HIV Prevention for Female Spouses of Seafarers	6 September 2008	Women and Ecology Wholeness Farm, Mendez Farm, Cavite	<ul style="list-style-type: none"> <li>• Reproductive Health</li> <li>• HIV Situationer</li> <li>• HIV101</li> <li>• Sexually Transmitted Infections</li> <li>• Safer Sex</li> <li>• Condom use demonstration</li> <li>• Testimony on vulnerability</li> </ul>	14
	Gender Training For Female Spouses Of Seafarers	4 October 2008	Women and Ecology Wholeness Farm, Mendez Farm, Cavite	<ul style="list-style-type: none"> <li>• Sex, Gender, and Sexuality</li> <li>• Gender Equality and Women Empowerment Framework</li> <li>• Action Planning to promote gender equality and equity</li> </ul>	11
	Peer Educator's Training	21-23 November 2008	Hotel Kimberly, Tagaytay City	<ul style="list-style-type: none"> <li>• Answering questions participants ask</li> <li>• Core Messages for Peer Educators</li> <li>• Condom Demonstration</li> <li>• Safer sex activities</li> <li>• Risk Continuum</li> <li>• Fun Games</li> <li>• Initial Assignments</li> <li>• Individual Lecture Demo</li> </ul>	7
<b>DAVAO GROUP:</b>  • Mary Star of the Sea Seafarers' Families Association (MSSSFA)  • Veritas Allottees' Circle (VAC)	Reproductive Health Awareness Seminar Workshop	11-12 September 2008	Microtel Inn and Suites, Davao City.	<ul style="list-style-type: none"> <li>• Basic Gender Concepts</li> <li>• Manifestations of Gender Bias</li> <li>• RA 9262 – Violence Against Women and Children (VAWC)</li> <li>• Gender Equality and Women Empowerment Framework</li> <li>• Concept of Power</li> <li>• Reproductive Tract Infections</li> <li>• Body Image and Health</li> <li>• HIV 101</li> </ul>	25 - MSSSFA (22) - VAC (3)
	Skills Training on Sexual and Reproductive Health for Female Spouses of Seafarers	17-18 October 2008	Eden Nature Park and Resort, Davao	<ul style="list-style-type: none"> <li>• Communication Skills</li> <li>• Safer Sex Communication</li> <li>• Condom Use Demonstration</li> <li>• Rights and Responsibilities of Allottees</li> <li>• Sexuality</li> <li>• Testimony on vulnerability</li> </ul>	25 - MSSSFA (22) - VAC (3)
	Peer Educator's Training	14-16 November 2008	Hotel Elena Davao City	<ul style="list-style-type: none"> <li>• Answering questions</li> <li>• Core Messages for Peer Eds</li> <li>• Condom Demonstration</li> <li>• Safer sex activities</li> <li>• Risk Continuum</li> <li>• Initial Assignments</li> <li>• Individual Lecture Demo</li> </ul>	14 - MSSSFA (11) - VAC (3)
Metro Manila - VAC		22 November 2008	Veritas Training Center, Manila	<ul style="list-style-type: none"> <li>• HIV 101</li> <li>• HIV Situationer</li> <li>• Wildfire</li> <li>• Testimony on vulnerability</li> <li>• Condom Use Demonstration</li> </ul>	15



## 1. Cavite Training Workshops

6. The training workshops in Cavite were carried out in partnership with Health Development Initiatives Institute (HDII) headed by its Executive Director Ms. Gladys Malayang, and staff Mr. Arnold Vega and Ms. Cyril Dalusong.

7. *HIV Prevention Workshop for Female Spouses of Seafarers* on 6 September 2008 raised their level of awareness on sexual and reproductive health issues, fundamentals of HIV and AIDS and the Philippines situation, STIs, safer sex practices and a demonstration on the proper use and disposal of condoms. To assess the level of awareness of the participants about RH, the participants wrote down on meta cards their responses to the question “What crosses your mind when you hear the word RH?” The participants mentioned family planning, contraceptives or birth control; sexual hygiene; diseases; sexual acts; sexual organs of men and women; giving birth; women’s empowerment and gender-related issues; forming of a family; health education for teenagers; and awareness of the changes in the bodies. On sex and gender, the participants were divided into two groups. Group 1 drew the reproductive system of a female and listed down what they thought were the characteristics of a male. Group 2 drew the reproductive system of a male and listed down what they thought were the characteristics of a female. The participants drew the reproductive organs of a male and female correctly and they listed down stereotypes or characteristics that are commonly associated with being a man or woman.

8. The workshop was capped with a **testimony by a person living with HIV (PLHIV)**. Also a spouse of a former seafarer, the invited resource person gave her testimony as a spouse of a former seafarer who are both HIV positive. She spoke about (i) the reasons why her husband became a seafarer; (ii) how she prepared herself as a seafarer’s wife; (iii) how her husband was diagnosed as HIV positive and its impact on their lives. The couple is actively involved with NGOs responding to PLHIV and is committed in the campaign to fight HIV. Some of her recommendations on the HIV response, particularly for female spouses of seafarers were: (i) effective and up-to-date IEC on HIV campaign; (ii) involvement of spouses in the PDOS; (iii) assistance from the government and concerned organizations, e.g. providing employment for active and health members and livelihood projects for positive communities; and (iv) support from society to eliminate stigma and discrimination.

9. *Gender Training For Female Spouses of Seafarers* was conducted on 4 October 2008 by HDII Executive Director Ms. Gladys Malayang and Mr. Arnold Vega. The training aimed to (i) provide an orientation on gender concepts, (ii) relate the gender concepts to participants’ experiences, and (iii) assist participants to develop personal action plans in relation to Longwe’s empowerment framework. The 11 participants gained a deeper perspective on the differences among gender, sex, and sexuality. Sex primarily refers to physical attributes—body characteristics, notably sex organs which are distinct in majority of individuals. It is biologically determined—by genes and hormones, and is relatively fixed/constant through time and across cultures. *Gender* is the composite of attitudes and behaviour of men and women (masculinity and femininity). It is learned and perpetuated primarily through: the family, education, religion (where dominant) and media. Thus, it is an acquired identity. Because it is socialized, it may be variable through time and across cultures. *Sexuality* encompasses personal and social meanings as well as sexual behaviour and biology. It includes ways our bodies develop and respond sexually; includes sexual acts such as kissing, touching, intercourse; includes feelings about these activities and responses; includes what we think is right and wrong, good or bad; and includes life experiences that have shaped these feelings and values.

10. Significant realizations of the participants delved on equality and equity, power and decision-making, and sex and gender.

- (i) The lesson on **equity and equality** made them realize that “we really have to evaluate ourselves on what we really want—equality or equity.” In the words of another participant, she summarized that “equality recognizes equal treatment of men and women, but equity



takes into consideration the differences between men and women and what needs to be in place to produce outcome that is equitable.”

- (ii) The lesson on **power and decision-making** made them realize the difference between “power over” and “power within”, and that power over does not necessarily mean triumph over gender issues.
- (iii) The lesson on **sex and gender** made them realize that “we as wives need to have *equal rights*.”

## 2. Davao Training Workshops

11. Female spouses of seafarers from MSSSFA and VAC of Davao City, took a full weekend off in the months of September and October 2008 to attend the foundation training courses leading to their being developed as peer educators.

12. The *Reproductive Health and Awareness Workshop* was conducted on 11-12 September 2008 at the Microtel Inn and Suites in Davao City with 25 female spouses of seafarers. The Workshop taught the participants how to (i) protect themselves from the irresponsible sexual behaviours of their partners while on tour of duty; (ii) be aware of their rights; (iii) negotiate for safe sex; (iv) recognize signs and symptoms of STIs in themselves and in their partners. The workshop closed with a wildfire exercise followed by a testimony from a resource speaker who gave a face to the HIV situation. The training team was composed of (i) Ms. Rose Sanchez, a faculty of Ateneo de Davao University who discussed sex and gender issues; (ii) Ms. Lourdesita Sobrevega-Chan, also of Ateneo de Davao, who spoke on women’s rights and RA 9262 (Anti-Violence Against Women and Children (VAWC)); and (iii) Dr. Reggie Ingente, of the Brokenshire Medical Center, who lectured on STIs. RETA Team Leader Ms. Malu Marin conducted the session on HIV and AIDS.

13. The spouses were moved and overwhelmed with the testimony of the resource speaker, a female spouse of a former OFW, who is living with HIV. For many of them this is their first encounter with a person living with HIV and they are amazed to see her living a life of giving and reaching out to others instead of reclusive self pity. The spouses discussed among themselves their next steps in inviting more spouses to the next training event and in their own way reach out to their spouses like them to talk about the information gained in the two-day training.

14. The *Skills Training on Sexual and Reproductive Health for Female Spouses of Seafarers* conducted on 14-16 October 2008 built the capacities of 25 women to (i) look deeply into their own sexuality, (ii) communicate verbally with their spouses, (iii) express their sexuality, (iv) negotiate for safe sex practices, and (v) appreciate and be comfortable with their own sexuality. The training team was composed of the following: Ms. Malu Marin, Project Team Leader, who gave an overview on HIV and AIDS, Ms. Gladys Malayang, HDII Executive Director, conducted the communication workshops and hands-on use of condoms, Ms. Carolina Agdamag, OIC of POEA, spoke of the rights of allottees, and Dr. Alexandrina Marcelo spoke on sexuality and answered questions of the female spouses. The participants were encouraged to speak on their own sexuality and share problems and triumphs which they are comfortable to share with the group.

15. In response to the training received, the participants expressed their profuse thanks to ADB, PRIMEX and ACHIEVE. Acknowledging that knowledge is power, they expressed that they have learned so much and are glad that they have started building a support group with the friendships they have made in the two-day workshop. Being plain housewives, they admitted that their knowledge has been stagnant, now, they are able to share new knowledge even with their own children with more relaxed confidence. The communication skills made them look at how they have been communicating with their spouses and children. They admitted that asserting their sexual needs and expressing their fears to their spouses is something that they cannot do, and ashamed to do. They have just been passively obeying the husband’s demands. They are glad to have met people who are in the same situation – spouses of



seafarers, now they can reach out to each other and strengthen ties and enrich each other's lives. Project leader Ms. Marin thanked the MSSSFA and its president Ms. Elizabeth Malonzo for facilitating the arrangements and local coordination with the spouses of MSSSFA and the Veritas Allottees Circle of Davao City.

**3. Metro Manila Training Workshop**

16. On 22 November 2009, a one-day orientation-workshop on *HIV Prevention for Female Spouses of Seafarers* was conducted at the Training Center of Veritas Manning Agency. The workshop aimed to provide a brief orientation on HIV and AIDS and vulnerability of female spouses of seafarers. There were 16 participants; 14 are female spouses/partners of seafarers employed at Veritas Manning Agency while two are mothers of seafarers who are with Veritas. The lecture inputs were on HIV 101, HIV situationer, and Risks and vulnerabilities of female spouses of OFWs. The training team was composed of Ms. Amara Quesada and Ms. Leslie Arididon of ACHIEVE. Innovative activities were the (i) **cabbage peel** method to determine their entry knowledge level on the topic, (ii) **wildfire** to simulate HIV transmission, (iii) **testimony** from an infected female spouse of a seafarer to deepen their realization that they are vulnerable to HIV, and (iv) **condom demonstration** to enable them to know how they can protect themselves.

**D. Development of Peer Educators' Training Module**

17. In designing the peer educators' training, a TNA was carried out by the Training Team. A TNA form, included as Annex C was distributed in Cavite during the Stakeholders' Forum held on 18 November 2008. The five women present during the forum filled up the form and submitted these to the Project Coordinator as soon as these were accomplished. The data was collated and sent to the Peer Educator Trainors for their analysis and initial feedback in determining the design of the training course. In Davao, the TNA form was accomplished at the start of the workshop and processed on site together with the participants and trainer.

18. **Results of Cavite TNA.** The age of the peer educators of Cavite range from 37 to 56. Four of them have attended orientation sessions on HIV outside the Project, i.e. from HDII and PDOS. When asked what they recall from these trainings, the common response is the statistics and definition of HIV and AIDS. They are aware that STIs, HIV and AIDS are serious diseases, HIV and AIDS cannot be cured, and seafarers are most prone to HIV. Knowledge and skills gaps that were raised are summarized Table A2.2 below:

**Table A2.2. Knowledge and Skills Gap identified through the TNA**

What knowledge would you like to be clarified on?	<ul style="list-style-type: none"> <li>• In-depth understanding of HIV/AIDS</li> <li>• How to empower women</li> <li>• Process on how to effectively echo what we learn</li> <li>• Statistics</li> <li>• Medical information</li> <li>• More information on how to prevent being infected by HIV</li> </ul>
What questions or issues might be difficult for you to answer?	<ul style="list-style-type: none"> <li>• How will be able to handle peers who are positive?</li> <li>• How can we affect them in a positive way?</li> <li>• How will we know if the person is infected without being tested or did not go through HIV Test</li> </ul>
What skills do you want to develop for this topic?	How to become an effective educator/facilitator – effective process or approach Report writing
What issues do you think might be difficult for you to discuss or handle?	Gender issues
What questions from participants might be difficult for you to answer?	What is our clear stand on this issue? How are we going to handle this ourselves? How can we totally eradicate HIV Medical terms for HIV/AIDS symptoms
What skills as peer educators do you want to develop?	Public speaking, how to become an effective educator Talking clearly and slowly Knowledge on the issue





## E. Peer Educator's Training

### 1. Davao Training

19. The Peer Educators' Workshop for Davao spouses was held on 14-16 November 2008 at the Hotel Elena in Davao City. The training had 14 participants who have attended previous training workshops conducted by the Project. The training was conducted by Mr. Joselito de Mesa, a well versed and sought after resource speaker/facilitator. The program of activities is in Annex D.

20. To develop the peer education skills of the participants, Mr. de Mesa had an activity wherein the participants wrote down on meta cards their answers to the question "*What is a peer educator?*" After the participants posted the meta cards on the board, Mr. De Mesa ran through the answers, facilitated the discussion, and gave his inputs.

21. According to the participants, their role as peer educator is to educate the spouses about HIV and AIDS and its prevention. A peer educator should be knowledgeable about HIV and AIDs and the prevention methods such as safer sex and condom use, and about HIV and AIDS issues. A peer educator should also be resourceful, committed, responsible, friendly, approachable, confident, reliable, credible, patient, non-judgmental, observant, have a sense of humor, and knows how to segue or transition smoothly between topics.

22. **Practicum.** For their practicum, the participants were divided into four teams—Team JVAR, Team Glam, Team Hot Mamas, and Team RVM. Each team was composed of three to four members and was assigned to prepare and give a presentation on the following topics: HIV/STIs, condom use, and safer sex. Each member chose the topic that they preferred and was given some time to prepare their presentation. The presentation of each participant was recorded using a video camera. After each presentation, the other participants acted as the audience and asked questions to the presenters. During the viewing of the recorded presentation, the facilitators and participants gave their feedback on the strengths and weaknesses of each presenter and how to improve on their presentation skills.

23. **Evaluation.** The participants generally rated all the sessions as excellent—in terms of content, process, time management and technical aspects. They agreed that the objectives of the training were met; the methodology used in the training was effective; the facilitators were effective, well-trained, and well-informed. The venue was generally rated as very good and that it was conducive for learning. There were comments that time was not managed well because most of the participants came late. In terms of the food, some of the participants found the food good and some didn't.

24. The participants found all the topics useful but that they needed more information about HIV and AIDS, safer sex, and condom use. The participants also suggested that they needed more meetings to clarify and familiarize themselves about the topics and issues and more time to practice and improve their skills.

### 2. Cavite Training

25. The Peer Educators' Workshop for Cavite spouses was held on 21-23 November 2008 at the Hotel Kimberly in Tagaytay City. The training had 7 participants who had attended previous training workshops conducted by the Project.

26. Mr. De Mesa gave some tips on dress code and personal grooming when giving a presentation. He said that a peer educator should dress appropriately for the occasion as first impressions influence the audience's attitudes towards her. Some of the tips that he gave on dress code and grooming were: on wardrobe, overall appearance should be impeccable and well-groomed, makeup should be subtle and understated.



27. Mr. De Mesa also gave some tips on communication and presentation skills such as misconceptions about public communication, how to become a successful presenter and a competent communicator, the elements of the voice, how to use the body to communicate effectively, and parts of a presentation.

28. **Practicum.** The participants were divided into three teams. Each team was composed of two to three members and was assigned to prepare and give a presentation on the following topics: HIV 101, safer sex and condom use. Each member chose the topic that they preferred and was given some time to prepare their presentation. The presentations of everyone were recorded using a video camera. After each presentation, the other participants acted as the audience and asked questions to the presenters. All of the participants and the facilitators or resource persons viewed the videos of the practicum. The facilitators and participants gave their feedback on the good points and problematic areas, and suggestions on how to improve their presentations and how to conduct themselves. The facilitators gave tips on the proper use of meta cards; what facial expressions, body language, or mannerisms to avoid or use; proper dress code and personal grooming; and tips on the flow and content of the presentations.

29. **Evaluation.** The participants generally rated all the sessions as very good—in terms of content, process, time management and technical aspects. They agreed that the objectives of the training were met and the training was done well. The venue was generally rated as very good. Most of the participants didn't find the food good. The participants found all the topics useful but that they needed more information about the modes of transmission of HIV.

#### F. Next Steps

30. After completing the Peer Educators' Training, the trained participants will re-echo their learnings on HIV and AIDS, gender and sexual and reproductive health to their peers through Learning Group Sessions (LGS). Two LGS with 20 female spouses of seafarers per learning session will be conducted by the peer educators. One LGS will be conducted in December 2008 and another one in January 2009. PRIMEX will provide support for coordination, food, transportation, venue, supplies, and other related expenses for these LGS. PRIMEX will coordinate with the peer educators regarding the LGS.



**Annex A-1**

**LIST OF PARTICIPANTS**  
Female Spouses in Dasmariñas, Cavite

No.	Name of Participant	SRH Awareness	Gender Awareness	Stakeholders' Forum	Peer Educators' Training
		6 Sept 2008	4 Oct 2008	18 Nov 2008	21-23 Nov 2008
		Wholeness Farm Mendez, Cavite	Wholeness Farm Mendez, Cavite	David's Tea House, Dasmariñas, Cavite	Kimberly Hotel Tagaytay
<b>CRAFTSTRUCK CLUB OF SEAMAN'S VILLAGE</b>					
1	<b>Afan, Ana Ma.</b>		✓		✓
2	Asoy, Janet		✓		
3	<b>Bañez, Reizel</b>	✓	✓	✓	✓
4	Dialogo, Jeanette	✓			
5	Esguerra, Ana Liza	✓	✓		
6	Estabillo, Edna		✓		
7	<b>Gavino, Hailani</b>	✓	✓	✓	✓
8	Gertos, Ma. Edelina	✓			
9	Lutero, Jo Ann	✓	✓		
10	<b>Moralina, Socorro</b>	✓	✓	✓	✓
11	<b>Olivares, Andrea S.</b>	✓	✓		✓
12	Rollorata, Odessa	✓	✓		
13	Romero, Laiza	✓			
14	<b>Salazar, Nancy</b>	✓		✓	✓
15	Sanchez, Soledad	✓			
16	<b>Setenta, Shirley B.</b>	✓	✓	✓	✓
<b>TOTAL</b>		<b>13</b>	<b>11</b>	<b>5</b>	<b>7</b>

Note: Names in bold font are peer educators

**LIST OF TRAINORS/SPEAKERS**  
Dasmariñas, Cavite

No.	Name of Participant	SRH Awareness	Gender Awareness	Stakeholders' Forum	Peer Educators' Training
		6 Sept 2008	4 Oct 2008	18 Nov 2008	21-23 Nov 2008
		Wholeness Farm Mendez, Cavite	Wholeness Farm Mendez, Cavite	David's Tea House, Dasmariñas, Cavite	Kimberly Hotel Tagaytay
1	De Mesa, Joselito TL-SHARE				✓
2	Malayang, Gladys HDII		✓	✓	
3	Dalusong, Cyril HDII	✓			
4	Vega, Arnold HDII	✓	✓		
5	Pinoy Plus	✓			✓



**Annex A-2**

**LIST OF PARTICIPANTS**  
Female Spouses in Davao City

NAME	Reproductive Health Awareness Seminar Workshop	Stakeholders' Forum	Skills Training on Sexual and Reproductive Health for Female Spouses of Seafarers	Peer Educators' Training
	11-12 Sept 2008	16 October 2008	17-18 October 2008	14-16 November 2008
	Microtel Inn and Suites, Davao City.	Garden Oases Resort and Restaurant Davao City	Eden Nature Park and Resort, Davao	Hotel Elena Davao City
<b>MARY STAR OF THE SEA SEAMEN'S FAMILIES ASSOCIATION</b>				
1. Arcelon, Pialita			✓	
2. Ayo, Ma. Socorro S.	✓			
3. Bacong, Luz D.	✓			
4. Baoc, Anna Liza S.	✓			
5. Buranday, Carmen Pilar D.	✓			
6. Cañon, Vanessa	✓			
7. Chavez, Estrella			✓	
8. del Mundo, Luz			✓	
9. Francisco, Yolanda			✓	
10. Fuego, Roselyn P.	✓			
11. Gabo, Emily	✓	✓	✓	✓
12. Dorothea B. Geoca	✓			
13. Francsica T. Gersava	✓		✓	
14. Carmencita L. _____	✓			
15. Sonia M. Langbid	✓		✓	✓
16. Jury Magallanes			✓	✓
17. Alberta Malano		✓	✓	✓
18. Elizabeth Malonzo	✓	✓	✓	✓
19. Victoria Medel			✓	✓
20. Concepcion Mercado			✓	
21. Melamy Milan	✓			
22. Ma. Salome Padon	✓			
23. Jaclyn D. Peña	✓	✓	✓	
24. Josephine E. Regodin	✓			
25. Maria Victoria I. Reoja	✓			
26. Candelaria B. Padilla	✓			
27. Cerenia T. Plaza			✓	✓
28. Emma Rodrigo			✓	✓
29. Janet Sacupayo	✓			
30. Minierva Sagun	✓			✓
31. Vilma L. Salvador	✓			
32. Cristina G. Sotto			✓	
33. Julieta Suarez	✓			
34. Ma. Fe Tomambid		✓	✓	✓
35. Mita Tuban			✓	
36. Antoineta Y. Ubalde	✓		✓	
37. Ruby Young	✓		✓	✓
<b>VERITAS ALLOTTEES' CIRCLE, DAVAO CHAPTER</b>				
38. Cecilia Bahan		✓	✓	✓
39. Rossanna Yambao		✓	✓	✓
40. Leticia Teh		✓	✓	✓
<b>TOTAL</b>	24	8	23	14



**LIST OF TRAINORS/SPEAKERS**  
Davao City

NAME	Reproductive Health Awareness Seminar Workshop	Stakeholders' Forum	Skills Training on Sexual and Reproductive Health for Female Spouses of Seafarers	Peer Educators' Training
	11-12 Sept 2008	16 October 2008	17-18 October 2008	14-16 November 2008
	Microtel Inn & Suites, Davao City.	Garden Oases Resort and Restaurant Davao City	Eden Nature Park and Resort, Davao	Hotel Elena Davao City
1. Marin, Ma. Lourdes PRIMEX/ACHIEVE	✓	✓	✓	✓
2. De Mesa, Joselito TL-SHARE				✓
3. Malayang, Gladys HDII		✓	✓	
3. Sanchez, Rose Ateneo de Davao University (ADDU)	✓			
4. Sobrevega-Chan, Lourdesita ADDU	✓			
5. Dr. Reggie Ingente Brokenshire Medical Center	✓			
6. Pinoy Plus	✓			✓



**Annex A-3****LIST OF PARTICIPANTS**

Female Spouses from Veritas Allottees Circle  
Metro Manila Chapter  
22 November 2008

- |     |                             |   |
|-----|-----------------------------|---|
| 1.  | Albano, Norzayda C.         | Member                                    |
| 2.  | Albios, Fely C.             | Member                                    |
| 3.  | Alfaro, Roleth C.           | Member                                    |
| 4.  | Angeles, Editha J.          | Area Leader – Makati                      |
| 5.  | Bacud, Rofelia              | Member                                    |
| 6.  | Calumpang, Mary Jeanette P. | Area Leader - Coordinator                 |
| 7.  | Cortuna, Conchita V.        | Member                                    |
| 8.  | Factor, Epifania C.         | Area Leader - Laguna                      |
| 9.  | Francisco, Aurora G.        | Asst. Vice President for External Affairs |
| 10. | Gavadan, Helen G.           | Vice President – External                 |
| 11. | Marcelino, Lydia I.         | Vice President – Internal Affairs         |
| 12. | Ragay, Zenaida              | Area Leader                               |
| 13. | Santiago, Cecilia C.        | Secretary                                 |
| 14. | Tubaque, Olivia C.          | External Officer                          |
| 15. | Vallarta, Prescilla B.      | President                                 |
| 16. | Villamor, Marilou G.        | Area Leader                               |

**LIST OF TRAINORS/SPEAKERS**

Metro Manila

1. Ms. Amara Quesada, ACHIEVE
2. Ms. Leslie Arididon, ACHIEVE



**Annex B-1****HIV PREVENTION FOR FEMALE SPOUSES OF SEAFARERS**

Women and Ecology Wholeness Farm, Mendez Farm, Cavite  
6 September 2008

**PROGRAM OF ACTIVITIES**

8:30 AM	Registration	HDII/Primex
9:00	<ul style="list-style-type: none"> <li>• Introduction of Participants</li> <li>• Expectation Check</li> <li>• Project Overview</li> </ul>	Ms. Joy Pavico, PRIMEX
9:30	<ul style="list-style-type: none"> <li>• RH Overview</li> <li>• Overview on HIV and AIDS in the Philippines</li> </ul>	Mr. Arnold Vega, HDII
10:30	<ul style="list-style-type: none"> <li>• Sexually Transmitted Infections (STI)</li> </ul>	Ms. Cyril Dalusong, HDII
12:00 PM	Lunch	
1:00	<ul style="list-style-type: none"> <li>• AIDS 101</li> </ul>	Ms. Cyril Dalusong, HDII
2:00	<ul style="list-style-type: none"> <li>• Safer Sex</li> </ul>	Mr. Arnold Vega, HDII
3:30	<ul style="list-style-type: none"> <li>• Next Steps</li> </ul>	Ms. Joy Pavico, PRIMEX
4:00	<ul style="list-style-type: none"> <li>• Evaluation and Closing</li> </ul>	HDII/Primex

**GENDER TRAINING FOR SEAFARER'S SPOUSES**

Women and Ecology Wholeness Farm, Cavite  
4 October 2008

**PROGRAM OF ACTIVITIES**

8:30 AM	Registration	HDII/Primex
9:00	<ul style="list-style-type: none"> <li>• Welcome</li> <li>• Expectations and Objectives</li> </ul>	Ms. Joy Pavico, PRIMEX
9:15	Introductions (Gender Bingo)	
9:45	Is there a difference between sex and gender?	Gladys Malayang
10:45	How is gender constructed in our lives?	
12:00 PM	Lunch	
1:00	How does gender impact our lives? (Multiple Roles Of Women, Who Has Access, Control And Power)	Gladys Malayang/ Arnold de Vega
3:00	What can we do to promote gender equality and equity? (Empowerment Framework)	
4:00	What can I do to promote gender equality and equity? (Personal Action Plan)	
4:30	Evaluation and Closing	



**Annex B-2****REPRODUCTIVE HEALTH AWARENESS SEMINAR WORKSHOP**

Microtel Inn & Suites, Lanang, Davao City  
11-12 September 2008

**PROGRAM OF ACTIVITIES**

<b>Day 1 September 11, 2008</b>		
0800 – 0830	Registration of Participants	PRIMEX
0830 – 1030	Opening Ceremonies Invocation Welcome Introduction Expectations Setting Overview of the seminar-workshop	
1015 – 1030	Coffee Break/ Group Photo	
1030 – 1230	Session 1: Basic Gender Concepts	Rose Sanchez
1230 – 1330	Lunch Break	
1330 – 0600	Session 2: Manifestations of Gender Bias/ Violence Against Women/Gender Equality and Women Empowerment Framework/Concept of Power/Sexuality, Gender, Human Rights and Development Concepts	L. S. Chan
<b>Day 2 September 12, 2008</b>		
0800-1230	Reproductive Tract Infections/ Body Image and Health	Dr. Regina Ingente
1230-0130	Lunch Break	
0130- 6000	Carousel/HIV-AIDS Testimony	
0600-0630	Evaluation/Token for Participants	

**SKILLS TRAINING ON SEXUAL AND REPRODUCTIVE HEALTH  
FOR FEMALE SPOUSES OF SEAFARERS**

Eden Nature Park and Resort Davao, Davao City  
October 17-18, 2008

**PROGRAM OF ACTIVITIES**

<b>DAY 1: October 17, 2008</b>		
8:30 – 8:30	Registration	PRIMEX
9:00 – 9:30	Introduction and Project Overview	Malu S. Marin
9:30 – 10:30	Communication Skills	Ms. Gladys Malayang
10:30 – 10:45	Break	
10:45 – 12:00	Safer sex communication	Ms. Gladys Malayang
12:00 – 1:30	Lunch and Check-in	
1:30 – 2:00	Exercise	Malu S. Marin
2:00 – 4:00	Rights and Responsibilities of Allottees (Spouses of Seafarers)	Ms. Carolina Agdamag OIC, POEA Region XI
4:00 – 5:00	Discussion	
6:00	Dinner	
<b>DAY 2: October 18, 2008</b>		
8:30 – 9:00	Recap	
9:00 – 10:00	Self-introduction related to Sexuality	Ms. Reena Marcelo
10:00 – 12:00	Sexuality: definitions and elements	
12:00 – 1:00	Lunch	
1:00 – 4:45	Sexuality: workshop and discussion	Ms. Reena Marcelo
4:45 – 5:00	Closing and Evaluation	





TRAINING NEEDS ASSESSMENT (TNA) FORM

NAME: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age \_\_\_\_ Sex  Male  Female Civil Status \_\_\_\_\_

Contact Nos. \_\_\_\_\_ E-mail address/es \_\_\_\_\_

Have you attended any seminar/training on HIV/AIDS and/or Migration?

Yes  No

If yes, please enumerate:

Date	Title of Seminar/Training on HIV/AIDS
_____	_____
_____	_____
_____	_____
_____	_____

What do you remember from these trainings?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you expect from the Training?

Content \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Process \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Facilitators \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Co-participants \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your answers to the following questions will greatly enhance the content and process of the training so please answer as honestly as you can. Thank you very much.



After the training, it is expected that you will conduct peer education activities on HIV and AIDS. To become an effective peer educator:

\* What knowledge items or information items would you like to be clarified about?

---

---

---

\* What questions or issues about this topic might be difficult for you to answer?

---

---

---

\* What skills do you want to develop for this topic?

---

---

---

In the peer education sessions you will conduct, you will also need to include a discussion on safer sex issues and condom use. In relation to this:

\* What issues do you think might be difficult for you to discuss or handle?

---

---

---

\* What questions from participants might be difficult for you to answer?

---

---

---

\* What skills as a peer educator do you want to develop for this topic?

---

---

---

Please check any of the following:

\_\_\_\_\_ It is ok to call me for In case there are questions for clarification or need to follow-up on this TNA,

\_\_\_\_\_ It is NOT ok to call me for follow-up.



**Annex D**

**PEER EDUCATOR'S TRAINING WORKSHOP  
PROGRAM OF ACTIVITIES**

TIME	TOPIC	ACTIVITY	RESOURCE PERSON/ FACILITATOR
<b>Day 1</b>			
8:00 – 8:30	Registration		PRIMEX
8:30 – 9:00	Opening Program	Welcome Remarks	
		Introduction of Participants Expectations Check Programme Flow	Joel de Mesa
9:00 - 10:00	HIV and AIDS 101:	Carousel Q & A	Joel de Mesa
10:00 – 10:15	Break		
10:15 – 12:00	More on HIV and AIDS	Answering questions participants ask Core Messages for Peer Educators	Joel de Mesa
12:00 – 1:00	Lunch break		
1:00 – 4:00 (with one break)	Safer Sex 101	Condom Demonstration Safer sex activities Risk Continuum Fun Games Initial Assignments?	Joel de Mesa
4:00 – 5:30	Values Clarification	Opinion Poll	Joel de Mesa and Imelda
<b>DAY 2</b>			
8:30 – 9:00	Recap		Joel de Mesa/ interactive – 2 groups?
9:00 – 10:00	Skills Building	Discussion/Exercises	
10:15 – 10:30	Break		
10:30 – 11:30	Skills Building	Discussion/Exercises	
11:30 – 12:00	Assignments and Initial Preparation		
12:00 – 2:00	Lunch Break and Preparations		
2:00 – 6:00	Practicum with Feedback and VIDEO	Demo and Discussion	
<b>DAY 2</b>			
8:30 – 9:00	Recap		Joel de Mesa/ interactive – 2 groups?
9:00 – 12:00	Practicum with Feedback Video Showing	Demo and Discussion	Joel de Mesa
12:00 – 1:00	Planning, NEXT STEPS Synthesis and Evaluation		



**Appendix 3:**  
**TRAINING EVALUATION REPORT OF**  
**PEER EDUCATION OUTREACH SEMINARS**

**TRAINING EVALUATION REPORT OF PEER EDUCATION OUTREACH SEMINARS****A. Introduction**

1. The ADB Regional Technical Assistance **Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines** (RETA 6143), an ADB-assisted Project of the Department of Health (DOH), aimed, among others, to increase knowledge and awareness of female spouses of seafarers on the following: (i) their vulnerability to HIV and AIDS, (ii) gender, (iii) sexual and reproductive health (SRH), and (iv) HIV prevention. The Project was managed, on behalf of ADB, by PRIMEX, in association with Action for Health Initiatives (ACHIEVE) Inc. and Remedios AIDS Foundation (RAF). In the months between September to November 2008, female spouses of seafarers in two Project areas, Cavite and Davao, underwent a series of training courses as part of the package of interventions for community-based education and awareness on Gender, HIV and AIDS, and Sexual and Reproductive Health (SRH) issues. It was envisaged that the series of training courses will prepare these women to be peer educators who can echo the information to other female spouses of seafarers.

2. After the peer educators' training of the Cavite spouses, the group came up with their own design of their training module which they called Let's Be Safe – HIV/AIDS Awareness and Prevention for Female Spouses of Seafarers. The seminar tackles (i) basic information on HIV and AIDS, (ii) safer sex activities with condom demonstration, and (iii) issues and impacts of HIV and AIDS on the lives of seafarers and their families. The design was adapted by the peer educators in Davao, who devised their own motivational games and short learning events to give it their own flavor and local color. The program Let's Be Safe is included as Annex A.

3. The Project reached out to 72 women from three groups of female spouses from Cavite, Davao, and Metro Manila: (i) Craftstruck Club of Seaman's Village (CCSV) in Dasmariñas, Cavite (16 pax); (ii) Mary Star of the Sea Seafarers' Families Association (MSSSFA) in Davao City (37); and Veritas Allottees' Circle (VAC) Davao (3) and Metro Manila (15) chapters. Of the 72 women trained, the Project developed 21 peer educators disaggregated as: CCSV (7), MSSSFA (11), and VAC (3).

4. **Cavite Peer Educators.** In celebration of World AIDS Day (WAD), the seven peer educators in Cavite conducted their Kick-off event on 1 December 2008 and launched their group as the *Women's Circle of Seaman's Village* etched with a deeper commitment and advocacy to fight the spread of HIV and AIDS among their peers. They conducted a total of three outreach seminars and reached out to a total of 62 women, all of whom are female spouses of seafarers.

5. **Davao Peer Educators.** There are 14 peer educators in Davao City under this Project, 11 of whom are from MSSSFA and three are from VAC. The kick-off event in Davao was held on 17 December 2008 and was presented as a Christmas Party event held at Linmar where 20 spouses gathered to be oriented on HIV and AIDS and share the Christmas cheer. On 17 January 2009, the second outreach seminar was held at Villa Margarita Hotel and had 17 participants. A total of 37 peers benefited from the outreach seminars of the peer educators in Davao.

6. The **Let's Be Safe** program designed by the peer educators was able to reach out to a total of 99 peers. This number can be disaggregated as 65 in Cavite and 45 in Davao. Table A3.1 summarizes the peer educators' activities in terms of number of peers reached.



**Table A3.1: Peer Educators' Outreach Activities**

Date	Venue	Number of Participants
1 December 2008	David's Tea House, Dasmarinas, Cavite	23
6 December 2008		17
24 January 2009		25
<b>Total number of female spouses of seafarers reached in Cavite</b>		<b>65</b>
21 December 2008	Linmar, Davao City	20
17 January 2009	Villa Margarita, Davao City	25
<b>Total number of female spouses of seafarers reached in Davao City</b>		<b>45</b>
<b>Overall number of female spouses of seafarers reached by peer educators</b>		<b>110</b>

## B. Training Evaluation

7. This Training Evaluation Report contains the results of the evaluation of the peer educator-led outreach seminars using the following modes of evaluation: (i) pretest/posttest administered at the start and end of the seminar, respectively, and (ii) exit evaluation survey accomplished by participants at the end of the seminar.

8. **Pretest/Posttest.** The pretest/posttest (Annex B) is composed of two parts: (i) Knowledge on HIV and AIDS (20 statements) and (ii) Attitudes towards HIV and AIDS (15 statements). At the start of the seminar or prior to information input, the participants are given time to accomplish a pretest to determine their entry level of knowledge. At the end of the seminar, a posttest is carried out, after which the pretest is returned to the participants for them to compare changes in their knowledge and attitudes at the end of the seminar. The peer educators process the self-realized changes in knowledge and attitudes of the participants. In Davao, an exit opinion poll was carried out with the participants agreeing or disagreeing with the statements and the number of responses for each statement is recorded. The opinion poll measures the exit knowledge and attitudes of the participants.

9. **Evaluation Form.** In the evaluation form (Annex C), the participants rate on a scale of 1 to 4 (*1 = needs improvement, 2 = good, 3 = very good, 4 = excellent*) the conduct of the seminar in terms of (i) objectives being met, (ii) quality of workshop process, (iii) time management, as well as (iv) food and venue. The form inquires into which topics were most useful or needed more discussions. An open ended section allows the participants to write any comments or impressions about the seminar.

## C. Pretest/Posttest

### 1. Cavite Outreach Seminar

10. The pretest/posttest analysis for Cavite outreach seminars is presented in Annex D. Posttest answers showed that the participants are relatively well informed on HIV and AIDS. Although there are still some prevailing myths, they seem to understand the basics of HIV and AIDS. In comparing the results of the second batch with the first batch, the participants in the second batch were more likely to answer correctly. It seems that the trainers have been able to effectively educate their peers with succeeding batches. It was noted that many are willing to encourage a friend to use condoms and discuss HIV prevention with their husbands.

### 2. Davao Outreach Seminar

11. This section will focus on statements where the participants are unsure of their responses on knowledge on HIV and AIDS and their attitudes towards HIV and AIDS. Of the 20 statements on



knowledge, seven statements were still unclear to some participants. Of the 15 statements on attitudes, eight statements had unsure responses from the participants. The cumulative tally of responses is presented in Annex E.

12. Knowledge statements with unsure responses are: (i) getting infected with HIV by kissing an infected person, (ii) HIV transmission through manicure and pedicure, (iii) AIDS is the stage of HIV infection when the body can no longer fight off other diseases, (iv) the only way to tell if you are infected with HIV is to have an HIV test, (v) you will never get infected with HIV as long as you eat a balanced diet and exercise regularly, (vi) getting infected with HIV through mosquito bites, (vii) HIV can be prevented by being faithful to one partner.

13. Attitude statements towards HIV and AIDS with unsure responses are: (i) people with HIV having equal rights, (ii) AIDS as a disease of homosexuals, (iii) willingness to be employed in the same office with an HIV positive person, (iv) HIV positive persons should be isolated from society, (v) willingness to care for an HIV positive person, (vi) HIV positive person should not get pregnant, (vii) HIV persons have the right to get married and have children, and (viii) HIV infection is a punishment from God.

14. It is interesting to note that all respondents (37) are willing to get tested for HIV. In the first seminar, all respondents (17) acknowledge that PLHIV have equal rights as people without HIV infection, are willing to discuss how to prevent HIV with their husband, will encourage a friend to use condoms for safer sex.

#### D. Evaluation of Seminar

##### 1. Cavite Outreach Seminar

15. *To what extent do you think the objectives of the activity were met?* Participants rated the objectives being met from very good (30%) to excellent (70%). Some further commented that the seminar was well presented. One participant who is not a condom user commented that the objectives were met because she became convinced and will use condoms for protection.

16. *Please rate the quality of the workshop process.* Participants rated the quality of the workshop process from very good (45%) to excellent (55%). One commented that the workshop was very well delivered. While another said that the “*process is perfect because the participants are cooperative and comfortable.*”

17. *Please rate the time management of the workshop.* The trends in the evaluation of time management varied from batch to batch. During the kick-off event, when the peer educators were just learning to work as a team and getting used to each other's time and motion synchronization, the participants rated time management through the entire spectrum from needs improvement (4%), good (13%), very good (61%), and excellent (22%). Ironically, one participant commented that there was “right timing for each topic delivered.” However in the subsequent seminars, time management rated from very good (64%) to excellent (36%).

18. *Please rate the quality of venue and food.* The outreach seminars were conducted at David's Tea House is a Chinese restaurant which is accessibly located on the main road in Dasmariñas, Cavite. The participants rated the place and the food as very good to excellent. Many commented that “**the venue is excellent and of course the food is clean, delicious, and perfect.**”

19. *Which topics were most useful?* All topics, i.e. HIV 101 and safer sex, were identified as most useful.



20. *Which topics needed more discussion?* Many were satisfied with the information gained and said that all topics were well discussed. Others wanted to know more about (i) how the virus develops in the body, (ii) how to counsel a person who is HIV positive, how to detect the presence of HIV in her spouse,

21. *Other comments.* The participants were generous in their praises for the peer educators for doing an excellent job in sharing information with wives of OFWs and sounding off the importance of having other spouses know of this valuable information. Some insist that there should be a follow-up seminar. One thanked the organizers for having empowered the peer educators to be speakers. Many commended the peer educators for their enthusiasm and passion and blessed them with a green light to go and share the healthy topic with others. One asked for another seminar for husband and wife together. There was also a request to have a field trip to the Research Institute for Tropical Medicine (RITM) which conducts that confirmatory tests for HIV.

## 2. Davao Outreach Seminar

22. *To what extent do you think the objectives of the activity were met?* Participants rated the objectives being met as good (9%), very good (56%) to excellent (35%). One commented that she is really satisfied with the way the objectives of the activity were met.

23. *Please rate the quality of the workshop process.* Participants rated the quality of the workshop process as good (15%), very good (58%), and excellent (27%). One commented that she enjoyed the workshop very much.

24. *Please rate the time management of the workshop.* The participants rated time management of the workshop as good (38%), very good (35%), and excellent (27%).

25. *Please rate the quality of venue and food.* The outreach seminars were conducted in two places. The kick-off event was done in Linmar and the venue was rated as good (23%), very good (18%), and excellent (59%). The food at Linmar's was rated as good (18%), very good (23%), and excellent (59%). The activity in January was held at Villa Margarita Hotel, which participants found to be a nice and cozy place, rated as good (5%), very good (59%), and excellent (36%). The food, which one participant described as healthy food was rated as good (11%), very good (47%), and (42%).

26. *Which topics were most useful?* All topics, i.e. HIV 101, safer sex, and how to properly use the condom were identified as most useful.

27. *Which topics needed more discussion?* Many were satisfied with the information gained and said that all topics were well discussed. Others requested for actual videos or pictures of people living with HIV and AIDS, further discussion on how HIV damages the immune system, and more explanation and information on STIs.

28. *Other comments.* Many found the workshop as informative and were satisfied with its content and delivery. For the kick-off event, a few participants commented that the speakers need to improve on their delivery and ability to explain the topics fully. For the second seminar, the comments affirmed that the topics are all informative and clamored for more training sessions in the future.

## E. Synthesis and Recommendations

29. The efforts of the peer educators is commendable. Being responsible for immediate and extended families, they were able to find the time and energy to learn and be trained to be educators and reach out to their peers. As is expected in all neophyte trainers, there is still a wide room for improvement but needs to be matched with willingness to pursue beyond Project life.





30. The peer educators have expressed their willingness to partner with PRIMEX and ACHIEVE in reaching out to more peers in other crewing agencies. Most are willing to do this as a new career.

31. Below are some recommendations to further improve the training design and delivery:

- (i) Revisit the pretest and posttest findings of the peers – the peer educators can sit with their coaches to review the strengths and weaknesses of their training based on the posttest results, so as to improve on the exit knowledge and attitudes of their participants
- (ii) Involvement of people living with HIV – During the foundation training of the PEs, the impact of PLHIVs was very evident as they were able to give a face to the situation and shake the participants into the reality of their vulnerability. During the outreach seminars, PLHIV involvement was also included however, it was agreed that they need not reveal their HIV status. The difference is that the peer educators witnessed through their example that PLHIVs can have meaningful involvement in society. This reality did not seem to sink in with the peers reached during the outreach seminars.
- (iii) A refresher course will help the PEs discuss and level off with their coaches on their experiences as educators and deepen their understanding and update information on HIV and AIDS.
- (iv) Linking the PEs to other crewing agencies would help sustain the PEs' initiatives.
- (v) Supporting the peer education activities even after the Project timeframe.



Annex A

**LET'S BE SAFE:  
HIV/AIDS AWARENESS AND PREVENTION**

Venue

Date

**PROGRAMME**

TIME	TOPIC	PERSON RESPONSIBLE
9:30 – 10:00 AM	Registration	
10:00 – 10:05	Invocation	
10:05 – 10:25	Welcome, Introduction, and Project Overview	
10:25 – 10:30	Warm Up Exercise	
10:30 – 10:45	Self Introduction	
10:45 – 10:50	House Rules	
11:50 – 11:00	Pre-Test	
11:00 – 12:00	HIV 101	
12:00 – 1:00	LUNCH	
1:00 – 1:15	Ice Breaker	
1:15 – 2:00	Safer Sex	
2:00 – 2:30	Open Forum with Group Dynamics	
2:30 – 2:45	Synthesis	
2:45 – 2:55	Impact of HIV	
2:55 – 3:00	Closing and Evaluation	

**Emcee:**

**Organized by:**

Pacific Rim Innovations and Management Exponents (PRIMEX), Inc.  
in association with Action for Health Initiatives (ACHIEVE), Inc.



**Annex B**

**PRETEST/POSTTEST  
Questionnaire on HIV and AIDS-related Knowledge and Attitudes**

Participant Number: \_\_\_\_\_

Please read the following statements or questions carefully and tick the box that corresponds to your answer.

**A. Knowledge on HIV and AIDS**

Statements	Yes	No	Not Sure
1. HIV is the virus that causes AIDS.			
2. A person infected with HIV can look and feel healthy.			
3. HIV infection is considered a sexually transmitted infection.			
4. A person can get infected with HIV by sharing a meal with an infected person.			
5. A person can get infected with HIV by having unprotected, penetrative sexual intercourse with an infected person.			
6. AIDS is the stage of HIV infection when the body can no longer fight off other diseases.			
7. The only way to tell if you are infected with HIV is to have an HIV test.			
8. HIV can be transmitted from an infected mother to her child during pregnancy or childbirth.			
9. You will never get infected with HIV as long as you eat a balanced diet and exercise regularly.			
10. Using condoms can effectively reduce the risk of HIV infection.			
11. A person can get infected with HIV from mosquito bites.			
12. You can get infected with HIV by shaking hands with an infected person.			
13. It is possible to get infected with HIV from using public toilets.			
14. HIV can be transmitted through using and sharing contaminated needles.			
15. A person can get infected with HIV by kissing an infected person.			
16. HIV can be transmitted through manicure/pedicure sets.			
17. HIV infection can be prevented by being faithful to one partner.			
18. Receiving blood from an infected person is the most efficient way to get infected with HIV.			
19. There are drugs that can prolong the life of people infected with HIV.			
20. Abstaining from any sexual activity can effectively prevent HIV infection.			



**B. Attitudes towards HIV and AIDS**

Questions/Statements	Yes	No	Not Sure
1. Do you know if you are HIV positive or negative?			
2. People with HIV have equal rights as people without HIV infection.			
3. AIDS is disease of homosexuals.			
4. Are you willing to be employed in the same office with a HIV positive person?			
5. There should be a campaign to promote condoms for HIV prevention.			
6. HIV positive persons should be isolated from society.			
7. Are you willing to take care of an HIV positive person?			
8. Women infected with HIV should not get pregnant.			
9. Will you encourage a friend to use condoms for safer sex?			
10. HIV positive persons have the right to get married and have children.			
11. Sex workers are to blame for the spread of HIV.			
12. HIV infection is a punishment from God.			
13. People with HIV can lead a normal and productive life.			
14. Are you willing to get tested for HIV?			
15. Will you discuss how to prevent HIV with your husband?			



**LET'S BE SAFE:  
HIV/AIDS AWARENESS AND PREVENTION**

**EVALUATION FORM**

Please evaluate the Training Workshop by rating the following:  
1 = needs improvement, 2 = good, 3 = very good, 4 = excellent

ITEMS		Evaluation Ranking			
		1	2	3	4
1. Objectives	To what extent do you think the objectives of the activity were met?				
	Comments:				
2. Process	Please rate the quality of the workshop process.				
	Comments:				
3. Time Management	Please rate the time management of the workshop.				
	Comments:				
4. Overall	Please rate the quality of:				
	Venue (Function Room): Comments:				
	Food Comments:				
5. Which topics were most useful?					
6. Which topics needed more discussion					
7. Other Comments (if any)					

**THANK YOU**



Annex D**ANALYSIS OF POSTTEST DATA:  
CAVITE OUTREACH SEMINAR****A. Knowledge on HIV/AIDS:**

1. All subjects know that HIV causes AIDS.
2. All subjects know that people who have HIV make look and feel healthy
3. All subjects said Yes, HIV is considered a sexually transmitted disease.
4. Five participants feel that you can contract HIV by sharing a meal with an infected person.
  
5. All are clear that unprotected sex can cause HIV.
6. Some are still unsure that AIDS is the last stage of HIV.
7. Majority agree that testing is the only way to detect HIV.
8. Responses were varied on the issue that HIV can be transmitted from mother to child during pregnancy.
9. If you eat a balanced and healthy diet you will not get HIV – majority answered NO.
10. Dataset 2 one subject said No, condoms will reduce the risk of HIV, and one person was Not Sure. Two subjects said No in Dataset 3.
11. You can contract HIV through a mosquito bite. A few are not sure on this issue.
12. Three answered YES and one was NOT SURE to the statement - you can get infected by shaking hands with an infected person.
13. To the statement - you can get infected using a public toilet, 7 answered YES and two were unsure.
14. All said YES, HIV can be transmitted through shared contaminated needles.
15. Ten answered YES, to the statement - you can get HIV by kissing an infected person.
16. HIV can be spread through manicure/pedicure sets – 13 answered YES
17. HIV can be prevented by being faithful to one partner – 4 answered NO.
18. Majority agreed that receiving blood from an infected person is the most efficient way to get HIV. A few are not sure on this.
19. A few are not aware that there are drugs that prolong the lives of people infected with HIV.
20. Abstaining from sexual activity can effectively prevent HIV infection – 4 said NO and 3 are NOT SURE.

**B. Attitudes towards HIV/AIDS:**

1. Most do not know if they are HIV positive or negative.
2. People with HIV have equal rights as those that do not. Majority said YES and one was NOT SURE.
3. HIV is a disease of homosexuals – three said YES
4. Are you willing to be employed with someone who has HIV – Eight said NO and one was NOT SURE.
5. All said YES, there should be a campaign to promote condom use.
6. People with HIV should be isolated from society – 11 answered YES and one was NOT SURE.
7. Are you willing to take care of someone infected with HIV - Nine said NO and four answered NOT SURE.
8. Women infected with HIV should not have children – 19 answered YES.
9. All would encourage a friend to use a condom.
10. Persons with HIV have the right to get married and have children – Ten said NO and two answered NOT SURE.



11. Sex workers are to blame for the spread of HIV – 13 answered YES, and three are NOT SURE.
12. Eight view HIV as a punishment from God.
13. Eight do not agree that people infected with HIV can lead a normal and productive life.
14. Only two are not willing to get tested for HIV.
15. All are willing to talk to their spouses about HIV prevention.



**Annex E****EXIT - OPINION POLL  
DAVAO**

Below are the responses of the participants who responded during their opinion poll conducted at the end of the workshop. N = 37

**A. Knowledge on HIV and AIDS**

Statements	Yes	No	Not Sure
1. HIV is the virus that causes AIDS.	37		
2. A person infected with HIV can look and feel healthy.	18	19	
3. HIV infection is considered a sexually transmitted infection.	32	5	
4. A person can get infected with HIV by sharing a meal with an infected person.	21	16	
5. A person can get infected with HIV by having unprotected, penetrative sexual intercourse with an infected person.	32		5
6. AIDS is the stage of HIV infection when the body can no longer fight off other diseases.	31	1	5
7. The only way to tell if you are infected with HIV is to have an HIV test.	33		4
8. HIV can be transmitted from an infected mother to her child during pregnancy or childbirth.	17	20	
9. You will never get infected with HIV as long as you eat a balanced diet and exercise regularly.	16	17	4
10. Using condoms can effectively reduce the risk of HIV infection.	29	8	
11. A person can get infected with HIV from mosquito bites.	14	22	1
12. You can get infected with HIV by shaking hands with an infected person.	20	17	
13. It is possible to get infected with HIV from using public toilets.		37	
14. HIV can be transmitted through using and sharing contaminated needles.	37		
15. A person can get infected with HIV by kissing an infected person.	8	27	2
16. HIV can be transmitted through manicure/pedicure sets.	2		
17. HIV infection can be prevented by being faithful to one partner.	27	6	4
18. Receiving blood from an infected person is the most efficient way to get infected with HIV.	37		
19. There are drugs that can prolong the life of people infected with HIV.	37		
20. Abstaining from any sexual activity can effectively prevent HIV infection.	37		





**B. Attitudes towards HIV and AIDS**

Questions/Statements	Yes	No	Not Sure
1. Do you know if you are HIV positive or negative?		37	
2. People with HIV have equal rights as people without HIV infection.	17	13	7
3. AIDS is disease of homosexuals.	1	29	7
4. Are you willing to be employed in the same office with a HIV positive person?	20	14	3
5. There should be a campaign to promote condoms for HIV prevention.	23	14	
6. HIV positive persons should be isolated from society.	6	29	2
7. Are you willing to take care of an HIV positive person?	30		7
8. Women infected with HIV should not get pregnant.	25	8	4
9. Will you encourage a friend to use condoms for safer sex?	33	4	
10. HIV positive persons have the right to get married and have children.	28	6	3
11. Sex workers are to blame for the spread of HIV.	22	15	
12. HIV infection is a punishment from God.		29	8
13. People with HIV can lead a normal and productive life.	16	21	
14. Are you willing to get tested for HIV?	37		
15. Will you discuss how to prevent HIV with your husband?	32	5	



**Appendix 4:**  
**REVIEW OF EXISTING BEHAVIORAL CHANGE  
COMMUNICATION (BCC) MATERIAL AND  
IDENTIFICATION OF HIV INFORMATION NEEDS  
OF FEMALE SPOUSES OF SEAFARERS**

## REVIEW OF EXISTING BEHAVIORAL CHANGE COMMUNICATION (BCC) MATERIAL AND IDENTIFICATION OF HIV INFORMATION NEEDS OF FEMALE SPOUSES OF SEAFARERS<sup>1</sup>

### A. Introduction

1. Subproject 5 of the ADB Regional Technical Assistance for Fighting HIV/AIDS in Asia and the Pacific (RETA 6321) provides technical assistance to the Philippine Department of Health (DOH)<sup>2</sup>, local government units (LGUs), and non-government organizations (NGOs) to strengthen the country response to HIV/AIDS, specifically for two groups considered vulnerable, viz., injecting drug users (IDUs) (Component 1) and overseas Filipino workers (OFWs) (Component 2). During the implementation of Subproject 5, several gender-related concerns emerged which needed to be addressed to strengthen the gender-perspective of the Project outputs. To address these issues, additional funding was requested by DOH, and a **Proposal for Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines** was then submitted to ADB for consideration. In April 2008, the said Proposal was approved by ADB for funding through the **Gender and Development Cooperation Fund (GDCF) established under Promoting Gender Equality and Women's Empowerment (REAT 6143)**, which supports initiatives to promote gender mainstreaming in ADB operations, gender capacity development, and strategic partnerships.

2. To carry out the Project, ADB<sup>3</sup> engaged the services of **Pacific Rim Innovation and Management Exponents, Inc. (PRIMEX)**, the consulting firm implementing RETA 6321, Subproject 5, through single source selection, and the consultancy contract was signed on 23 May 2008. Upon receipt of the Notice to Proceed (NTP) from ADB, **PRIMEX and its Associates, Action for Health Initiatives (ACHIEVE), Inc. and Remedios AIDS Foundation**, mobilized the Consultant Team<sup>4</sup> on 26 May 2008.

3. RETA 6143 is intended to enhance and strengthen the gender-specific outputs of RETA 6321 and provide gender-specific recommendations for national HIV/AIDS and harm reduction programs and policies. The Project activities are expected to complement ongoing activities of RETA 6321 by enriching the gender perspective in the analysis and interventions to lessen the HIV vulnerability of female seafarers, female spouses of seafarers, and female IDUs. They will also facilitate community-based HIV prevention activities directly for the OFW sector, a component that was not included in the original TA.

4. One of the activities identified is the revision and replication of existing behavior change communication (BCC) materials on sexual and reproductive health (SRH) and HIV for female spouses. In the absence of adequate materials, the Project will pilot and pre-test the production of relevant, applicable, and acceptable BCC materials intended mainly for female spouses of seafarers.

5. The BCC Specialist assessed the existing and only material for female spouses on gender, SRH, and HIV, which was produced by ACHIEVE.<sup>5</sup> The Consultant Team distributed this material to two groups of female spouses of seafarers; viz., Craftstruck Club of Seaman's Village (CCSV) and the Veritas Allottees' Circle (VAC) in Manila, with a request to provide specific comments on

<sup>1</sup> This paper was prepared by *Dr. Maria Theresa Ujano-Batangan*, the Project's BCC Specialist.

<sup>2</sup> The National Center for Disease Prevention and Control (NCDPC) is the unit within DOH that is responsible for TA implementation. Oversight supervision is provided by *Dr. Yolanda E. Oliveros, MD, MPH, Director*, with *Dr. Mario Baquilod, Chief of the NCDPC Infectious Disease Unit* and *Dr. Gerard Belimac, Program Officer*, as counterparts.

<sup>3</sup> The ADB Project officer is *Ms. Barbara Lochmann*, Social Sector Specialist

<sup>4</sup> The Consultant Team is composed of the following specialists: *Ms. Ma. Lourdes S. Marin*, Behavior Change Communication (BCC) Specialist/Team Leader; *Mr. Pedrito B. dela Cruz*, Policy Advisor on Harm Reduction; *Dr. Maria Fiscalina Amadora-Nolasco*, Research Consultant, Female IDU Research Study; *Dr. Carolyn I. Sobritchea*, Research Consultant, Female Seafarers Research Study; *Ms. Sonia T. Tongco*, Research Assistant, IDU Research Study; *Ms. Raquel T. Ignacio*, Research Assistant, Female Seafarer Study; and *Ms. Josefina Ma. Ferriols-Pavico*, Project Coordinator. Providing oversight is *Ms. Elvira C. Ablaza*, President and CEO of PRIMEX, as Project Director.

<sup>5</sup> ACHIEVE. 2003. *Taking Control*. Life Skills Guidebook for Female Spouses of Migrant Workers.



sections they want to retain or remove. In addition, two focus group discussions (FGDs) involving CCSV (9 female spouses) and VAC (12 female spouses) were held to solicit information from the spouses on the kinds of BCC material that would appeal to them in terms of content, design, and type.

6. This Report presents the findings of the BCC Specialist on the document review and FGDs and highlights the assessment and recommendations on possible storylines, core messages, layout, and type, among others. As the spouses are inclined to prefer an illustrated pamphlet or comics-type material, another consultant, who specializes in producing IEC materials on HIV prevention, has also been tapped. This consultant wrote the storyline and all relevant texts (e.g., basic information on HIV and AIDS) to be included in the pamphlet.

## B. Study Methodology

7. Behavior change communication stemmed from various theories on how various modes and strategies of communication impact on behavior. These theories include: (i) stage/step theories; (ii) cognitive theories; (iii) social process theories; (iv) emotional response theories; and (v) mass media theories.

8. Across the different theories, the critical steps to behavior change have been identified to be knowledge, approval, intention, practice, and advocacy (Piotrow *et al.*, 1997). Effectiveness of communication strategies must include positive changes in the different aforementioned stages or domains – from knowledge to sustained action of the individual and to others. Studies show that variations exist as to the process of change – some go through all the stages, while others miss on some and proceed to other steps. The duration of responses to particular messages vary: some take a longer time, while others do not. The nature of messages also shift based on the nature and stage of the program or strategy – from the first few steps to later steps. There are different factors that influence the process of behavior change, thus, the need to determine these and work on their contributions/effects to the process.

9. Due to the varying factors which need to be considered in developing and implementing a behavior change strategy or program, it is necessary to go through the following phases:

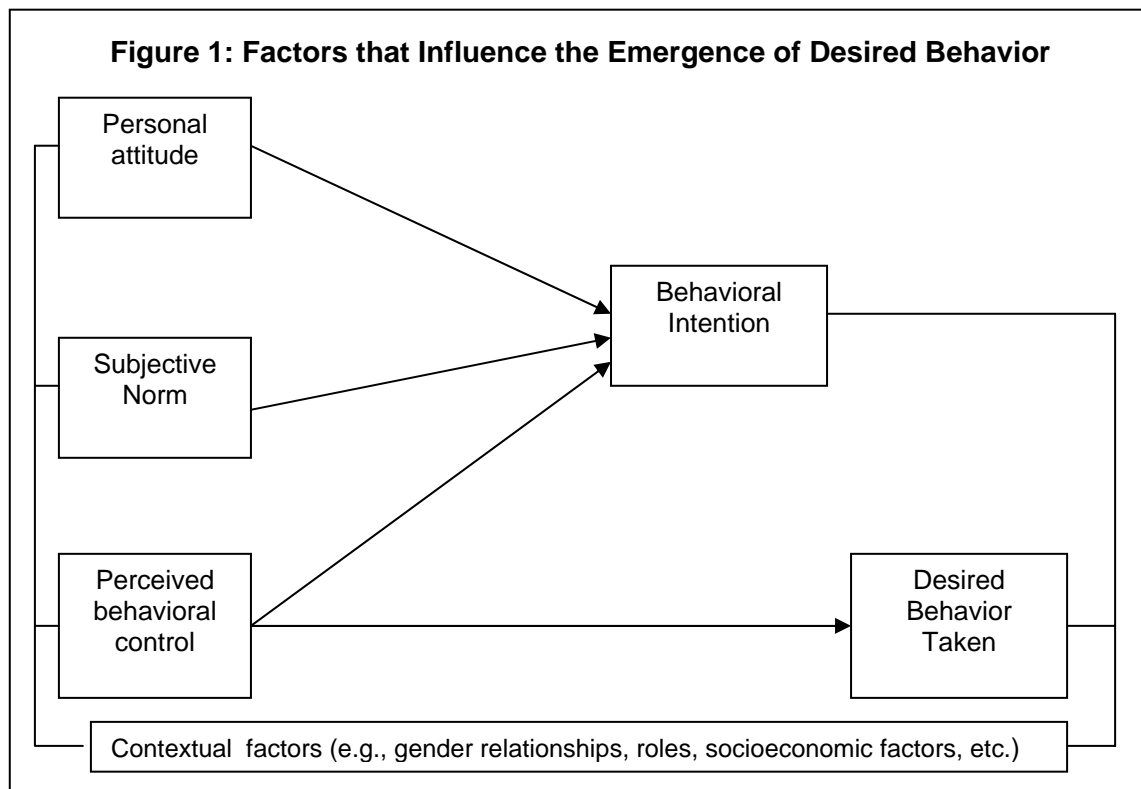
- Analysis of the potential audience, existing programs, policies, resources, strengths and limitations, and communication resources;
- Strategic design of the program including the identification and clarification of the objectives, audience segment, behavior change model, channels of communication, action plan and evaluation design;
- Development, pre-testing, revision, and production of message concepts, audience concept, materials, modalities of communication, etc.;
- Management, implementation, and monitoring of the behavior change strategy/program;
- Evaluation of the impact of the program and determining improvements for future projects;
- Planning for continuity to sustain the gains and address the limitations posed by the implementation of the strategy/program.

10. The current research addresses the first stage of the process. Thus, this subcomponent of the Project on *Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines*, focuses on addressing the following objectives:

- To review existing material on SRH and HIV for female spouses of seafarers;
- To determine the HIV information needs of female spouses of seafarers; and
- To draw recommendations in the development of IEC materials to promote HIV/AIDS awareness among female spouses of seafarers.



11. Results of this subcomponent will feed into the process of revising IEC materials on SRH and HIV for female spouses of seafarers. Interventions that allow for the use of educational materials are premised on the assumption that information and knowledge promotion will effect changes in the attitudes, perceptions, and behaviors among individuals comprising the target population. This is reflected in the *Theory of Reasoned Action and Personal Behavior (TRAPB)* developed by Fishbein and Azjen (McKee *et al.*, 2000), which stipulates that a particular behavior is a product of one’s personal attitude, subjective norm, perceived behavioral control, and behavioral intent. It is, however, important to understand these elements vis-à-vis contextual variables. Gender relations, roles, socioeconomic factors, and other cultural factors definitely impact on an individual’s attitudes, norms, perceived control, behavioral intent, and desired behavior. Given this perspective, a revised TRAPB framework was developed for this study, as shown in Figure 1.



12. Interventions (including those that entail the use of information education materials) should influence the aforementioned aspects for the desired behavior to be expressed and sustained. Given these elements of behavior change, it is important to understand the current attitudes, norms, level of control, behaviors, and related contexts of individuals to be able to design materials that will effect change at the individual level.

13. To address the objectives of this subcomponent, two methods were employed in the process of data gathering: document review and focus group discussion (FGD).

**1. Document Review**

14. The primary document or material reviewed was, “*Taking Control: Life Skills Manual for Female Spouses of Migrant Workers*,” produced by ACHIEVE. Apart from the researcher, the FGD participants were also asked to evaluate the primary material in preparation for their participation in the FGD. Their individual evaluation of the material provided data in the review, specifically what information they need on SRH and HIV.



## 2. Focus Group Discussions

15. **Participants.** There were two groups of participants in the FGDs: one group comprised of nine female spouses from Cavite (FGD-1); another composed of 12 participants from Manila (FGD-2). Their socio-demographic characteristics are summarized in Table 1.

**Table 1: Socio-demographic Characteristics of the FGD Participants**

Socio-demographic characteristics	FGD-1 (N=9)	FGD-2 (N=12)
<b>Age groups (years)</b>		
20-24	0	0
25-29	1	0
30-35	2	0
36-40	3	1
41-45	0	0
46-50	2	7
51-55	0	1
56-60	0	1
61-65	0	1
No response	1	2
<b>Educational attainment</b>		
Elementary	0	0
High school	0	0
Vocational	0	0
College		
- Undergraduate	3	0
- Graduate	5	8
Postgraduate	1	0
No response	0	4
<b>Occupation</b>		
Housewife	3	5
Entrepreneur	2	1
Sales	2	2
Catechist	1	1
Professor	0	1
Retired	0	1
Telephone operator	0	1
No response	0	0
<b>Number of years husband has been a seafarer</b>		
Less than 10 years	2	3
More than 10 years	6	7
No response	1	2

16. Initially, the plan was to group the female spouses/partners of seafarers based on their chronological age, which corresponds to their stage in the developmental cycle (i.e., Group 1 will comprise of 34 years old and below who are in early adulthood; Group 2 will be composed of 35 years old and above and are in middle and late adulthood). However, these groupings were not strictly followed given the limitations posed by the tasks of identifying individuals, satisfying the requirements for each group, securing the participants' informed consent, and adjusting to the participants' availability. Gleaning from the profile summarized in Table 1, one of the groups (FGD-1) is a mixed group comprised of female spouses of different age ranges from early to middle adulthood, while the second (FGD-2) included individuals from middle to late adulthood.

17. The socio-demographic profile of the participants indicates that majority of them (13) graduated from college and are currently working (12). Three participants of FGD-1 and five in FGD-2 opted to stay home or stop working after their husbands left for overseas work due to a variety of



reasons, such as the need to (i) take care of their children's daily needs, (ii) respond to their children's emerging problems, and (iii) respond to their respective husband's request for them to stay home.

18. Most of the female spouses who participated in the FGDs have husbands who have worked for more than 10 years as a seafarer (13). In FGD-1, the participants identified the following jobs of their husbands: chief mate, master, chief cook, 3<sup>rd</sup> engineer, 2<sup>nd</sup> mate, chief engineer, chief steward, and chief TSM. The respondents in FGD-2 gave the following jobs of their seafaring husbands: chief engineer, cargo-deck, cargo, engine, car ship, and welder. The latter group members are not aware of the specific job and rank of their respective spouses.

19. **Preparatory Activity.** Prior to the conduct of the FGDs, individuals who qualified and agreed to be participants were oriented on the objectives of the research, research process, and their rights as participants. After securing their informed consent, they were provided a copy of the material, *Taking Control: Life Skills Guidebook of Female Spouses of Migrant Workers*, and two highlighters (blue and orange). They were then given the following instructions:

*“Pakitignan po ang babasahin na ibinigay po namin bago po kayo lumahok sa FGD. Gamitin po ang mga highlighters para matukoy ang nilalaman ng materyal. Pakigamit po ang blue/bughaw na highlighter para markahan ang mga paksa na sa tingin po ninyo ay kailangan pong manatili sa materyal kung ito po ay gagamitin sa pagpapalawak ng kaalaman ng mga asawa ng seafarers ukol sa HIV/AIDS. Gamitin po ang orange/kahel na highlighter para markahan ang mga paksa na sa tingin po ninyo ay hinid na kailangang isama. Makakatulong po ng malaki kung maitatala din po ninyo ang mga katanungan at suhesyon ninyo sa materyal na binasa. Huwag po nating kalimutan na dalhin ang mga komento at ang babasahin po sa FGD. Salamat po at magkita po tayo sa FGD sa (tukuyin ang petsa at oras.”* (Please go through the material provided to you before attending the FGD. Use the highlighters to mark particular contents of the material. Please use the blue highlighter to mark the topics which need to be retained in the material if it will be utilized to promote HIV/AIDS awareness among spouses of seafarers. Use the orange highlighter to note the topics which you think should not be included anymore. It will also help a lot if you note down any questions or suggestions you have while reading the material. Please do not forget to bring your comments and the material to the FGD. Thank you and we'll see you in the FGD on (specify date and time).

20. **Conduct of FGD.** The process of conducting the FGD, presented in Annex A, shows the procedural guide for the facilitator and the guide questions to process the following topics: (i) notions of SRH and HIV/AIDS; (ii) advocacy/information dissemination campaign; (iii) evaluation of the material “Taking Control”; and (iv) feedback on the method of conduct of the FGD.

21. **Data Analysis.** The results of the document review and FGDs were analyzed using both quantitative and qualitative perspectives.

### C. Results and Discussion

22. The results of the document review and the FGD constitute a rich body of data/information. Various domains were drawn in the course of analyzing the materials.

#### 1. Notions of SRH and HIV

23. The FGD participants associated the concept, “Sexual and Reproductive Health,” with the following domains:



- Pregnancy: “*meeting ng kwan*” [meeting of something], *egg and sperm; giving birth* (FGD-1)
- Reproduction: “*pagpaparami*” [“multiplying”] (FGD-1); *reproduction* (FGD-2)
- Sex and sexual activities: “*paano ginagawa*” [how (sex) is done]; “*positions...madami*” [many], “*missionary, anal, Kama Sutra; love making*” (FGD-1; FGD-2)
- Sexual and reproductive organs: *vagina, penis, cervix; puke, pekpek, kepyas, bilat, pipi, antak, buday* [female organ], *titi* [penis]; *ovary, bayag* [testicle] (FGD-1)
- Diseases and infections: *herpes, gonorrhea; Hepatitis B, C, cervical cancer, breast cancer, HPV* (FGD- 1); *karamdaman ng mga babae* [sickness related to women], *related doon sa* [to the] *reproductive organs* (FGD-2)
- Care of the reproductive system: *regular check-up, pap smear, minimal check-up, if you’re taking pills; HIV testing* (FGD-1)
- Family planning : *condom; birth spacing; 2-3 years ang healthy spacing* (FGD-1)
- Sexuality: “*sekswalidad, malalim; pagkatao; kaloob ng Diyos; kasama sa sexuality ang pangangailangan ng mag-asawa na sa kaso naming may irregular sexual activity, sa kabuuan wala sila ng pangangailangang sekswal*” (FGD-2) [sexuality, deep, being human, God-given, with sexuality comes the needs of married couples which in our case, has irregular sexual activity, as a whole, they do not have any sexual needs]
- Intimacy: “*paraan ng mag-asawa para mapalapit sa isa’t isa; dapat nauunawaan ang pangangailangan at kalagayan ng bawat isa na hindi ganun kadali*” (FGD-2) [a way for a married couple to be close to one another, one should understand the situation of the other and it is not easy]
- Reproductive rights: “*hindi lang sexual e, karapatan mo bilang asawa, karapatan mo na igagalang ng lahat bilang , kung sino ka*” (FGD-2) [it is not only sexual, it is your right as a spouse, it is your right to be respected for who you are]

24. In the process of discussing infections as part of SRH, the participants also reported the following associations, when asked about what they know of sexually transmitted infection or STI:

- Presence of discharge (FGD-1)
- Foul odor from the vagina/penis : “*malansang amoy*” (FGD-1)
- Pain in the lower abdominal area: “*masakit ang puson* (FGD-1)”;
- Pain in urination: “*masakit ang pag-ih,*” “*burning sensation*”(FGD-1)
- Gender differences in the experience of STI: “*especially for women, kasi matagal madetect ang STI kasi sa loob nagsisimula and infection; unlike men na madali makita kasi nakalabas ang ari nila*” (FGD-1) [...it is difficult to detect STI because the infection begins from within, unlike men where it is easier to detect STI because the man’s penis is outside his body]

25. When notions of HIV/AIDS were probed, the female respondents stated that the acronym HIV stands for *Human Immunodeficiency Virus*. Another term used was *Human Immunodeficiency Syndrome*. Some of the respondents in both groups are cognizant of the differences between HIV and AIDS, the latter being described as the *full-blown* manifestation of the infection, while HIV being *simula lang* or the initial stage of the infection (FGD-1). In the area of HIV transmission, the participants are knowledgeable of the usual modes of contracting the virus, specifically sexual intercourse, blood transfusion, and sharing of needles. The first group also discussed the possibility of getting the infection from saliva, but recognized that it *takes gallons of saliva para mahawa ka*. [for you to get infected]. The other respondents (FGD-2) also identified sperm and semen as carriers of the virus. The participants are aware that HIV/AIDS is currently incurable and that prevention is the only recourse. Only one of the participants (FGD-2) has encountered someone living with AIDS and dying of the infection. Various ways of preventing transmission identified by the respondents are:





- Safe sex (FGD-1)
- One partner (FGD-1); monogamy (FGD-2)
- Abstinence (FGD-1)
- Use of condom (FGD-2)

26. Among the participants of FGD-1 and FGD-2, no one has experienced going through HIV testing. They think that there is no need for them to go through this primarily because their husbands have passed the medical examinations required by employers. They believe that *the fact na pumapasa ang mga mister namin sa medical, means ok kami. Automatic Yun...kumpleto naman sila ng medical, bago umalis may medical, pagdating post medical.* [the fact that our husbands pass the medical exam, means we should be okay. That is automatic, they are complete in medical, before they leave they have a medical exam, when they arrive, a post medical]

27. The wives who participated in the FGDs, however, recognize that their husbands are at risk to STI and HIV infection. They know that seafarers have multiple sexual partners as reflected in the succeeding responses:

- *"They have sex with different partners kaya susceptible sila sa AIDS. Kasi talaga promiscuous talaga sila."* (FGD-1) [ ... that is why there are susceptible to AIDS. Because they are indeed promiscuous.]
- *"Kasi mahilig silang gumamit ng bayarang babae."* (FGD-1)[ because they are fond of using commercial sex workers]

28. Despite the presence and recognition of the risks of being acquiring STIs and HIV, the participants fail to address the need to monitor their own sexual health. This is due to a variety of factors, such as lack of time:

- *"Actually siguro kasi minsan, karamihan ay kababaihan na spouses ng seamen, in terms of reproductive health, hindi regular ang check-up, hindi nagagawa yan. Kasi nakakaligtaan, because of work o ibang factors niyan. So hindi alam kung healthy pa sila o hindi na."* (FGD-1)  
[maybe sometimes, many female spouses of seamen, in terms of reproductive health, o not have regular check ups, they do not do this, because they forget to do it, because of work or other factors. So they are not aware if they are healthy or not]
- *"Minsan kasi ang schedule e, meron talagang full-time moms nakakalimutan na ang sarili. Least na sa priorities dahil sa responsibilities."* (FGD-1)  
[sometimes my schedule, there are really full-time moms, they forget themselves. Least of priorities because of responsibilities]

29. Another reason is the absence of symptoms:

- *"Dahil din, wala naman nararamdaman."* (FGD-1)  
[Because also one does not feel anything]
- *"E ganyan naman ang tao, hindi magpapatingin hanggat walang nararamdaman. Kung nararamdaman na, tsaka lang magpapa check-up."* (FGD-1)  
[Well, people are really like that, they do not go see a doctor not until they feel something. Only when they feel something will they go for a check up.]

30. The emotional burden of knowing that one is ill is also one reason why spouses avoid being tested:

- *"Meron po akong isang friend na narinig na ayaw magpacheck-up dahil takot siyang malaman kung ano ang lalabas sa resulta."* (FGD-1)



[I have a friend whom I learned does not want to go for a check up because of fear of knowing what could possibly be the results of the test]

- “*Ako naman masyadong hypochondriac, kung kahit wala akong sakit akala ko na may sakit ako. Kahit iba ang sinabi ng doctor, masyado akong paranoid.*” (FGD-1)  
[I am very hypochondriac even if I am not sick, I think that I am sick. Even if the doctor says otherwise, I am such a paranoid.]

31. **SRH Needs.** The FGD participants identified several SRH needs of women spouses of seafarers. These needs were based on their own experiences and other women’s experiences who share the same plight:

- **Education:** All the participants reported that they should have more information on SRH. The second group would also want inputs on menopause, aging, and coping.
- **Empowerment:** The participants recognize the lack of power among women in relationships, which they think is further exacerbated by their lack of education and economic resources, as well as the lack of government services: “...ang mga babae lalo na sa mga lugar na hindi nakapagtapos ang babae, sa mga depressed area, submissive sila masyado, oo lang ng oo. Kaya umaabot ang mga anak nila sa 15,17. Wala silang choice e, wala naman support from the government, pangalawa wala din silang magawa sa asawa nila.” (FGD-1) [ ... women, especially those areas where women do not finish their education, the depressed areas, these women are very submissive ... they jus say “yes” and “yes”, that is why they get to have 15, 17 children. They have no choice, there is no support from the government. Second, there is nothing they can do with their husbands]
- **Livelihood programs:** The participants of FGD-1 related the need for these programs in the context of empowering women economically, making them more independent from their husbands.
- **Interventions for couples:** Respondents also verbalized the need for interventions that would allow them to deal with difficulties faced in the relationship (e.g., financial, relational and in- law problems) (FGD-2).

32. Sex is considered by the women respondents as pleasurable, but they also recognize that it is associated with certain risks such as pregnancy and infections (i.e., STI and HIV). These risks are associated with the lack of knowledge, poverty, and the unavailability of contraceptives. They also recognize that spouses of male seafarers have to contend with the realities that their husbands face in their jobs, such as the need for “*social interaction*” after long months at sea (FGD-1; FGD-2). They do not deny the possibility of their partners engaging in unsafe sexual behaviors with commercial sex workers or even with co-workers. The respondents also feel that risks co-vary with age and type of vessel of their partners. Husbands who are younger are said to be more at risk, although some disagree with this. Those coming from passenger ships and bulk/reefers have more time in the port and more individuals to socialize with, thus, there is greater possibility and frequency to engage in sex. Though there are stricter measures being imposed now (e.g., prohibition on commercial sex workers [CSWs] boarding ships; allowing only wives to visit; post-medical exams) and spiritual/religious programs being implemented on board, these have not deterred seafarers from engaging in causal and unprotected sex.

33. Once their respective husbands come home, female participants reported that they would frequently engage in sex (i.e., 4-7 times a day), thus increasing the risk of their experiencing *gasgas* (lacerations) and infections. This was mirrored by the following response: “*biro na PLDT, gamit na gamit kami pag umuwi ang asawa*” (FGD-2). [a joke of PLDT (phone company), we are so used when our husbands come home.]



34. Their partners' lifestyle, which includes getting drunk, serves as a gateway for unprotected sex. The physical and economic mobility of their husbands also contributes to their engagement in extramarital relationships abroad and even in the Philippines. One participant even caught her husband having sex with their household help (FGD-2). All these contexts make the respondents vulnerable to sexual and reproductive risks.

35. It is interesting to note that in the initial part of the discussions among younger spouses, the concept of SRH was purely related to physical health and did not include discussions on well-being. It was at the latter part of the discussion on SRH needs when issues related to women's lack of power (associated with lack of education, economic resources, and ability to negotiate) and the concepts of individual sexual needs and desire became more salient. The older spouses, on the other hand, also associated SRH with sexuality, intimacy, and rights.

36. The FGD participants recognize their need to engage in sex even when their partners are not around. They stated that they also experience sexual urge or "*libog*," and deal with it in various ways:

- Sublimating the need by engaging in other activities
  - "*Busy- busyhan ang lola mo.*" (FGD-1) [ the old woman will feign to be busy]
  - "*Sa gabi, tutulog na lang.*" (FGD-1) [ at night we just go to sleep]
  - "*Labas na lang kasama ng mga anak ko, imbes na S na sex; S na lang na shopping.*" (FGD-1) [we just go out with my children, instead of S for sex, S is for shopping instead]
  - "*Taking a bath.*" (FGD-2)
  - *Faith in God as God supplies the strength.* (FGD-2)
- Engaging in autosexual and alternative sexual behaviors
  - "*Meron din kaming kakilala na binilhan siya ng dildo ng husband niya. Pag tumawag ang husband niya ginagamit niya iyon.*" (FGD-1)  
we know of one whose husband bought a dildo and everytime he calls, they will use it.
  - "*Ok naman yan e, kesa manlalaki ka. Una, hindi mo maoofend ang husband mo. Ikalawa, ikaw lang. Ikatlo, free ka sa mga sexually transmitted infections.*" (FGD-1)  
[that is okay rather than you going after men. First, you will not offend your husband, second you are by yourself, and third, you are safe from contracting STIs]
  - *Phone sex.* (FGD-2)
- Denying the existence of the need
  - "*Wala. Manhid.*" (FGD-1) [none, numb]

37. Although masturbation is one of the identified behaviors which allow the participants to address their sexual needs, they expressed reluctance in engaging in this behavior because of a variety of reasons: (i) reported inability to attain gratification; (ii) fear that they will no longer enjoy having sex with their husbands when they get used to the pleasure derived from autosexual behavior; and (iii) cultural expectations that prohibit women from exhibiting any form of behavior, other than that in shared sex. One participant verbalized that she does not want to have sex toys, even if her husband volunteered to buy her one because she fears that she might get used to it and look for it – *baka hanapin ko lang* (FGD-2).

38. One of the SRH needs that participants also identified pertain to the need to address the incidence of gender-based violence, specifically economic and psychological: "...*hindi naman domestic na binubugbog, pero financial violence. Parang everytime na may gagawin siya sasabihin niya na babawasan ng allowance.*" (FGD-1) "*Isa pang violence sa spouses ay yung pambabae ng husband...masakit yun, talagang masakit.*" (FGD-1) [it's not like domestic (violence) where in one



gets beaten up, but financial violence. It is as if everytime he will do something, he will deduct it from our allowance,] another act of violence of the husband is his philandering ways and still has another woman – that is painful, really painful.”

39. Though some of the participants recognize the emotional turmoil they feel when they learn about their husbands’ philandering ways, they admitted to just accepting their situation:

- *“Hindi sa binibigyan ko ng excuse, pero may mga needs na ganyan ang mga lalaki..ang mga lalaki ay mahina ang control. And sinasabi ko ay lawakan nyo din ang inyong pananaw.” (FGD-1)*  
[It is not that I am condoning, but men have certain needs, and have weak self control. What am saying is widen your thinking.]
- *“Pero I agree with her na pangangailangan nila yan e, kahit na sabihin ng asawa mo, wala akong babae, mahal na mahal kita. Tao lang naman tayo, nadadarang...” (FGD1)*  
[But I agree with her that those are their needs. Even if your husband says that he has no woman and that he truly loves you, They are but human.]

40. There were participants, however who believe that the standard of abstinence should apply to both the husband and wife, and find direct and indirect ways of putting this message across to their partner:

- *“Ang sinasabi ko noon, na kung hindi mo matiis, ako din. Lalo na ako, nandito, kung sinu-sino ang makikita ko. Pero kaya ko yun, dapat kaya mo din. Kaya ng puso ko, kaya ng damdamin ko, kaya din ng puson ko.” (FGD-1)*  
[I used to say (to my husband) that if you cannot control, I too cannot control, what more with so many other men I see. But I can take it, and so should you. My heart can take it, my feelings can take it, so also can my womb take it.]
- *“Ginagawa ko nag-iinternet research ako tapos pinapadala ko sa kaniya. So ganun ang trabaho ko “Pa, tell the rest of the crew to take care.” (FGD-1)*  
[I surf the internet for information and then I send it to him. Then I tell him...]

41. Despite the participants’ attempts to negotiate sexual fidelity in their relationships with their spouses, there is still the recognition that they have to accept the “fact” that the experience of sexual urge among males is “biological” and “harder to control.” Most of the FGD respondents related that they really cannot say whether their partners are faithful to them or not:

- *“Kasi ang mga husband, hindi naman laging honest, wala kang assurance na wala siyang ginagawa sa labas.” (FGD-1)*  
[Husbands are not always honest, you have no assurance that he is not doing anything outside]
- *“Kasi ang asawa ko simpatiko siya masyado at masyado siyang mapagbigay. Kasi ang lalaki ay hindi aamin, kahit didkdikin mo sila.” (FGD-1)*  
[My husband is very charming and very accommodating. Men will never admit to philandering even if you beat them to a pulp.]
- *“Iba ang asawa ko, lalong lumalala.” (FGD-2)*  
[My husband is different, he is getting worse]

42. The aforementioned responses led one of the respondents to suggest the need for an external mandate (e.g., law) that will require their spouses to be tested for STI and HIV upon arrival. Though the participants recognize that this may be a violation of the rights of their partners, the presence of a law will allow them to “comfortably” ask their husbands to be tested, thus protecting themselves from possible infection. This further mirrors the inability of most female spouses to negotiate for safer sex in the context of their relationship with their seafarer husbands.



43. For the wives in middle and late adulthood, menopause serves also as context for changes in the participants' sexual needs. Some of the participants used the term "*maglayag*" and "*paglalayag*" to denote the journey females embark on at their climacteric period. One participant shared that she had menopause at 48, but because she believes that sex is a need of the husband, she felt the necessity of reading up on the topic. She did this to understand what she is going through and how to attend to her partner's sexual needs so that the latter will not go astray: "...*dahil need ng lalaki yan...para di maghanap ng iba ang asawa*" ["...because that is a need of a man ...so that the husband will not seek someone else"] (FGD-2). Another participant from the same group stated that when the wife has gone through menopause, the husband starts to have fears regarding the former's sexual fidelity (primarily because the former is no longer fertile). This poses another issue or concern in their relationship. Some participants stated that they are flattered by comments from their husbands that their vagina is still tight (*makipot*) and that they are still like virgins, which is also an assurance to their partners of their sexual fidelity.

44. In some cases, in-law problems may lead to issues in marital relationships, which impact on the sexual relationships of the couple.

45. **Advocacy/Information Dissemination Campaigns.** Most of the female participants who had received information on HIV/AIDS remember being provided with knowledge about the definition of HIV/AIDS and modes of transmission. They also remember some of the images they have associated with HIV, such as "*may psoriasis, mukhang nagdra-drugs, nasisira ang skin, payat, and Sarah Jane.*" ["with psoriasis, looks like being on drugs, skin is deteriorating, thin ..."] The participants however, recognize that there is no one image of someone who has been infected, and that the symptoms of the illness are not really evident until the last stage of AIDS. The most common media and contexts through which information on HIV/AIDS are conveyed to them are:

- Television, e.g., stories, DOH plugs (FGD-1; FGD-2)
- Movies, e.g., Philadelphia, Sarah Jane (FGD-1; FGD-2)
- Internet (FGD-1)
- Magazines (FGD-1)
- Books (FGD-1)
- Consultation in a private clinic (FGD-1)
- Lectures/seminars on family planning and STI (FGD-1; FGD-2)
- Posters in hospitals (FGD-1)

46. Some of the core messages, which the respondents remember from the abovementioned media and contexts, are:

- "*Kailangan safe sex.*" [needs safe sex] (FGD-1)
- *Be careful.* (FGD-1)
- *Anybody can be contaminated.* (FGD-1)
- "*Vulnerable lahat.*" (FGD-1)
- "*Walang age bracket, walang pinipili.*" (FGD-1)

47. All of the abovementioned messages pertain to the disease being deadly and incurable, of all individuals being vulnerable, and that the transmission of the virus can be prevented through safer sexual practices (e.g., abstinence, condom use, monogamy).

48. Some of the participants reported that they became more aware about HIV/AIDS after receiving information. One stated that she would constantly nag her husband about sexually transmitted infections after learning about the possibility of being infected. Some used the information they got to open the doors of communication with their husbands. They talked about what they have learned about HIV, which allowed their husbands to narrate their experiences



overseas. Others also expressed their fears of being infected by their husbands. These new information, however did not impact on their sexual behaviors:

- *“Oo naman, may nagbago, pero sa sexual practice wala naman, kaya lang sa natutunan namin sa seminar hindi naman basta nakakahawa. Not unless TB, yun nakakahawa. Yun sa HIV hindi talaga...Ang perception mo nabago, yung knowledge.” (FGD-1)*  
[Yes, there have been changes in knowledge and perceptions but not in our sexual practices, What we have learned from our previous seminars is that HIV is not that contagious, unlike TB.]
- *“Wala naman nabago sa sexual practice naming mag-asawa kasi alam naman namin na negative kami pareho.” (FGD-1)*  
[Nothing has changed in our sexual practices because my husband and I know that we are both negative (for HIV).]

49. The reasons why knowledge has not been translated into action relate to discourses of “trust” (*tiwala*) and “sincerity.” The participants stated that there is a need to trust one’s partner and assume that one’s partner is faithful. Asking one’s partner to use condom or to have himself tested are violations of the marital pact of trusting each other. This directly conveys suspicion on the husband’s and the wife’s faithfulness to the partner. The respondents claimed that they could gauge their partners’ fidelity by assessing the latter’s level of sincerity:

- *“Kasi masasabi mo naman kung nagsasabi ng totoo ang asawa mo o hindi e, kasi kung hindi nagsasabi ng totoo e di dapat may sakit na siya dati pa, dati ka pa nahawa. Di ba, so ita- trust mo ang sincerity ng asawa mo.” (FGD-1)*  
[You can determine if your husband is telling the truth or not. If he is not telling the truth, then he should have shown signs of being ill way back, and you should have been infected, isn’t it? So trust the sincerity of your husband.]
- *“So ang lumalabas na values ay trust, sincerity.” (FGD-1)*  
[So the outstanding values here are trust and sincerity]

50. “*Pakikiramdam*” [Gut feel] seems to be a critical tool utilized by the female spouses to assess whether or not their partners have been faithful to them and whether they are infected or not.

51. Although most of the FGD participants have received information on HIV/AIDS, most of them feel that these are not enough and that they have not yet fully understood the various means of transmission and how they can protect themselves. They recognize that spouses of seafarers are not a monolithic group and that variations may stem from differences in age, educational attainment, economic status, and life experiences. They, however, think that the following suggestions (in conveying information on HIV/AIDS) would be more effective to their group:

- Methods of presentation should be more visual. The use of pictures (not just text) and videos are highly recommended. (FGD- 1; FGD-2)
- Content and language should reflect the layman’s point of view. (FGD-1)
- Testimonies of individuals living with HIV will make discussions more interesting and rooted in real life. (FGD-1; FGD-2)
- Prevention should be highlighted in the messages. (FGD-1; FGD-2)
- Consequences of infection should also be discussed. (FGD-1; FGD-2)
- Coping with the infection should also be tackled. (FGD-1)
- Stories and storylines used/developed should reflect the lives of seafarers’ families. (FGD-1; FGD-2)



- Various ways of conveying information should be explored, e.g., radio, internet. (FGD-1; FGD- 2)
- Rights-based perspective should be integrated in the discussions on prevention and treatment. (FGD-2)
- Financial and emotional burden of the infection should be emphasized. (FGD-2)
- Differences in the contexts of spouses and their husbands as they impact on sexual partnerships and practices should be explored (why some engage in extra-relational sexual relationships and others do not). (FGD-2)

52. In developing the core messages it is also important, according to the FGD participants, to consider doing the following:

- Conducting interview/s with family members of infected seafarers (FGD-1)
- Documenting true to life stories (FGD-1; FGD-2)
- Reflecting on the lifestyle of seamen (FGD-1)
- Capturing differing experiences (e.g., a wife having an affair, onboard gay affairs, extramarital relationships) (FGD-1; FGD-2)

53. Some of the messages identified by the participants, which can be developed further, are:

- *"Result nung sadaling pagkalimot, nung kalibugan, yung ang naging result niya, negative."* (FGD-1) [Result of the time when he could not restrain himself of his libido, that was the result, negative]
- *"Sa sandaling kaligayahan, sa sandaling kalibugan, habang buhay na paghiirap."* (FGD-1) [In that instance of happiness, moment of heightened libido, a whole lifetime of endurance.]

54. In developing written materials, the FGD participants suggested that (i) there should be a main character around whom the story will revolve; (ii) the material should be simple and should comprise of around 12-20 pages only; and (iii) it should reflect the lives of seafarers and their families. It should also satisfy the need for the material to be considered *light reading*. There were conflicting perspectives on whether the main character should be attractive or not. When asked as to identify the characteristics of the main character they could relate with, the participants agreed that the female main character should embody the following (FGD-1):

- *in her 30's kasi yun ang prime time, prime age nang mga seaman na promiscuous, ang mga time na you are in heat* [in her 30's because that is the prime time, prime age when seamen are promiscuous and the times that you are in heat]
- *not working ang asawa, yung wife na di exposed, nasa bahay lang, nakadaster ang asawa* [not working wife, wife is not exposed, stay at-home wife clad in a duster.]
- *normal, di mapayat, di mataba* [normal, not skinny and not fat]

55. The male character, on the other hand, should be:

- *macho, maayos ang katawan* [good physique]
- *30's ang asawa* [husband in his 30's]
- *simpatico* [charming]
- *pwede rin na ipalabas, na one shot deal lang ang sex, minsan lang pero na-infect* [show that sex engaged in was a one-shot deal, just once, but got infected]
- *hindi pasaway, very loving, very responsible* [not incorrigible, ...]
- *yang mga seamen, kung masyadong mabait dito, pagdating sa barko, tignan mo* [those seamen, if they are very good here, when they reach the boat, watch out]



56. The participants believe that IEC on HIV/AIDS prevention should be provided to wives of seafarers and should also be supported by manning agencies and principals.

57. Though most of the participants in FGD-1 think that they do not need further information on HIV/AIDS, some of them would like to know more about its prevention. One also expressed the need for information that will address the stigma felt by people living with HIV, so that individuals will be encouraged to be tested and diagnosed if they are at risk. There is also a need to have a more positive approach to discussing HIV/AIDS so as to prevent further stigmatization and stereotyping of individuals with HIV.

58. Other methods should include seminars and facilitated small group discussions among wives. Existing mechanisms, such as the PDOS, may serve as a context for information dissemination. It was suggested that wives be required to attend the orientation with their husbands.

59. **Evaluation of *Taking Control: Life Skills Manual for Female Spouses of Migrant Workers*.** The participants of FGD-1 reported that they found the material relevant, effective, and reflective of their experiences. Though most of them felt that all the content areas were relevant, some identified the following as the ones they find most relevant: home management, life skills/assertiveness, and dealing with in-laws. They, however, found the material “*too thick*” and may not be suitable to other spouses who do not have the time nor the educational background to read and understand the material.

60. Points for improvement include: having more colored pictures, reducing the number of pages, revising Chapter 5 because it is “*so disease-based*” and “*making it simpler, focusing more on the symptoms and prevention of HIV.*” The participants also suggested that discussions on handling of teenage children be included, including concerns and issues related to sexuality. Depending on the target audience, Tagalog, English or other local dialects/languages should be used.

61. Participants are cognizant of the following challenges in educating spouses of seafarers on SRH and HIV:

- lack of knowledge
- lack of time
- lack of information materials
- variations among the target group

#### D. Conclusion and Recommendations

62. Using the revised framework based on the developed by Fishbein and Azjen (McKee *et al.*, 2000), which stipulates that a particular behavior is a product of one’s personal attitude, subjective norm, perceived behavioral control, and behavioral intent, as well as cultural factors that impact or sustain the abovementioned elements of behavior change, the following conclusions are drawn.

63. Gauging from the responses of the participants, there are variations in the female spouses’ concept of SRH based on the age group and life cycle stage. The younger group initially focused more on notions of physical health and disease, while the older ones related the concept to sexuality and rights. The participants are aware of HIV/AIDS, but their knowledge is limited to transmission. They still have questions on the origin of HIV, other modes of transmission, treatment, and prevention. Both groups need this additional information to better understand HIV. For those who have benefited from IEC on HIV, the effects of increased knowledge have only influenced their behavior intent, but have not been translated to specific safer sexual behaviors.





64. The current attitude of the FGD participants towards HIV prevention is positive and is characterized by increased recognition of their vulnerability given the perceived sexual behaviors of seafarers overseas. However, there is still denial in terms of the possibility of their partners engaging in extra-relational sexual behaviors (as they persist in believing that their partners are sexually faithful), which serves as a hindrance to them fully recognizing the sexual and reproductive risks they need to face. This is further sustained by cultural expectations and discourses of “trust” and “sincerity” in intimate relationships, which shape the norms of the husband - wife interaction.

65. Furthermore, the FGD participants do not recognize that they have control over the maintenance of their sexual and reproductive health and needs. Though they can engage in autosexual behaviors to address their sexual needs when their partners are not physically present, they surrender this right when their husbands are around. They seldom negotiate when it comes to sex and are expected to remain available to their partners every time. Culturally defined gender roles and power relationships between males and females serve as contexts for this. Thus, although the behavioral intent of avoiding possible HIV infection is present, this is never translated into the desired behavior (i.e., practice of safer sex) with one’s husband.

66. In addressing the needs of female participants for materials that will promote SRH awareness and HIV/AIDS prevention, it is important to take the aforementioned findings into consideration. The FGD respondents have forwarded various suggestions in the development of these educational materials – messages, media, characters, storylines, etc. It is also imperative that the material tackle and deconstruct underlying cultural beliefs on gender relationships and roles that impede the full recognition of female spouses’ vulnerability to HIV and control over their sexual and reproductive health. It is equally important to show models of social competence (they can identify with) who can mirror specific behaviors and skills, which will allow them to address their own concerns and issues and increase the likelihood of expressing the desired behavior.

67. Furthermore, it is worth noting that the process of promoting SRH awareness and HIV prevention may best be actualized by providing not only education/information materials, but also venues for discussion among female spouses and between husbands and wives for them to address their SRH concerns and issues.

68. Given the abovementioned conclusions, the following recommendations on the development of written educational materials on SRH and HIV for women spouses of seafarers are forwarded:

- (i) Educational materials should be visually appealing and not text heavy. It is important to use the language of the target audience as the medium for conveying information; however, if this is not possible, Pilipino can be utilized. Since Pilipino is considered to be widely used as the first or second language in the Philippines, it will capture a wider audience of female spouses coming from different educational background, socio-economic standing and ethno-linguistic groupings.
- (ii) Stories are the best vehicle for conveying concepts on SRH promotion and HIV prevention. Apart from the fact that “*kwentuhan*” (storytelling) is a culturally appropriate way of sharing information, it is a powerful tool for engaging individuals to sit down to listen or read. Anecdotes and storylines have been established to be effective in promoting health. However, they should be reflective of the contexts and experiences of the families of seafarers and relationships between husbands and wives. This will enhance the identification of the audience with the stories, making the messages more appealing and persuasive. Characters should also mirror the realities and characteristics (i.e., physical, emotional, social, behavioral) of the audience, which will allow them to further identify with the attitude, norms, and behaviors of the main characters.



- (iii) Content of the educational material should include the following:
- (a) **Sexual and reproductive health (SRH) promotion:** The discussion on SRH needs to be nested in the rights framework and human well-being, making the discourse more inclusive of males and females. Domains of sexuality, such as changes in the life cycle (e.g., pregnancy, menopause), which accompany changes in one's sexual and reproductive attitudes, behaviors, and partnerships, should also be included. The concept of SRH should set the tone for the discussion on HIV prevention.
  - (b) **HIV transmission, diagnosis, treatment and prevention:** Information in this area should not be too clinical or disease-based. It is important to highlight the practices and partnerships that increase the vulnerability of seafarers and their spouses to STI and HIV infection. Attitudes and behaviors that increase their capacity to avoid contracting infections should also be modeled by the main characters in the stories and emphasized, repeated, and reinforced at different points of the narrative. The life skills perspective may be an effective framework in identifying critical skills (e.g., self-awareness, assertiveness, communication skills) which need to be salient in enhancing the capacity of individuals to deal with sexuality-related issues and concerns.
  - (c) **Gender relations, roles and expectations:** It is equally necessary to deconstruct gender relations, roles, and expectations governing sexual relationships and behaviors in the promotion of SRH and HIV awareness and prevention, as these serve as contexts for the emergence of attitudes, norms, and behaviors among males and females. Traditional gender relationships reduce the capacity of women spouses to negotiate for safer sex with their partners and increase their vulnerability to gender-based violence. They also contribute to the commodification and objectification of women, which shape the sexual attitudes and behaviors of male seafarers. The meanings of "trust" and "sincerity" in marital relationships reflect gender roles and expectations. These concepts can also be re-framed, emphasizing related constructs such as responsibility (*pananagutan*), care (*pangangalaga*), respect (*respeto*), and love (*pag-ibig/pagmamahal*) in the process of promoting SRH and safer sexual practices and behavior.
  - (d) It is important to be clear on the core messages that the material intends to convey to the audience. Calls for changes in attitudes, norms, and behaviors related to SRH promotion and HIV prevention should be specific, realistic, and unequivocal.
  - (e) Finally, it is important to recognize that though written educational materials could serve as stand-alone interventions, other modalities of intervention, such as videos, radio/TV plugs, and songs, may reinforce further the delivery of core messages in SRH promotion and HIV prevention. It is also important to consider providing venues for discussion among the target audience and their spouses, as these further facilitate and reinforce changes in attitudes, norms, and behaviors.

## REFERENCES

- McKee, N., E. Mannocourt, C. Saik, C. Yoan, and R. Carnegie. 2000. *Involving People, Evolving Behavior*. New York:UNICEF.
- Piotrow, P., D. Kincaid, J. Rimon, and R. Ward. 1997. *Health Education: Lessons from Family Planning and Reproductive Health*. Connecticut: John Hopkins School of Public Health, Center for Communication Programs.



**Annex A****PROTOCOL FOR THE CONDUCT OF FOCUS GROUP DISCUSSION**

1. Ask participants to fill up information sheet.
2. Introduce members of project team (facilitator, co-facilitator) to participants. Allow participants to introduce themselves.
3. Facilitate the discussion.

**A. Notions of SRH and HIV/AIDS**

- (i) What comes to mind when you hear the words/phrase “sexual and reproductive health”? Probe responses. (*Ano pong pumapasok sa isip ninyo kapag narinig ninyo ang mga salitang “sexual and reproductive health”? Talakayin ang mga sagot.*)
- (ii) What do you think are the sexual and reproductive health needs of Filipino seafarers’ spouses? Probe. (*Ano po sa tingin ninyo ang mga sexual at reproductive health na pangangailangan ng mga asawa ng mga seafarers/maglalayag? Talakayin.*)
- (iii) What is HIV? AIDS? Probe: transmission, prevention, diagnosis, and treatment. (*Ano po ang HIV? AIDS? Talakayin: pagkahawa, pag-iwas/pangangalaga, diagnosis, paggamot*)
- (iv) Do you think spouses of seafarers are at risk of contracting HIV/AIDS? (*Sa tingin po ninyo, may posibilidad/panganib po ba na magkaroon ng HIV/AIDS ang mga asawa ng mga seafarers?*)
- (v) Why/ Why not? Probe. (*Bakit oo? Bait hindi? Talakayin.*)

**B. Advocacy/Information Dissemination Campaign**

- (i) What information on HIV/AIDS have been provided to you? Who provided these information ? (*Anu-ano na pong impormasyon/kaalaman ukol sa HIV/AIDS ang naibigay sa inyo?*)
- (ii) Who were the target audience of such information? (*Kanino po nakalaan ang mga impormasyong ito?*)
- (iii) How was the information given (e.g. lecture, testimony, video, etc.)? What were the core messages? Probe. (*Paano po ibinigay ang impormasyon? Ano po ang mga pangunahing mensahe nito?*)
- (iv) Were the methods of providing information effective? Why / Why not? Probe. (*Epektibo po ba ang mga pamamaraan ng pagbibigay ng impormasyon? Bakit oo/hindi? Talakayin.*)
- (v) What did you learn about HIV/AIDS from the information provided to you? Probe. (*Ano po ang mga kaalamang natutunan ninyo ukol sa HIV/AIDS mula sa impormasyong binigay sa inyo? Talakayin.*)
- (vi) What were the effects of the information on you? Probe: changes in cognition, behavior, emotions, etc. (*Ano po ang epekto ng mga impormasyon ito sa inyo? Talakayin: pagbabago sa pag-unawa/kaisipan, pagkilos, damdamin, atbp.*)



- (a) What other questions on HIV/AIDS do you have? (*Ano pa pong mga katanungan meron kayo ukol sa HIV/AIDS?*)
- (b) If we are to develop print materials for the spouses of seafarers, on HIV/AIDS and HIV/AIDS prevention (*Kung tayo po ay magpapaunlad ng nakaimprentang materyales/babasahin na magbibigay ng impormasyon ukol sa HIV/AIDS at pagpigil nito*)
- (c) What do you think should be the information provided? Core messages? Which of these should be emphasized? (*Ano po sa tingin ninyo ang lalamanin na impormasyon nito? Pangunahing mensahe? Ano po ang kailangang bigyang halaga sa mga ito?*)
- (d) What characteristics/situations of seafarers' spouses needed to be taken into consideration in developing the messages? (*Anu- ano pong katangian/kalagayan ng mga asawa ng mga seafarers ang kailangang bigyang pansin sa pagbubuo ng mga mensahe?*)
- (e) What methods of providing information should be employed? (*Ano pong mga metodo ng pagbabahagi ng impormasyon ang kailangang gamitin?*)
- (f) Who should provide spouses with the materials? (*Sino po sa tingin ninyo ang dapat magbigay ng mga babasahin na ito sa mga asawa ng seafarers?*)
- (g) If we are to identify a storyline for a material on HIV/AIDS (*Kung tayo po ay kailangang magtukoy ng daloy ng istorya para sa isang materyal sa HIV/AIDS*),
  - What situations can we use for the story? Probe. (*Ano pong mga situation ang maaring gamitin sa kwento? Talakayin*)
  - Who are the main characters? What are their characteristics? (*Sino kaya ang mga pangunahing tauhan? Ano ang mga katangian nila?*)

### C. Evaluation of the material "Taking Control"

- (i) What do you think are the strengths of the material? (*Ano po sa tingin ninyo ang kalakasan ng materyal?*)
- (ii) What do you think are the gaps? (*Ano po sa tingin ninyo ang mga kakulangan?*)
- (iii) Do you think that you can benefit from having this kind of material? Why/Why not? (*Sa tingin niyo po ba ay makakatulong ang ganitong materyal para sa inyo? Bakit oo/hindi?*)
- (iv) What are your suggestions in improving the material? Probe. (*Anu- ano po ang inyong mga suhestyon sa pagpapaunlad ng materyal na ito? Talakayin.*)
- (v) What do you think are the challenges/barriers in promoting HIV/AIDS awareness and prevention among spouses of seafarers? (*Anu- ano po sa tingin ninyo ang mga hamon sa pagpapalaganap ng kaalaman at paraan ng pag-iwas sa HIV/AIDS sa mga asawa ng mga seafarers? Talakayin.*)

### D. Method

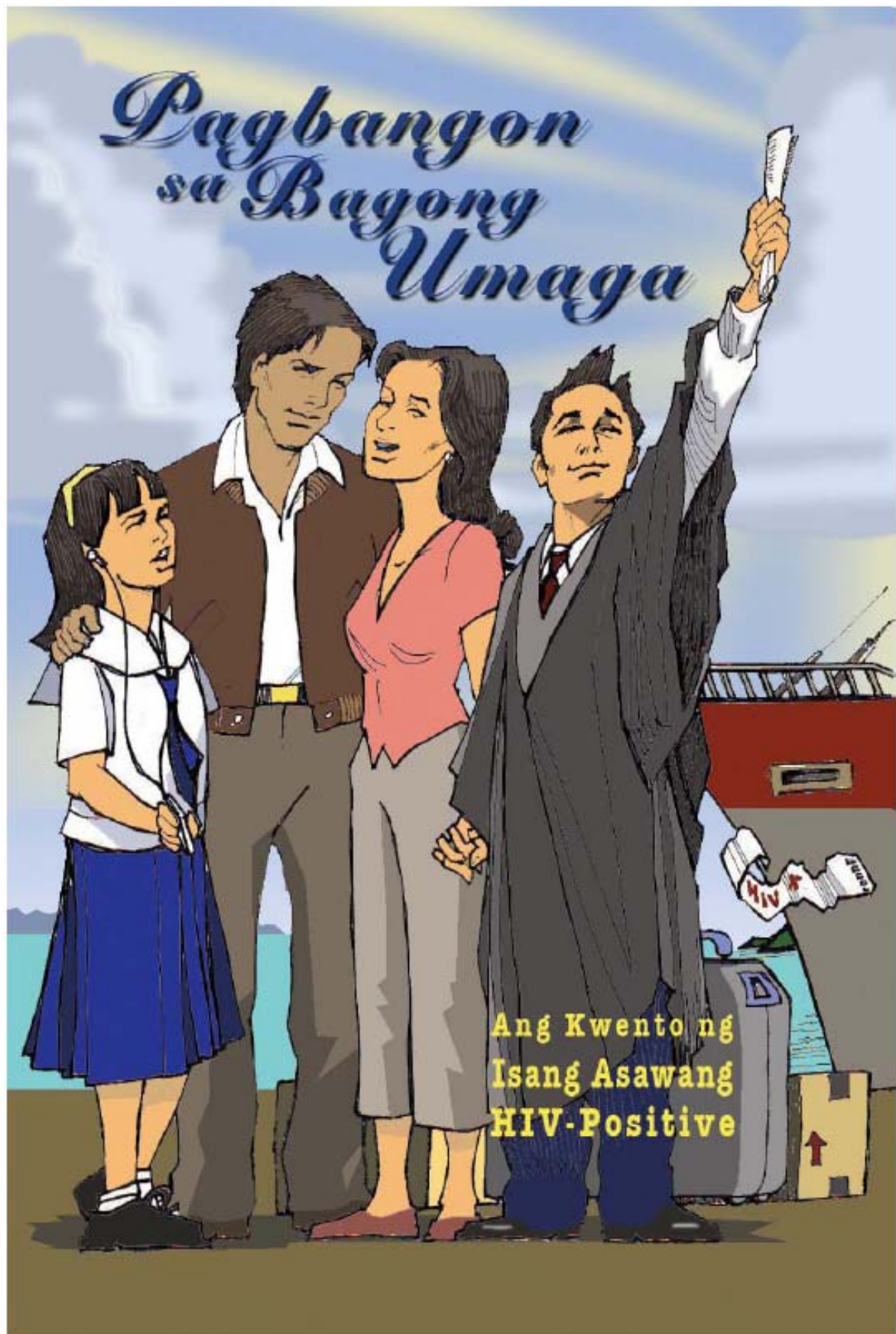
- (i) What do you think of the FGD process you participated in? (*Ano po ang tingin niyo sa proseso ng FGD na nilahukan ninyo?*)
- (ii) Address any inquiries from the participants regarding the research.



4. Summarize main points raised and clarify vague responses/concepts. Ask participants if they want to add to or delete portions from information/responses they provided.
5. Debrief participants.
6. Thank participants.



**Appendix 5:**  
***“PAGBANGON SA BAGONG UMAGA:  
ANG KWENTO NG ISANG ASAWANG HIV+”***



**Pagbangon sa Bagong Umaga**

**Inilathala ng Pacific Rim Innovation and Management Exponents  
(PRIMEX), Inc./**

**Action for Health Initiatives (ACHIEVE), Inc.**

**Nagsulat: Danton Remoto**

**Editor: Maria Lourdes S. Marin**

**Guhit at Disenyo: Nestor Escara**

**Tagapangasiwa ng Produksiyon: Maria Josefina Pavico**

**Ang paglathala nito ay sa pamamagitan ng suporta ng  
Asian Development Bank at ng Gobyerno ng Sweden sa ilalim ng  
RETA 6143 - Supporting Women at-Risk and Vulnerable to  
HIV/AIDS in the Philippines.**

**Para sa citation ng publikasyon na ito, pakigamit ng:**

**PRIMEX/ACHIEVE, 2009. Pagbangon sa Bagong Umaga**

**Ang impormasyon tungkol sa HIV at AIDS ay hango sa  
Ang Pagbabalik ni Leo**

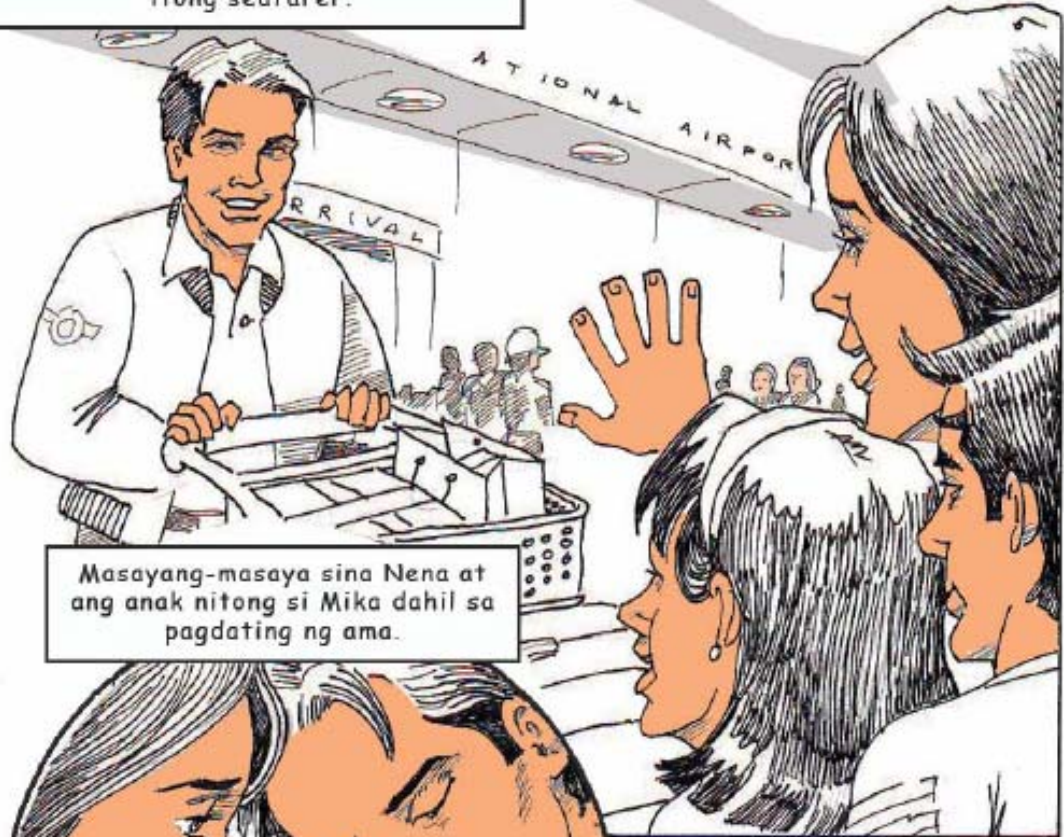
**Na inilathala ng ACHIEVE , Inc. at International Organization for  
Migration (IOM) noong 2005.**





# Pagbangon sa Bagong Umaga

At dumating ang araw na matagal nang pinakahihintay ni Nena at kanyang dalawang anak na tin-edyer: ang pag-uwi ni Juancho pagkatapos ng siyam na buwang paglalayag. Isa itong seafarer.



Masayang-masaya sina Nena at ang anak nitong si Mika dahil sa pagdating ng ama.



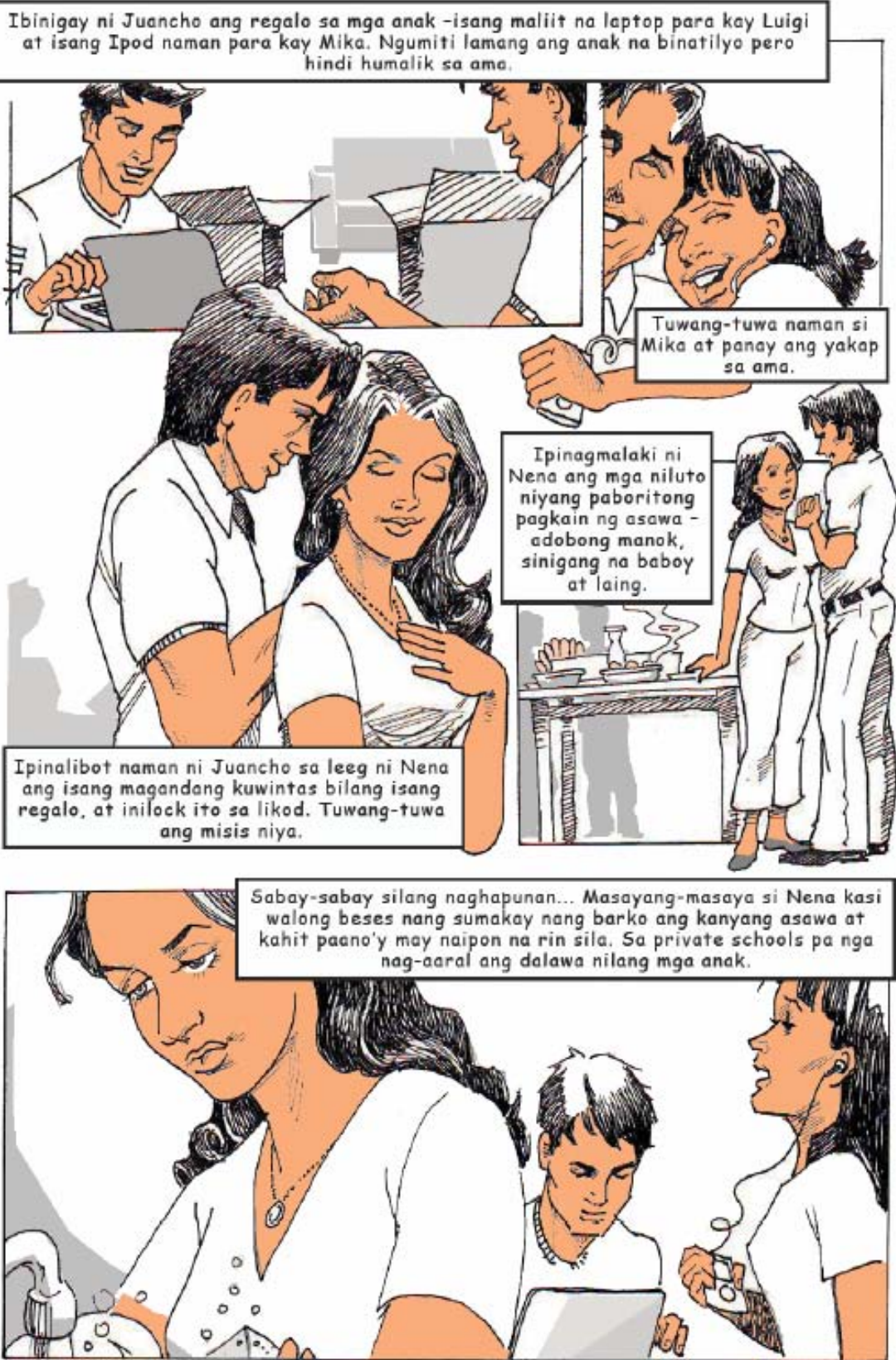
Napansin ni Nena na mas payat ngayon ang kanyang asawa.



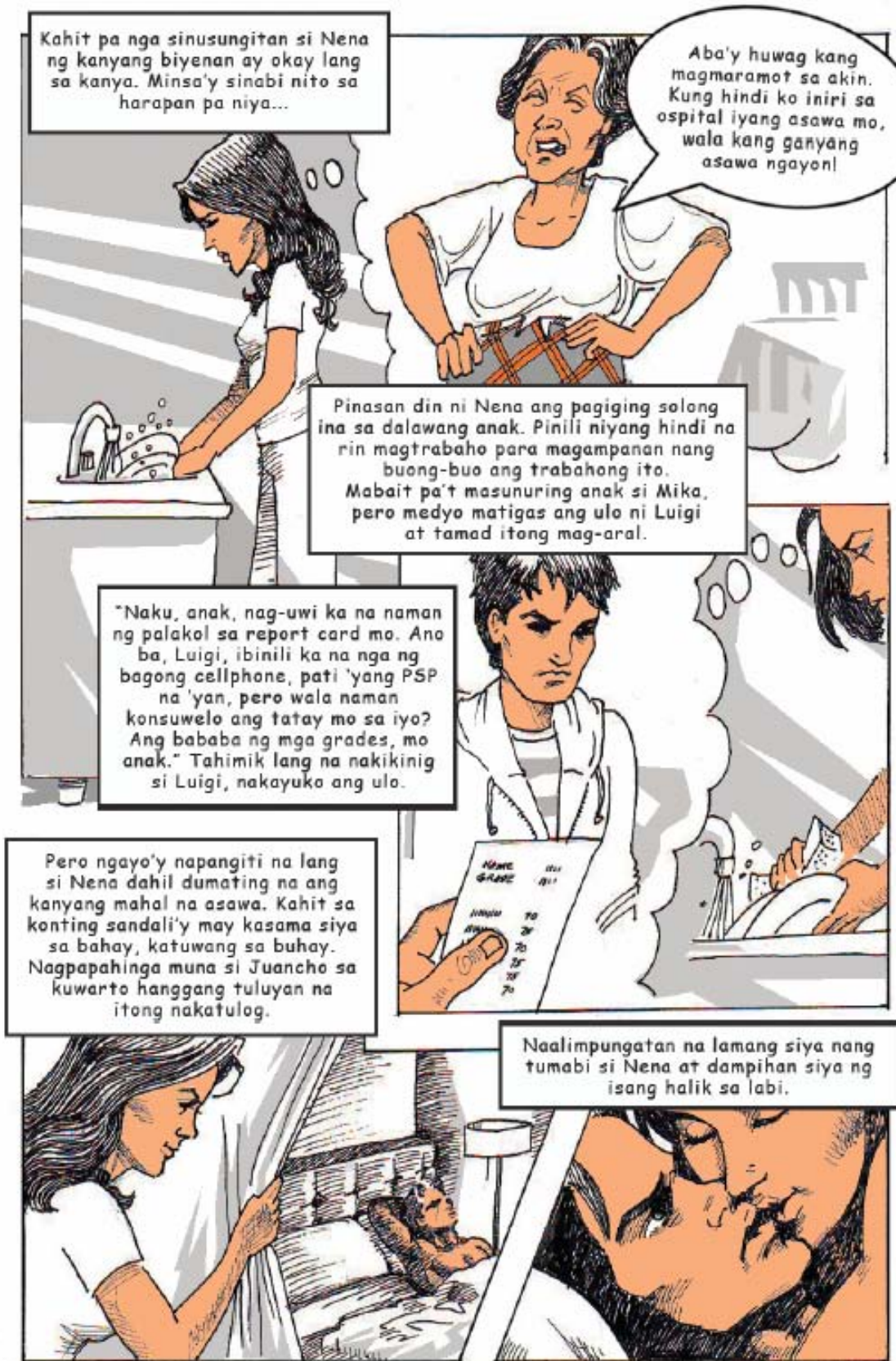
Tahimik lang si Luigi sa airport at habang nasa van na minamaneho ng isa nilang kapitbahay.

*Pagbangon sa Bagong Umaga 1*



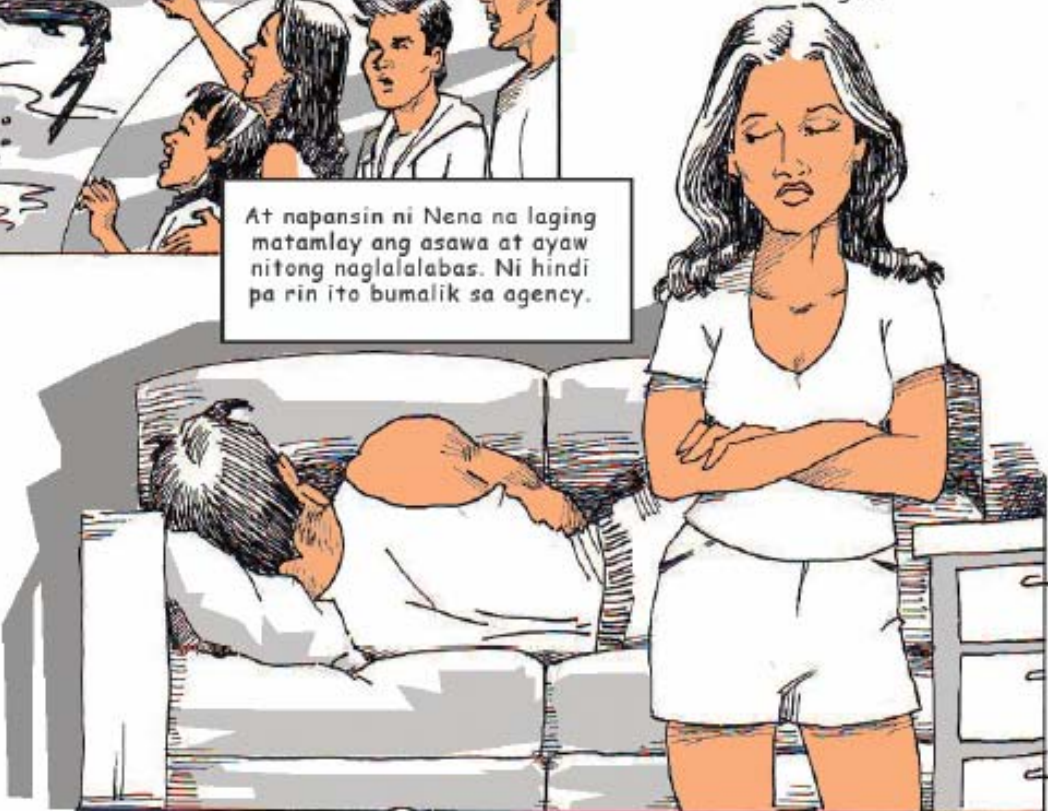
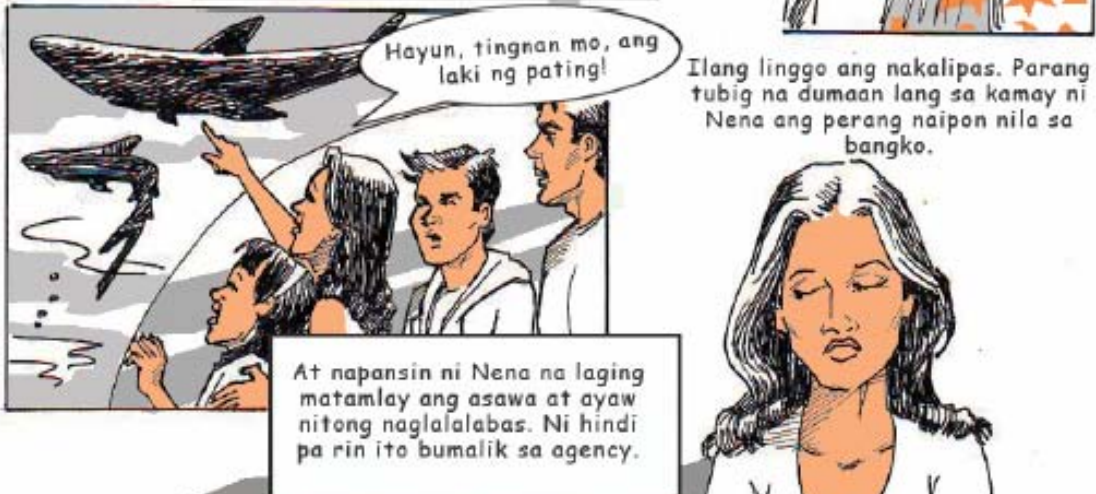


2 Paghuhugan sa Bayang Unang

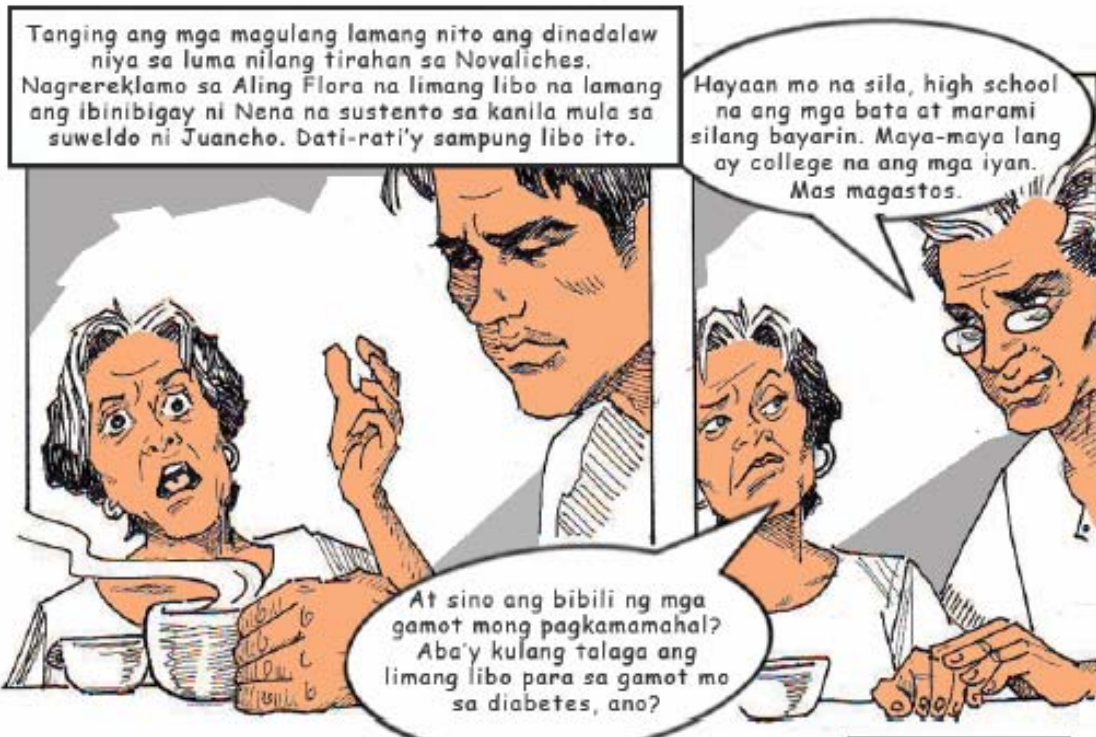


Pagbangon sa Bagong Umaga 3





4 *Angbangon sa Bagong Mundo*





Pero nagdaan na ang tatlong buwa'y narito pa rin si Juancho sa Pilipinas. Nababawasan na ang kanilang naipon sa bangko.

At madalas na bigla na lang magkakasakit si Juancho at dadalhin nila sa ospital. Pero hindi naman makita kung ano talaga ang kanyang sakit.

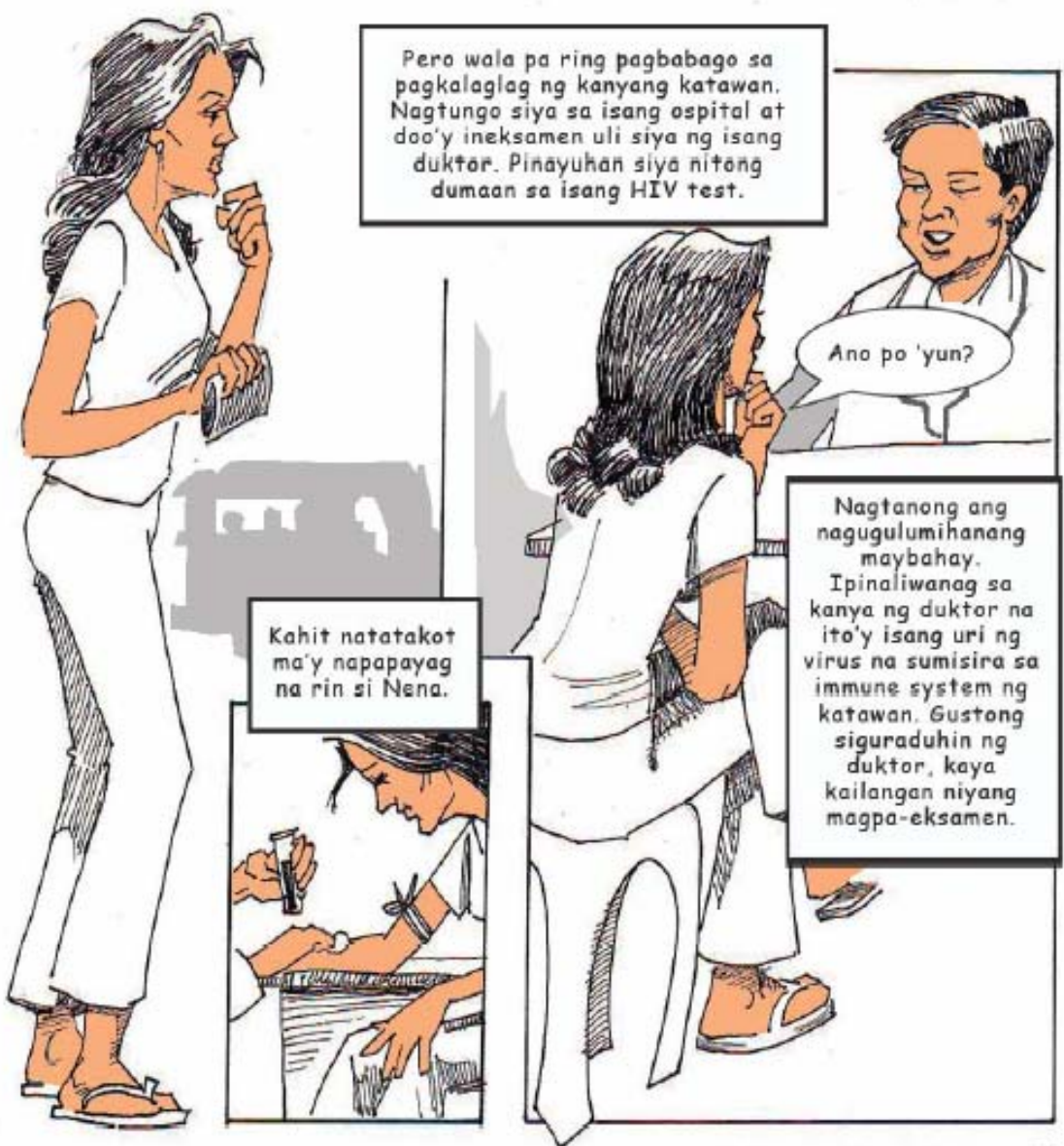


Isang araw, hindi mabuti ang pakiramdam ni Nena. Napansin niya na parang nalalaglag ang kanyang katawan. Hindi niya maipaliwanag kung ano ang nangyayari sa kanya.



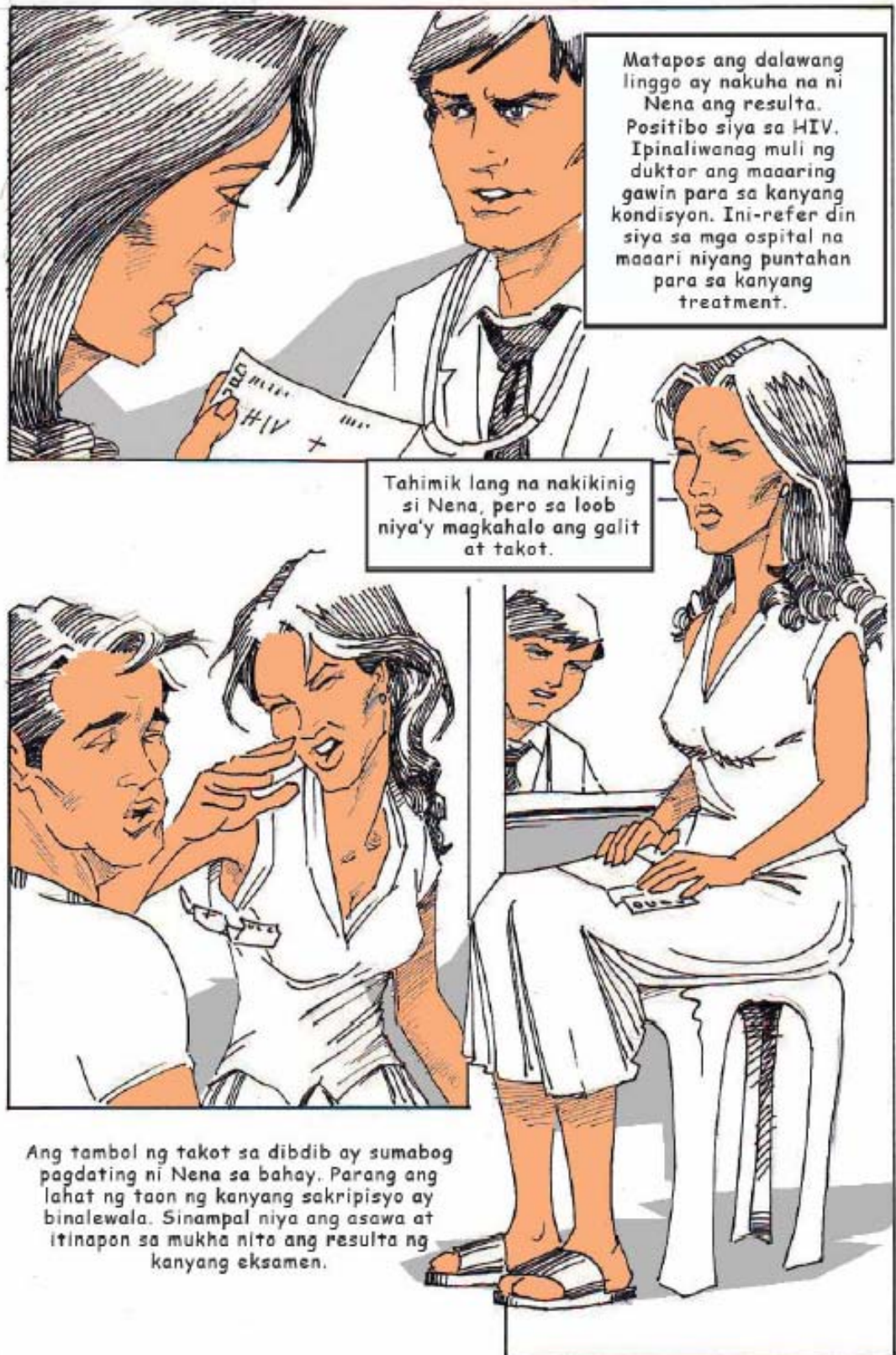
Nagpunta siya sa doktor. Ineksamen siya nito, pinayuhang magpa-check up nang kumpleto - dugo, ihi, dumi.





*Pagbangon sa Bayang Umaga* 7







Nang mabasa ni Juancho ang resulta'y lumuhod ito sa harap ni Nena at ni-yakap ito. Tuluyan na itong humagulgol.

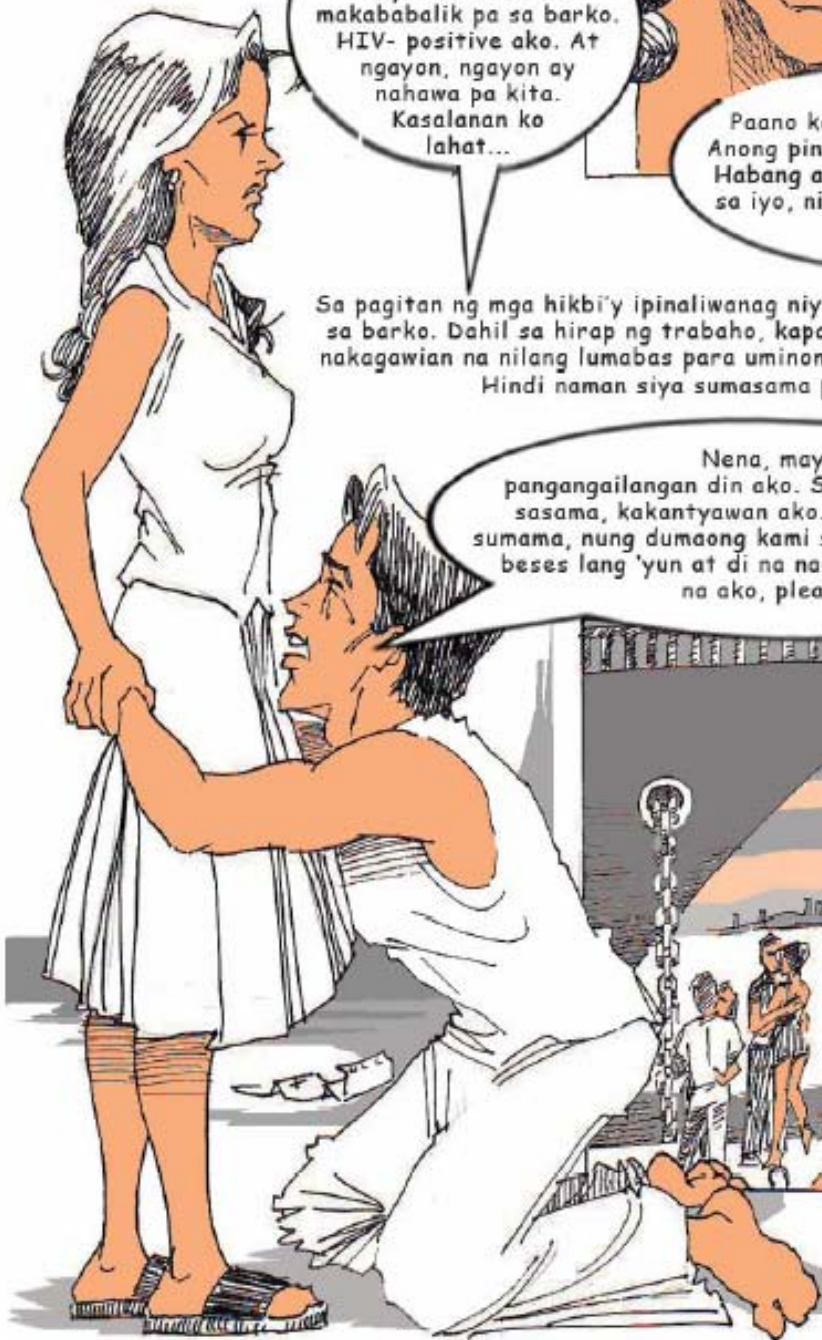


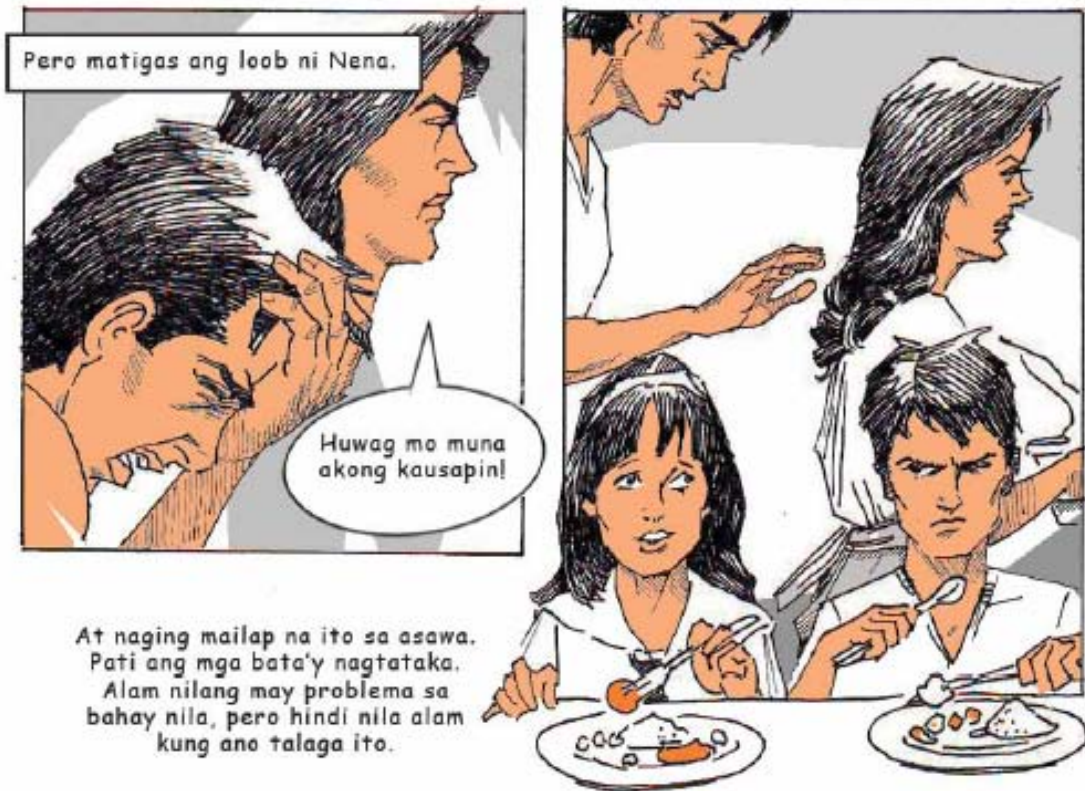
Patawarin mo ako, Nena. Iyan ang dahilan kaya hindi na ako makababalik pa sa barko. HIV- positive ako. At ngayon, ngayon ay nahawa pa kita. Kasalanan ko lahat...

Paano ka nagkaroon ng HIV? Anong pinaggagawa mo sa labas? Habang ako ay nanatiling tapat sa iyo, niloloko mo na pala akol!

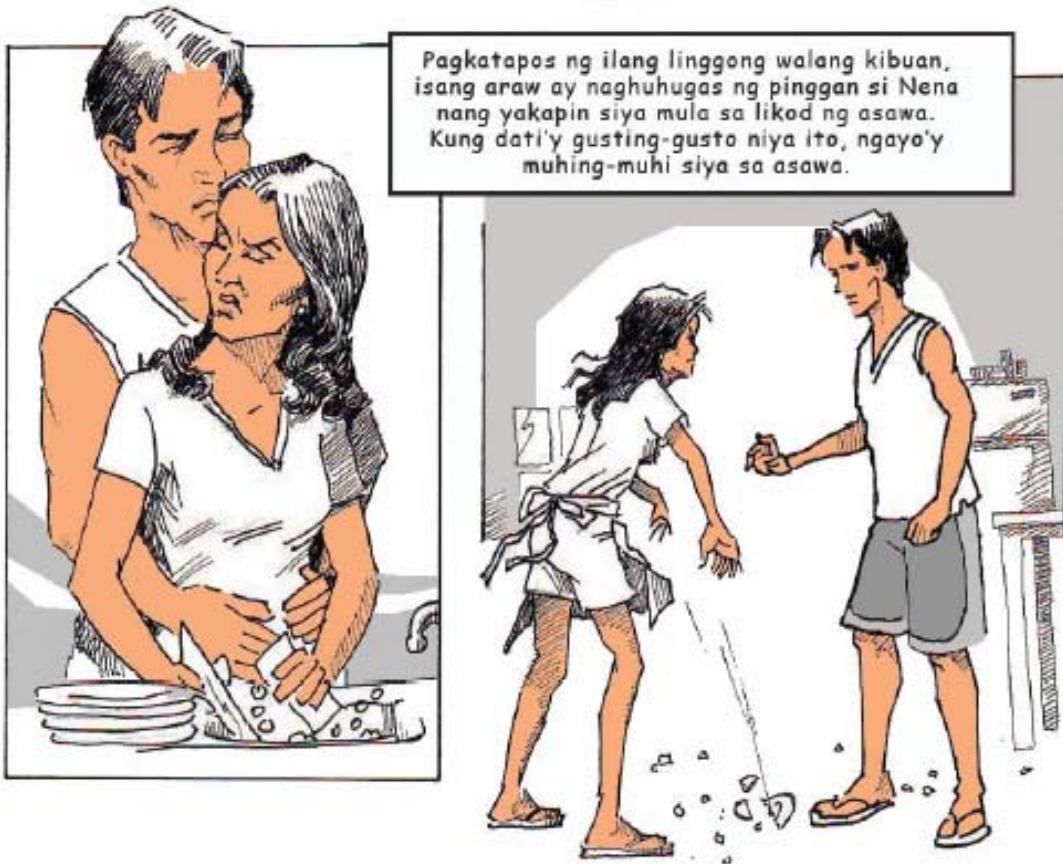
Sa pagitan ng mga hikbi'y ipinaliwanag niya ang sitwasyon nila sa barko. Dahil sa hirap ng trabaho, kapag dumadaong sila'y nakagawian na nilang lumabas para uminom at mag-good time. Hindi naman siya sumasama palagi.

Nena, may... pangangailangan din ako. Saka pag hindi ako sasama, kakantayanan ako. Minsan lang ako sumama, nung dumaong kami sa Brazil. Pero isang beses lang 'yun at di na naulit. patawarin mo na ako, please.





At naging mailap na ito sa asawa. Pati ang mga bata'y nagtataka. Alam nilang may problema sa bahay nila, pero hindi nila alam kung ano talaga ito.





Pinipigilan niyang umiyak. Pumunta siya sa kuwarto at dinampot lahat ng mga damit niya at ng kanyang mga anak. Inilagay sa malaking maleta at hinila ito palabas ng kuwarto.



Tila aninong nakatayo lamang si Juancho sa gitna ng sala habang palayo ang kanyang asawa. Alam niyang susunduin nito ang mga anak sa eskuwelahan, at tuluyan nang mawawasak ang kanilang pamilya. Tinatanaw niya ito sa pintong nakabukas.



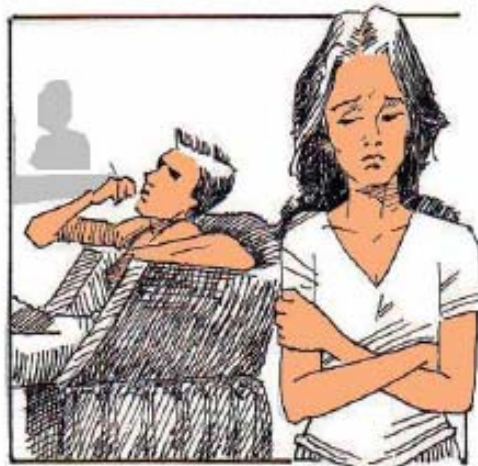
Naging lasenggo si Juancho. Lalong nalaglag ang katawan nito. Alam niyang nasa kanyang mga biyenang ang kanyang pamilya. Pero wala siyang lakas ng loob na pumunta doon at sunduin ang mga ito.



Si Nena nama'y kinalamay ang loob sa pag-aalaga ng kaniyang mga anak. Kahit minsan nagkakasakit pa rin siya, hindi na niya iniinda ang nararamdaman.



Hindi niya alam kung paano sasabihin sa kanyang tatay na si Mang Kiko at dalawang anak ang kanyang kondisyon. Pinagbawalan din niya ang dalawang anak na makipag-usap sa kanilang tatay. Iyak lang nang iyak si Mika at tiim ang bagang ni Luigi. Takot rin si Nena magsabi sa kanyang nakatatandang kapatid dahil baka pandirihan siya nito. Ayaw rin naman niyang pumunta sa ospital na "pinag-referan" sa kanya ng doktor na nakapag-diagnose sa kanya.



Minsan, tinanong ni Mika ang nanay kung ano talaga ang dahilan at iniwan nila ang tatay niya.

Pasensiya ka na, anak, alam kong mahal mo ang Daddy mo. Pero meron kaming hindi pagkakaunawaan.

Di ba sabi mo, pag nag-aaway kami ni Kuya Luigi, dapat magbati agad kami? Bakit kayo ang tagal-tagal na, magka-away pa rin?

Tuluyan nang hindi nakasagot si Nena at niyakap na lang ang bunsong umiiyak.

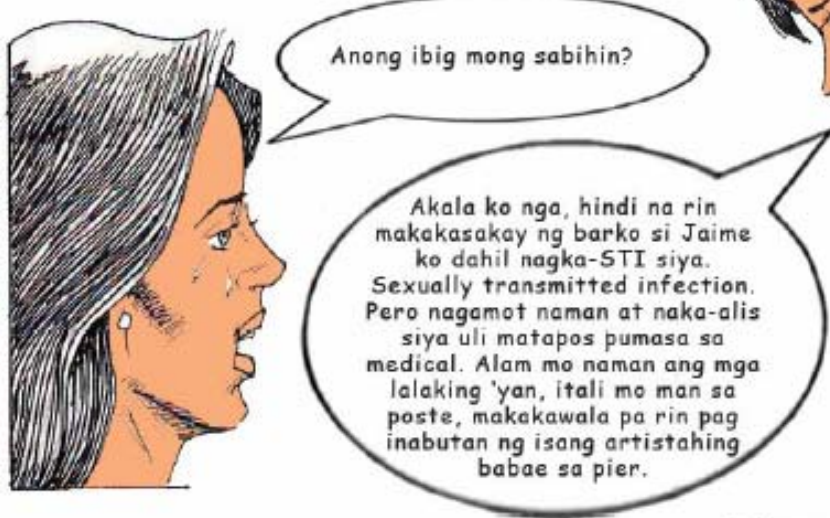
Pagkaraan ng isang buwa'y dinalaw si Nena ng pinsan niyang si Hilda. Isa itong nurse sa ospital at asawa rin ito ng isang seafarer.



Ate, ba't hindi na raw makakasakay uli ng barko si Kuya Juancho?

Kasalukuyang nagluluto noon si Nena. Bigla na lang itong huminto sa pagluluto, at tuluyan nang umiyak. At sinabi na nito ang sekretong kinikimkim niya.

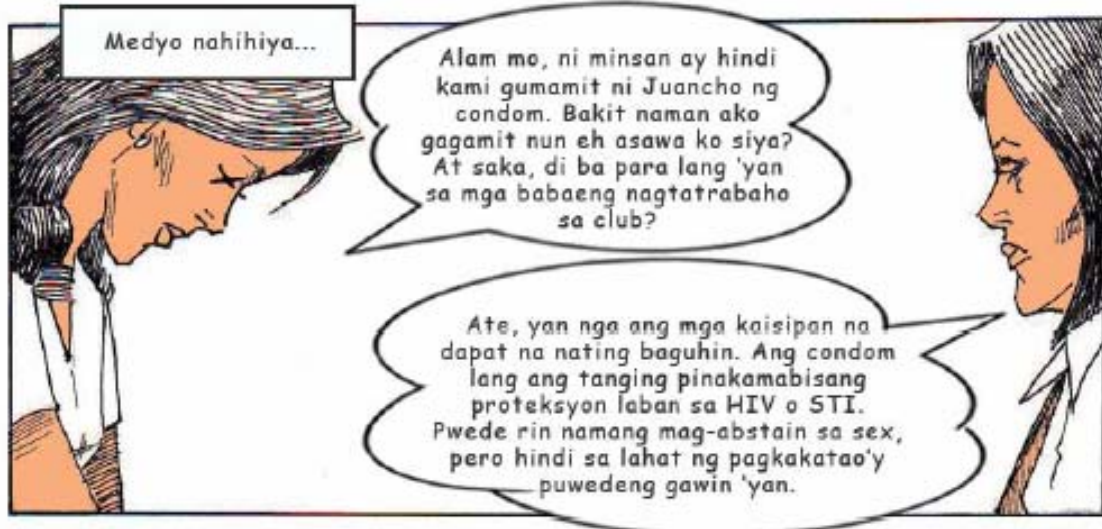
Naku, Ate. 'Yan talagang si Kuya Juanchol

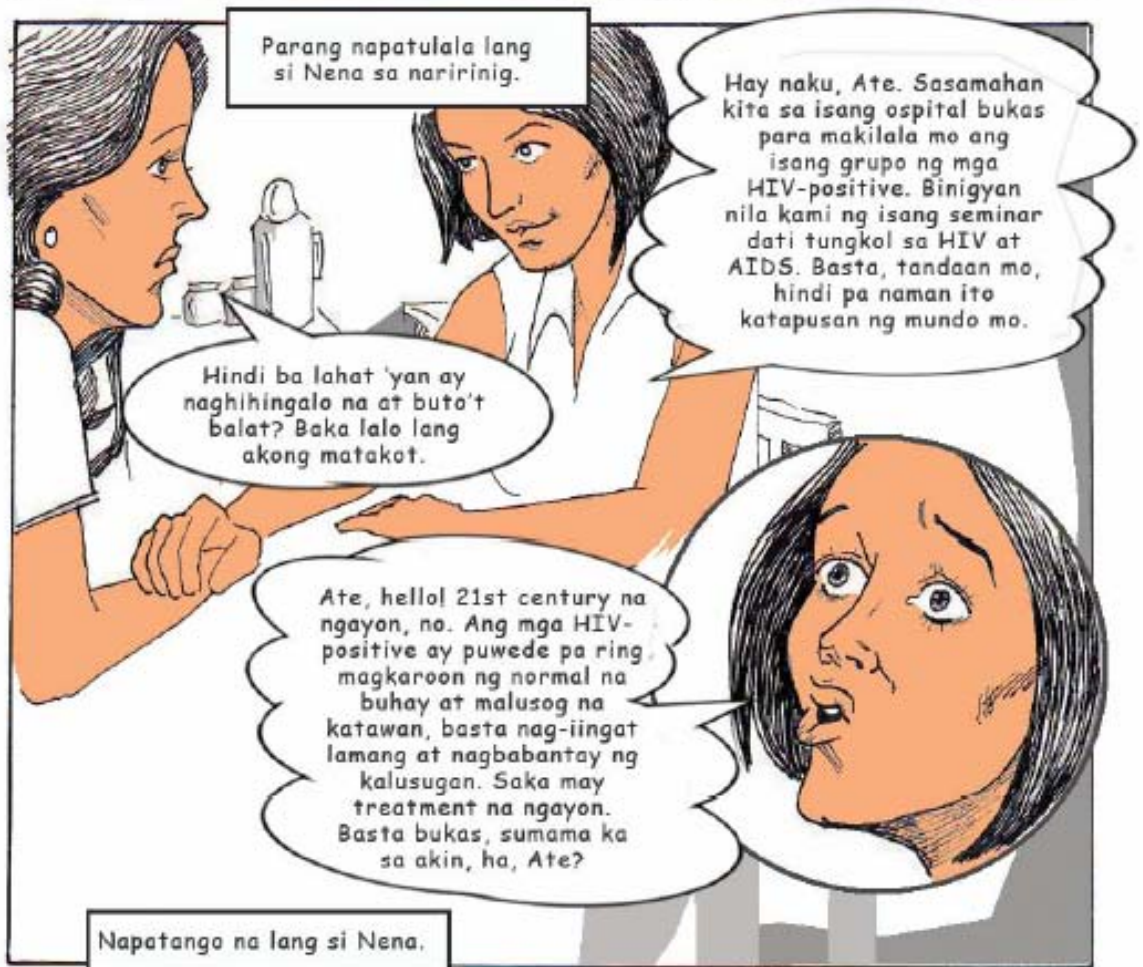


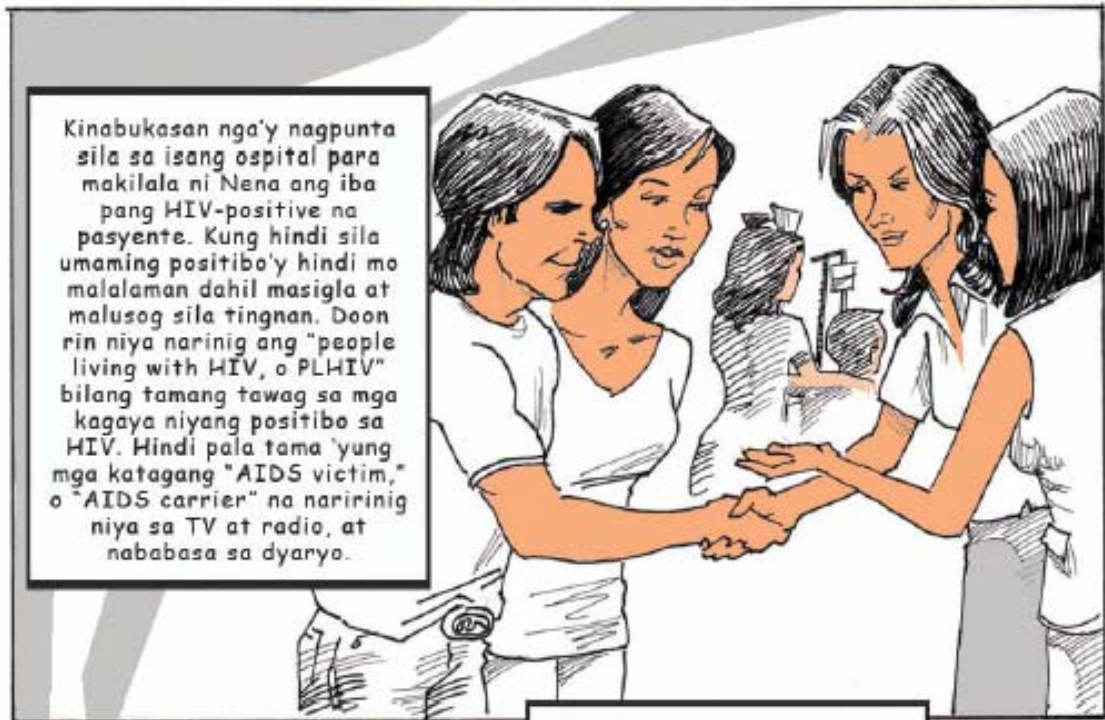
Anong ibig mong sabihin?

Akala ko nga, hindi na rin makakasakay ng barko si Jaime ko dahil nagka-STI siya. Sexually transmitted infection. Pero nagamot naman at naka-alis siya uli matapos pumasa sa medical. Alam mo naman ang mga lalaking 'yan, itali mo man sa poste, makakawala pa rin pag inabutan ng isang artistahing babae sa pier.









Habang pauwi'y kinausap uli ni Hilda ang pinsan.



16 Pagbuong sa Buong Umaga





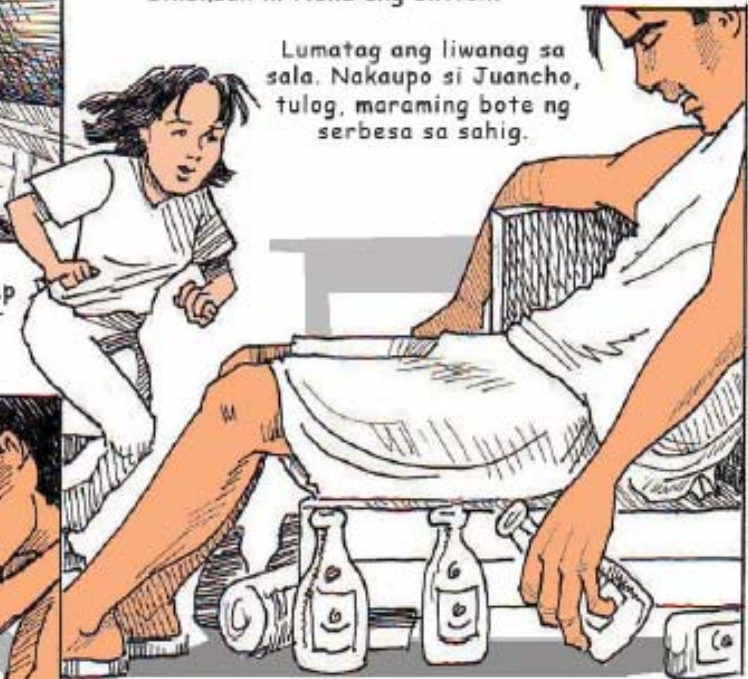
Pagdating sa bahay ay pinagbihis ang dalawang anak para dumalaw sila sa ama.



Ayaw sumama ni Luigi. Galit ito sa ama: masama rin ang loob sa ina. Alam niyang may itinatago sa kanya ang mga magulang. Ito ang lalong ikinasasama ng kanyang loob. Hindi na siya pinilit sumama ng kanyang nanay.



Madilim ang bahay pagdating nila. Binuksan ni Nena ang switch.



Lumatag ang liwanag sa sala. Nakaupo si Juancho, tulog, maraming bote ng serbesa sa sahig.

Tumakbo si Mika at niyakap ang tatay. Nagising ito at nakita ang mag-ina.



Umiyak na lang ito bigla at humingi uli ng tawad sa asawa.

Pumunta na rin si Nena sa asawa at hinalikan ito. Maya-maya'y nag-init na ito ng tubig para linisan ang mukha at katawan ng asawa.







Nagre-research si Luigi tungkol sa HIV at AIDS sa internet. Unti-unting lumiliwanag ang mukha niya habang binabasa ang mga impormasyon.





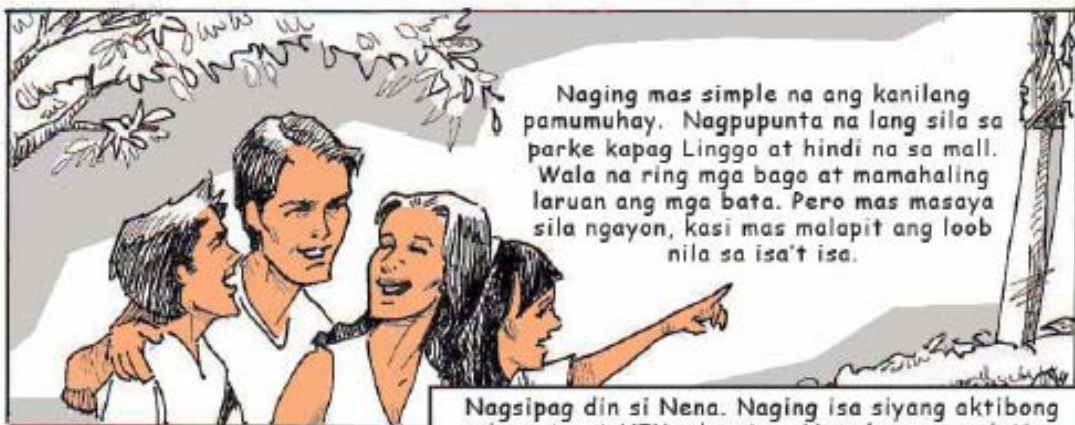
Nagpasiya si Juancho na gawin ang van nila na "for hire" at siya ang magda-drive nito.

Pinapa-rent niya rin ito sa mga NGOs kapag mayroon silang mga trainings sa malalayong lugar at kailangan nila ng driver at van. Kahit paano'y kumikita na uli si Juancho.



Lilipat na sana sa public schools ang dalawang nilang anak, pero tinulungan sila ng kuya ni Juancho na isa ring seafarer. Pinagalitan siya nito dahil sa pagiging pabaya, pero tinulungan na ring tustusan ang pag-aaral ng dalawang bata sa pinapasukang private schools. Nangako rin si Luigi na mag-aaral na nang mabuti.





Naging mas simple na ang kanilang pamumuhay. Nagpupunta na lang sila sa parke kapag Linggo at hindi na sa mall. Wala na ring mga bata bago at mamahaling laruan ang mga bata. Pero mas masaya sila ngayon, kasi mas malapit ang loob nila sa isa't isa.

Nagsipag din si Nena. Naging isa siyang aktibong advocate at HIV educator. Nawala na ang dating kimi at walang self-confidence na si Nena.

Naging gabay siya ng mga asawa ng mga seafarers. Nakapaglalakbay pa siya sa iba't-ibang bahagi ng Pilipinas at maging sa mga international conferences sa ibang bansa bilang tinig ng mga asawa ng mga seafarers. Nagsa-sideline din siya bilang ahente ng insurance para makadagdag sa kanilang kabuhatan.

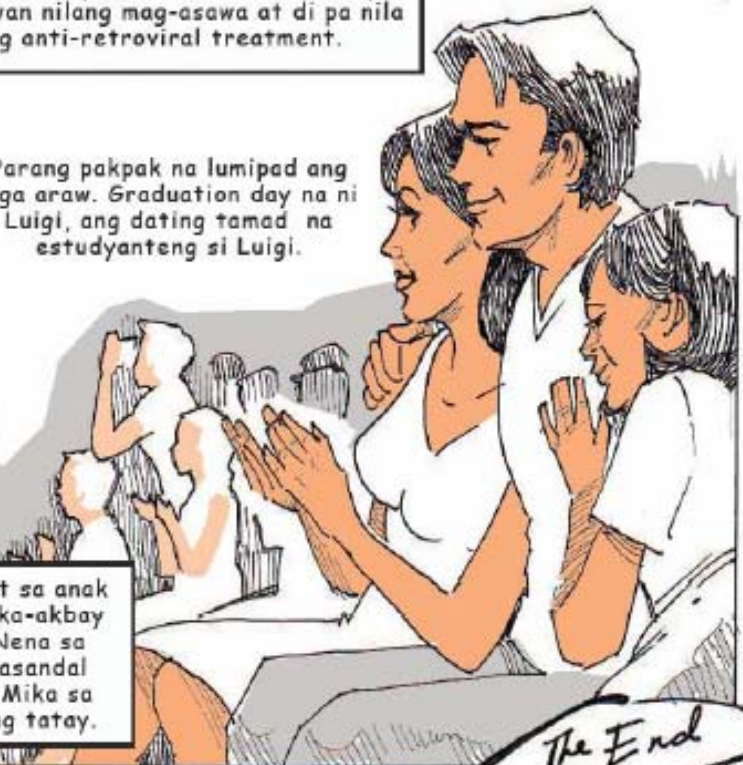


Regular na rin ang pagpapa-check-up nila sa isang hospital sa Maynila. Ayon sa doctor, malakas pa ang pangangatawan nilang mag-asawa at di pa nila kailangan ng anti-retroviral treatment.



Parang pakpak na lumipad ang mga araw. Graduation day na ni Luigi, ang dating tamad na estudyanteng si Luigi.

At habang iniaabot sa anak ang diploma ay naka-akbay si Juancho kay Nena sa audience, at nakasandal naman ang ulo ni Mika sa balikat ng kanyang tatay.



The End



**Impormasyon Hinggil sa HIV/AIDS**

**Ano ang HIV?\***

Human Immunodeficiency Virus ang ibig sabihin ng HIV. Ito ang virus na sumisira sa immune system ng ating katawan at pagkatagalan ay humahantong sa AIDS.

**Ano ang AIDS?**

Acquired Immune Deficiency Syndrome naman ang ibig sabihin ng AIDS. Kumbinasyon ito ng mga sintomas at sakit na lumalabas sa katawan bilang resulta ng pagkasira ng immune system na siyang lumalaban sa mga impeksyon sa loob ng katawan natin.

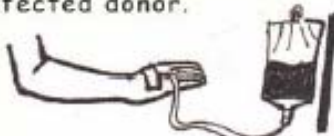
Magkaiba ang HIV sa AIDS. Hindi lahat ng taong may HIV ay may AIDS. Pero lahat ng taong nasa AIDS-stage ay merong HIV.

**Paano nahahawaan ng HIV?**

1. Kapag nagkaroon ng unprotected oral, vaginal, or anal sex sa isang infected partner.



2. Kapag nasalinan ka ng dugo o ibang blood products mula sa isang infected donor.



3. Sa pagtuturok ng droga; pakikipaghiraman ng karayom sa isang infected na tao.

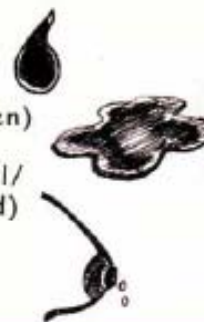


4. Mula sa isang infected na buntis patungo sa kanyang sanggol.



Apat na katas ng katawan ng tao lamang ang may taglay na sapat na dami ng HIV para maka-infect:

1. Dugo
2. Tamod (Semen)
3. Hima (Vaginal/ cervical fluid)
4. Gatas ng ina



**Tandaan**

Hindi mo makukuha ang HIV sa ganitong mga paraan:

1. Pakikipaghalikan sa isang taong may HIV
2. Pagyakap at pakikipagkamay sa isang taong may HIV
3. Paglangoy sa swimming pool kasama ang isang taong may HIV
4. Paggamit ng public toilets
5. Kagat ng lamok at iba pang insekto
6. Paggamit ng baso at kubyertos ng isang taong may HIV
7. Pagtatrabaho at pagtira kasama ang isang taong may HIV

**Paano umiwas sa HIV**

1. CONDOM USE at ibang paraan ng pagiging intimate na walang penetration. Kung hindi maiwasan ang penetration, gumamit ng condom.



2. DON'T SHARE NEEDLES. Iwasan ang paggamit ng droga at kung gagamit man siguraduhing huwag maghiraman ng karayom.



3. **BE FAITHFUL.** Kung makikipag-sex, sa isang tao lamang na hindi infected at siguraduhing ikaw lang din ang kanyang partner.
4. **ABSTINENCE.** Umiwas o ipagpaliban muna ang pakikipag-sex.



### May lunas na ba ang HIV o AIDS?

Sa kasalukuyan ay wala pang lunas ang HIV o AIDS. Subalit ang mga taong may HIV ay maaring bigyan ng Anti-Retroviral Drugs (ARVs) na makatutulong upang palakasin ang kanilang immune system at pababain ang dami ng HIV sa kanilang katawan. Sa ngayon, mayroon ng libreng ARVs na ipinapamahagi ang Department of Health (DOH), bagamat limitado ito at inilalaan lang sa mga talagang nangangailangan.

### Paano ko malalaman kung may HIV ang isang tao?

Hindi iba ang hitsura ng taong positibo sa HIV sa karaniwang tao kaya hindi ito malalaman sa tingin lamanag. Isa lamang ang paraan upang malaman: sa pamamagitan ng HIV Antibody Test. Tinatawag itong AIDS test ng iba ngunit mali ang katawagang ito. Sinusuri ng HIV Antibody Test sa dugo ng tao ang dami ng antibodies laban sa HIV.

Produkto ng ating immune system ang antibodies kapag nahaharap ito sa impeksyon. Para silang mga sundalong nakikipaggiyera sa mga sumasalakay na mikrobyo. Kapag na-infect ang isang tao ng HIV, gumagawa pa rin ng antibodies ang immune system ngunit hindi nila napapatay ang HIV.

Kailangan ng katawan natin ang tatlong lingo hanggang anim na buwan upang makagawa ng sapat sa dami ng antibodies na makikita sa test. Kaya mabuting maghintay ng anim na buwan mula sa huling exposure sa virus bago magpa-test para masigurong tama ang resulta ng test.

### Tandaan

Voluntary, anonymous at confidential ang HIV Antibody Test. Kailangan ding may pre- at post-test counseling bago kuhanan ng dugo ang sinuman para sa ganitong test.

### Ano ba ang safer sex?

Ibang paraan ito ng pagiging intimate nang walang penetration. Paghalik, necking at petting ang ilang halimbawa nito. Kung may penetration man, ang paggamit ng condom ang makapagbibigay ng proteksyon.

### Ano ang condom?

Ang condom ay isang manipis na supot na yari sa latex. Isang uri ito ng rubber na humaharap sa pagpasok ng tamod sa bibig, sa ari ng babae o sa puwit sa pamamagitan ng pagsalo nito. Jung gagamitin ito nang wasto at palagian, epektibo ang condom upang hindi mahawaan ng sexually transmitted infections (STIs) at HIV.

### Ilan na ba ang may HIV at AIDS sa Pilipinas

Ayon sa HIV/AIDS Registry, mayroon nang naitatalang 3,589 taong may HIV mula noong January 1984 hanggang December 2008. Sa bilang na ito, 1,184 o 33 porsyento ang mga overseas Filipino Workers, kabilang ang mga seafarers. Karamihan sa mga positibo sa HIV na OFWs ay mga lalaki (75%). Pakikipagseks ang pangunahing paraan ng pagkakahawa ng HIV (95%). Litaw ang bilang ng mga OFWs dahil sila ay sumasailalim sa mandatory HIV Antibody Testing (HAT) bilang requirement sa kanilang pag-alis.

### Ano ang Sexually Transmitted Infections (STI)?

Ang STI ay sakit na nakukuha sa pakikipagsex nang walang proteksyon sa isang taong mayroon nito. Kadalasan, tinatawag din itong STD o sexually transmitted diseases. Ilan sa mga halimbawa nito ay gonorrhoea, syphilis, Chlamydia, herpes, scabies, at iba pa.



Mayroon ding mga STI na puwedeng mailipat ng walang sexual contact, halimbawa kapag nasalinan ng dugo mula sa isang taong infected o mula sa isang infected na ina patungo sa kanyang pinagbubuntis na sanggol. Mayroon ring mga STI na naililipat sa pamamagitan ng close personal contact, sa pagsi-share ng personal na bagay sa isang masikip na tirahan kasama ang isang infected na tao.

### Sino ang puwedeng magkaroon ng STI?

Kahit sino, basta nakikipag-sex nang walang proteksyon ay maaring maha-waan nito. At habang paparami ang mga nakakatalik ng taong ito, tumataas ang posibilidad na magka-STI siya.

### Paano ko malalaman kung mayroon akong STI?

May kasamang senyales at sintomas ang karamihan sa STI. Makikita at mararamdaman ito mula dalawang araw hanggang ilang lingo matapos makipag-sex sa isang infected na partner. Ilang sintomas nito ang:

1. kakaibang katas mula sa ari
2. napakasakit na pag-ihi
3. pagkakaroon ng masasakit na butlig sa ari
4. pagkakaroon ng di masakit na sugat sa ari
5. sobrang pangangati ng ari at paligid nito
6. kulugo sa ari at paligid nito; at
7. pamamaga ng bayag



### Posible rin bang may STI ang isang tao kahit wala siyang nararamdang kakaiba?

Posible ito, lalo na sa mga babae. Karaniwang walang nararamdaman ang mga babae kung may STI sila kaya maari silang makahawa nang hindi nila nalalaman.

24 *Pagbabangon sa Bayang Maynila*

### Ano ang dapat kong gawin kung mayroon akong mga ganitong sintomas?

Kung hinala mong may STI ka, ganito ang maaari mong gawin: Una, huwag mahiya o matakot na komunsulta sa isang doktor dahil siya lang ang makakatulong sa iyo. Pangalawa, iwasan ang pag-inom ng gamot na inirekomenda ng iyong kaibigan o kakilala. Maraming klase ang STI at may kaniyakanang gamot para sa bawat isa. Mas maigi kung na-diagnose ka muna nang wasto upang maresetahan ng tamang gamot.

Madalas na nagrereseta ang doktor ng gamot na iinum sa loob ng isang linggo. Sundin mo ang payo ng doktor para maging epektibo ang gamot. Habang umiinom ka ng gamot, mas mabuting umiwas ka muna sa mga alcoholic drinks para makuha mo ang lubusang epekto ng gamot. At kung makikipag-sex, siguraduhing protektado ito ng condom o kung maaari, huwag munang makipag-sex habang naggagamot.

Mahalagang masabihan mo rin ang iyong sexual partner na mayroon kang STI upang magamot din siya.

### Ano'ng mangyayari kung hindi ko ipapagamot ang STI?

Maraming komplikasyon ang mga untreated STI katulad ng sterility (pagkabaog), urethral stricture (pagsara ng daanan ng ihi), hanggang sa mga impeksyong sumisira sa puso at utak. May mga STI rin na nagiging dahilan ng pagkakaroon ng ilang uri ng kanser kapag di naipagamot.

### Magiging AIDS ba ang STI na di naipagamot?

Hindi naman. Kaya lang, kapag nagkaroon ng STI, tumataas ang posibilidad na magkaroon ng HIV, lalo na kung hindi ka palagiang gagamit ng proteksyon kapag nakikipagtalik.





### Paano nga ba vulnerable sa HIV ang mga OFWs?

- Kaunti o kawalan ng kaalaman tungkol sa HIV at AIDS
- Lungkot at homesickness
- Pagharap sa pangangailangan sa sex
- Kawalan ng access sa condoms
- Kahirapan sa pagtanggì sa sex, hal. kapag nakaranas ng sekswal na pang-aabuso o rape

### Para sa mga seafarers

- Pagkasabik sa human contact dahil matagal sa laot
- Pagkakaroon ng unprotected sex sa maraming partners
- Kultura ng "binyag" para sa mga first timers
- Kultura't paniniwalang kailangang makipag-sex, minsan maaring mapagbibintangang bakla kung hindi kukuha ng babae
- Mga pagkakataong ang Kapitan o ang mga opisyal ng barko pa mismo ang nagbibigay ng babae sa mga seafarers
- Pagkakaroon ng mga "akyat-barko" sa ilang mga Puerto.

### Anu-ano naman ang mga isyung kinakaharap ng mga asawa't pamilya ng mga seafarers kaugnay ng HIV at AIDS?

- Higit na bulnerable sa HIV infection ang kababaihan. Una, biologically, sapagkat ang reproductive organ ng babae ay itinuturing na tagasalo at mas malapad kesa sa mga lalake kung kaya't higit na malapit sa pagkapunit at pwedeng daanan ng HIV. Pangalawa, ang kabuuang pananaw na mas mababa ang posisyon ng kababaihan sa lipunan ay higit ding nagpapalapit sa kababaihan sa pagkakaroon ng HIV.
- Kawalan ng boses sa pagdesisyon lalo na sa seks at kawalan ng negotiating power na gumamit ng condom ang asawa.
- Pagiging economically dependent sa mga asawa, kaya naman lahat ng gusto ng asawa ay gagawin.
- Kawalan at kakulangan din ng impormasyon tungkol sa HIV at AIDS.

### Anu-ano ang mga posibleng epekto ng pagkakaroon ng HIV o AIDS sa mga seafarers?

- Pang-ekonomiya - Pagkawala ng trabaho at kabuhayan. Di na pwedeng mag-abroad uli. Apektado ang Pamilya.
- Sikolohikal/ Emosyunal - kasama na dito ang depression, guilt, pagkahiya at takot na baka mahawa ang asawa
- Pisikal - pagkakasakit at panghihina ng katawan
- Posibilidad ng diskriminasyon at stigma mula sa kapwa seafarers at iba pa.

### Ano ang epekto nito sa asawa o partner?

Bukod sa malaking posibilidad ng pagkahawa, mayroon ding sosyo-emosyonal na epekto sa asawa o partner ang pagkakaroon ng HIV ng OFWs. Betrayal of trust ito o pagguho ng binuong pagtitiwala kasama ng pagmamahal. Naguguluhan din ang isip at damdamin ng asawa o kapartner na kasintindi rin ng nararanasan ng seafarer.

Nakabibigat din ang pang-ekonomikong agam-agam na kakaharapin ng pamilya dahil sa kawalan na ng kakayahang kumita ng seafarer. O kung kumita man, biglang pagliit ng kita niya kumpara sa dating kinikitang dolyares.


**"Pangalagaan ang Pamilya, Ingatan ang Sarili, Alamin ang Usaping HIV at AIDS."**

\*Ang buong seksyon na ito ay hango sa "Ang Pagbabalik ni Leo", isang publikasyon ng Action for Health Initiatives (ACHIEVE), Inc. at ng International Organization for Migration (IOM) na inilathala nung 2004.



*Pagbangon sa Bugang Umuay*

25

 **Kung gusto ninyong kumonsulta para sa HIV/AIDS Testing, pumunta sa:**

**San Lazaro Hospital (SLH)**  
Quiricada Street  
Sta. Cruz, Manila  
Dr. Rosario Jessica Tactacan  
- Abrenica  
HACT Leader/  
Medical Specialist II  
Head, HIV/AIDS Pavilion  
Tel: 309-9529/28  
740-8301 loc 6000

**Philippine General Hospital (PGH)**  
Taft Avenue, Ermita, Manila  
Dr. Jodor Lim /  
Ms. Dominga C. Gomez  
HACT, SAGIP/ PGH  
Telefax: 526-1705

**Research Institute for Tropical Medicine (RITM)**  
Filinvest Corporate City  
Alabang, Muntinlupa City  
Dr. Rossana A. Ditangco  
Head, HIV Research Unit  
Tel: 526-1705;  
807-2628/38  
local 801/208

**Ilocos Training and Regional Medical Center (ITRMC)**  
San Fernando, La Union  
Dr. Jeisela B. Gaerlan  
HACT Leader/  
Medical Specialist  
Clinic: (072) 700-3808

**Baguio General Hospital and Medical Center (BGHMC)**  
Baguio City  
Dr. Maria Lorena L. Santos  
HACT Leader/  
Medical Officer IV  
Tel: (074) 442-4216

**Cagayan Valley Medical Center**  
Tuguegarao City  
Cagayan Valley

**Jose B. Lingad Memorial Medical Center**  
San Fernando, Pampanga

**Vicente Sotto, Sr. Memorial Medical Center (VSSMC)**  
B. Rodriguez Street  
Cebu City 6000  
Dr. Maria Consuelo B. Malaga  
HACT Leader  
Tel: (032) 253-7564/9882

**Bicol Regional Training & Teaching Hospital**  
Legaspi City, Albay  
Dr. Rogelio G. Rivera  
Chief of Hospital III  
Tel: (052) 483-0016/0086/0017

**Corazon Locsin Montelibano Memorial Regional Hospital**  
Lacson St., Bacolod City  
Negros Occidental  
Dr. Cresilda Bacolor  
HACT Leader/  
Medical Specialist  
Tel: (034) 433-2697

**Western Visayas Medical Center (WVMC)**  
Q. Abeto St., Mandurriao  
5000 Iloilo City  
Dr. Ray Celis  
HACT Leader/  
Medical Specialist III  
Tel: (033) 321-2841 to 50

**Davao Medical Center (DMC)**

J.P. Laurel St., Bajada  
8000 Davao City  
Dr. Alicia Layug  
HACT Leader  
Tel: (081) 227-2731

**Zamboanga City Medical Center (ZCMC)**

Evangelista St.  
7000 Zamboanga City  
Dr. Jejunee Rivera  
HACT Leader/  
Medical Officer III  
Tel: (062) 991-0573

**Or visit/inquire at:**

Nearest Social Hygiene Clinics (Special STI Clinics);  
City/Municipal Health Offices NGO Partners at the local level

**NGO INFORMATION and COUNSELING****Action for Health Initiatives (ACHIEVE)**

162-A Scout Fuentebella Ext., Brgy. Sacred Heart, Quezon City  
1103 Philippines  
Ms. Ma. Lourdes S. Marin, President  
Tel. (+632)426-6147/(+632) 414-6130  
Website: [www.achieve.org.ph](http://www.achieve.org.ph)

**Positive Action Foundation Philippines, Inc. (PAFPI)**

2613 Dian St., Malate 1004 Manila, Philippines  
Tel No.: 528-4531  
Hotlines: 404-2911, 832-6239 (9am-6pm)  
Services: Abot-Kamay Drop-In Center, Bahay Kanlungan - Face to face counseling on HIV/AIDS, Training and lecture on prevention of STI/HIV/AIDS to Filipino workers (OFW), Telephone Counseling on STI/HIV/AIDS, Support Group Referral  
Requirement: Referral Letter

**Remedios AIDS Foundation (RAF)**

Remedios cor Singalong St., Malate, Manila  
Tel. No.: 524-0924, 524-4831  
Hotlines: 524-4427/0551 (10am-8:00pm)  
Schedule : Mon to Sat, 10am-10pm  
Services : Phone Counseling, Seminar, HIV-AIDS Testing, Pre & Post Test Counseling, STI Testing

**PINOY PLUS BAHAY LINGAP**

San Lazaro Hospital Compound, Quiricada St., Sta. Cruz, Manila  
Tel No.: 732-3776, 309-9941  
Schedule: Mon to Sat, 8:00am - 6:00pm  
Services: Care and support for People Living with HIV/AIDS (PHA), Defends and uphold the human rights of (PHA), Lecture on Prevention of STI/HIV/AIDS



*Pagbangon sa Bagong Umaga* 27



**Action for Health Initiatives, (ACHIEVE), Inc.**

Action for Health Initiatives (ACHIEVE), Inc. is an organization engaged in the development and implementation of programs on mobility and health, specifically addressing sexual and reproductive health (SRH) and HIV vulnerability of migrant workers and their families. Formed in 2000, ACHIEVE has undertaken pioneering researches on gender, migration and HIV issues and has implemented various community-based with various migrant and women's communities. ACHIEVE has been conducting capacity building activities for various stakeholders such as government agencies, civil society organizations and communities on gender, migration, HIV and sexuality issues. It is a member of the Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia), a regional network of NGOs and community-based organizations in Asia.

ACHIEVE, Inc.  
162- A Sct. Fuentebella Ext., Brgy. Sacred Heart, Quezon City Philippines  
Email: [achieve\\_caram@yahoo.com](mailto:achieve_caram@yahoo.com)  
Telefax: (+63 2) 426-6147 Tel: (+63 2) 414-6130  
Website: [www.achieve.org.ph](http://www.achieve.org.ph)





**Appendix 6:**  
**HIGHLIGHTS OF THE STAKEHOLDERS' FORUM  
ON ESTABLISHING A SEXUAL AND  
REPRODUCTIVE HEALTH (SRH) REFERRAL  
MECHANISM FOR FEMALE SPOUSES OF OFWs**

**HIGHLIGHTS OF THE STAKEHOLDERS' FORUM ON ESTABLISHING A  
SEXUAL AND REPRODUCTIVE HEALTH (SRH) REFERRAL MECHANISM  
FOR FEMALE SPOUSES OF OFWs**

**I. INTRODUCTION**

1. The ADB Regional Technical Assistance for Supporting Women at-Risk and Vulnerable to HIV and AIDS (RETA 6143), an ADB-assisted project of the Department of Health (DOH), aimed to (i) increase knowledge and awareness of vulnerable women on gender, SRH, and HIV prevention in the Project areas, and (ii) develop policy recommendations for female seafarers and women IDUs in the national HIV and AIDS Program. These women were categorized as female spouses of seafarers, female seafarers, and females who inject drugs (FIDUs). The Project was managed, on behalf of ADB, by PRIMEX, in association with Action for Health Initiatives (ACHIEVE) Inc. and Remedios AIDS Foundation (RAF). Under its component on female spouses of seafarers, the Team involved the following spouses' organizations: Craftstruck Club of Seamen's Village (CCSV) in Dasmariñas, Cavite; Mary Star of the Sea Seamen's Families Association (MSSSFA) in Davao City; and the Veritas Allottees Circle in Metro Manila and Davao city. Advocacy activities to establish an SRH referral system began in September 2008 in the Project areas. These activities included courtesy calls on key officials and conduct of Stakeholders' Forum on Establishing a Sexual and Reproductive Health Referral Mechanism for Female Spouses of OFWs in each location.

2. **Courtesy Calls.** During the first tripartite meeting among DOH, ADB, and the Consultant Team, on 10 July 2008, it was made clear that the Team should involve early on, the following concerned health offices in the conduct of activities for the female spouses: Regional Health Offices of Regions 4A and 12, the City Health Office of Davao City, the Provincial Health Office of Cavite, and the Rural Health Unit of Dasmariñas. Communication letters from DOH-NCDC were sent to the concerned mayors and city/rural health officers to facilitate the visit of the Consultant Team. The list of persons met during these visits is included as Annex A.

3. **Davao City.** On 10 September 2008, the Team visited the Office of the Mayor of Davao City where they met Dr. Josephine Villafuerte, Davao City Health Officer. The Team also visited the Department of Health - Center for Health Development for Davao Region and the Associated Maritime Officers' and Seamen's Union of the Philippines (AMOSUP) Seamen's Hospital.

4. **Cavite.** On 22 October 2008, the Team visited the Rural Health Unit I in Dasmariñas Cavite and met Dr. Cynthia Cristobal who also represented Dasmariñas Mayor Jennifer Barzaga. At the Provincial Health Office in Trece Martires, the Team conferred with the Dr. Gerardo Alcantara, Coordinator of the Local AIDS Council who invited the Project Coordinator to make a presentation about the Project during the province-wide meeting of the multi-sectoral Council on 5 November at the Legislative Session Hall in Trece Martires. The Program is included as Annex B.

**II. STAKEHOLDERS' FORUM**

5. The objective of the forum was to establish a sexual and reproductive health referral mechanism so that female spouses of seafarers can have access to SRH services and information, especially with regards to STI/HIV prevention. The forum had presentations on the **Overview of the Project** and the **Results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers**, as well as group discussions to map out the needs of the spouses of seafarers vis-à-vis the services offered by the participating SRH service providers. The Program is included as Annex C.



6. On 16 October 2008, the Davao Stakeholders' Forum was conducted at the Garden Oases Resort and Restaurant in Davao City with 23 participants, 11 of whom are spouses of seafarers from MSSSFA (8) and VAC (3). Also present were representatives from the government offices – viz., City Health Office, DOH-CHD for Davao Region, OWWA and the private sector – Alagad-Mindanao and Brokenshire Hospital.

7. On 22 November 2008, the Cavite Stakeholders' Forum was conducted at the David's Tea House with 23 participants, five of whom belong to CCSV. Also present were representatives from the public and private sectors. Government offices represented included the following: Sangguniang Bayan, Rural Health Units, Municipal Health Offices and Hospitals, Provincial Health Office, and DILG. Private hospitals represented were the De La sale University Medical Center and Asia Medical Hospital. The list of participants for the two events are included as Annex D and the photodocumentation is included as Annex E.

#### **A. Davao Forum**

8. **Opening.** To start off the session, Dr. Josephine Villafuerte, City Health Officer of Davao City and Co-chair of the Davao City AIDS Council, welcomed the participants and resource persons to the forum. Dr. Villafuerte stated that the project of the Davao City AIDS Council is geared towards OFWs and their families but that they are also looking at other at-risk populations like the students. She mentioned that in a recent surveillance on HIV and AIDS, the number of younger people who are getting infected is increasing. Dr. Villafuerte also said that they give free ARVs for PLHIV and that they are setting up a referral system for care and support. She ended her speech by saying that she looks forward to working with the participants and their families.

9. **Presentations.** Ms. Malu Marin, Project Team Leader and Executive Director of Action for Health Initiatives (ACHIEVE), Inc. gave an overview of RETA 6143, its objectives and activities undertaken. Ms. Gladys Malayang, RETA 6321 Pilot Implementation and Evaluation Specialist and Executive Director of Health Development Initiatives Institute (HDII) presented the main findings of the study "Home Alone: A Qualitative Study on HIV and HIV Risk Perceptions Among Partners of Seafarers" (Annex F).

10. The study was conducted in Dasmariñas, Cavite and Davao City and the respondents were grouped according to the rank of their seafarer husbands as follows: (i) seafarer spouses married for five or less years; (ii) seafarer spouses whose husbands are from the rank and file (ratings position); and (iii) seafarer spouses whose husbands have officer positions. Focus group discussions and key informant interviews were the methods used in gathering the data. The FGDs used a General Interview Guide approach coupled with participatory methods.

11. The study has shown that women spouses of seafarers, although economically secure, are more vulnerable to the risk practices of their spouses leading to STI and HIV. The women in the study know and are aware of possible high risk-taking behavior and practices of their seafarer partners. There is an acceptance of this behavior but at the same time a denial that it could not happen to them personally. Their vulnerabilities stem from their inability and disempowerment to negotiate for safer sex, their lack of knowledge on STI, HIV and AIDS, their multiple roles as a family decision-maker and their lack of social support in those times when their spouses are not around.

12. Recommendations pertaining to education and information include providing information on HIV and AIDS to older and younger women, extending seminars and workshops given to employment agencies or companies to wives and partners of seafarers, providing gender awareness training and practical applications on negotiations and communications. Recommendations pertaining to approaches to interventions include providing health and other services that take into consideration the social structures existing within the women partners of seafarers, and addressing the need to de-





stigmatize and have non-discriminatory practices for those diagnosed with HIV. Lastly, recommendations pertaining to services and programs include implementing measures to improve husband-wife communications on safer sex, sexual behaviors and practices; conducting education activities about condoms and safer sex; providing quality reproductive health services that are gender-sensitive and responsive to the specific needs of the partners of seafarers.

13. **Reaction to the presentation.** Ms. Elizabeth Malonzo, MSSSFA President affirmed that factors such as loneliness and pain of separation, the low level of knowledge about reproductive sexual health particularly in STIs, HIV / AIDS, female spouses' attitude of tolerating their husband's promiscuity, and female spouses' willingness to take the risk in contracting STI's, and HIV/ AIDS make wives of seafarers vulnerable to STIs and HIV. She also stressed that mobility contributes to the spread of HIV, especially among seafarers, because seafarers tend to have sexual partners in different locations. When the seafarers return home, they don't use condoms with their wives and this makes the wives vulnerable to HIV infection.

14. Ms. Malonzo further affirmed that seafarers' wives have low level of knowledge about STIs and HIV/AIDS. She mentioned that condoms are used mainly for family planning purposes, that condoms should be used by their husbands when they have sex with other women but not with them; and that condom use is equated with being unfaithful and not being trustworthy.

15. Her recommendations to prevent STI and HIV infection among spouses of seafarers included the following: (i) empowerment of migrant's female spouses through capacity building and other related activities; (ii) continuing education and information on STI and HIV; and (iii) working together with other stakeholders such as the NGOs or GOs in STI and HIV prevention.

16. **Discussion Points.** Alagad-Mindanao provides psychosocial care and support services for PLHIV and their affected families. RETA 6143 enabled ALAGAD to set up a referral mechanism in Davao City among service providers. The Davao Medical Center/HACT is the primary partner of ALAGAD in the care and support of PLHIV in terms of providing medical and laboratory services for PLHIV. ALAGAD also involves other stakeholders like the hospitals, community-based organizations, City Health Office, CSSDO, and private practitioners, particularly infectious disease physicians. These stakeholders refer PLHIV to ALAGAD. The Davao Medical Center provides medical intervention and ALAGAD provides counselling, therapy, and other follow-up sessions after the PLHIV has been discharged from the hospital.

17. The referral system on HIV and AIDS in Davao City has already been established and is working so this isn't much of a problem. Partnerships with stakeholders in Davao City have been tested. There has been no report of disclosed identity or sensationalized coverage from media of PLHIV.

18. The Reproductive Health and Wellness Center which is under the City Health Office provides services on STIs and HIV and AIDS. Their services include counselling, treatment, diagnosis for most common STIs, medicines for common STIs, screening test for HIV and syphilis. When they have HIV positive cases, they refer them to ALAGAD. Their patients are predominantly sex workers and MSMs.

19. In Davao City, there are NGOs such as the Bathaluman Crisis Center that works on RH issues, specifically VAW. The City Hall has an Integrated Gender Development Office and they respond to gender issues or concerns. RH concerns can be addressed by this office. The office also has lawyers who can respond to legal concerns regarding VAW or RH.

20. Female spouses of seafarers can avail of RH services at the Social Hygiene Clinic (SHC). The SHC caters to everyone, not only the high-risk groups.



21. Female spouses of seafarers who have RTIs or cancer can go to the SHC for basic screening and pap smear. If the test results show that they need to be referred to another hospital or clinic, they can be referred to DMC or other private hospitals.

22. **Issues raised.** The following were the issues raised during the open forum session.

- (i) Voluntary counselling and testing - Seafarers are asked to sign waivers saying that they went through HIV counselling. Under RA 8504, pre- and post-test counselling is a requirement when taking the HAT.
- (ii) Mandatory HIV testing - Seafarers take the HAT because it is required by the principal. In cases where the principal does not require it, employment agencies should not include it as part of the routine medical test because this entails cost on the part of the seafarer and is a violation of RA 8504. Mandatory HAT is a problem that OFWs face because this is the current system. The POEA and the DOH are discussing ways to address this problem because mandatory HAT contradicts the law.
- (iii) Spouses' suggestion - Some of the spouses suggested that their husbands should have a medical check up upon arrival so that they will be protected against diseases. Also, if the husband is found to be sick, the expenses can be covered by their health insurance. With regards to HAT, the resource persons explained that it should still be done on a voluntary basis. Also, there is no guarantee that the result of the test is accurate if it was done during the window period.

23. **Recommendations.** The following recommendations were made:

- (i) Map out existing networks and referral mechanisms on RH. Come up with a directory and disseminate this information.
- (ii) Organize the community or have interventions at the community level. Encourage groups to organize and integrate STIs, HIV and AIDs, RH issues and concerns into the activities of the associations.
- (iii) Since the referral mechanism is in place, the next step is to disseminate this kind of information to the community so that there is a better understanding of how the system works and how the community can access the services.

24. **Closing.** On behalf of the Department of Health - Center for Health Development of Davao Region, Dr. Socorro Garcia, Chief of the Local Health Support Division, commended and thanked the organizers for the findings of the Study presented. She said that they will use the research results as their guide in policy-making. Dr. Garcia stressed the need to harmonize and synchronize the health services available and all the researches done in Davao. She also mentioned that RH is one of the goals in the MDG and that there is a need to lower maternal mortality and to have more programs for mothers and children. She said that education is crucial because it leads to empowerment.

## **B. Cavite Forum**

25. **Opening.** Speaking on behalf of the Honorable Mayor Berzaga, SB member of Committee on Health Mr. Teofilo Lara welcomed the participants to the forum and expressed the Mayor's enthusiasm over the initiative focussed on the health needs of the female spouses of seafarers. The mayor is pleased that the Project selected Dasmaringas as one of its Project sites as the municipality



has a high population of seafarer families. This was followed by the Project Overview delivered by the Project Coordinator, Ms. Pavico and the presentation of the Study conducted by Malayang et al.

26. **Reactions.** Ms. Socorro Moralina gave her insights on the presentation of Ms. Malayang. She stated that for most of them who are busy, have businesses, and have children to care for, the wife will have little energy and time to think of having extra marital affairs. If a wife is busy with her career, then she can sublimate her sexual desires when her husband is away. Nowadays, technology has made it very easy to communicate and sustain long distance relationships. It is important that the couple demands mutual fidelity from each other. The spouses in this group live in one village and the village is one support group wherein they share the same experiences and have common friends. To start with the female spouses of Craftstuck Club of Seamen's Village is a group of friends engaged in crafts such as crocheting within the village. Their husbands may be on board ships of different crewing agencies. The Seamen's Village was set up by the Amosup exclusively for member seafarers. *"When our husbands are in town, our focus is more towards the family. This leads to lack of continuity of social life which is temporarily in suspended animation."*

27. **Mapping.** During the mapping session, the five female spouses were instructed to write down on meta cards *where do you go for health care, and what services do you seek*. The rest of the participants were instructed to list down the services available for women. The needs and services were then matched. Two types of services were identified: these are health related and livelihood assistance.

28. The following are the available services mentioned by those present:

- (i) **CHD 4-A** has a social hygiene clinic for STI related services. It also provides livelihood opportunities where by an NGO can apply for a Botika ng Bayan package to sell medicines at affordable prices.
- (ii) **Rural Health Unit** provides:
  - (a) Health Education on Family Planning – counseling, tubal ligation;
  - (b) Social Hygiene Clinic which targets GROs;
  - (c) One-stop cancer screening facility for cervical pap smear/acetic acid wash and breast exam; and
  - (d) Maternal and child care – immunization, check up, pre-natal / post partum care.
- (iii) **Health Center in Carmona** provides family planning services and commodities such as condom, IUD, BTL, DMPA, pills.
- (iv) **Provincial Hospital** in cooperation with the Korean Hospital is in a private-public partnership and can provide services with a private hospital set up. They are in a process of setting up services to do HIV testing and can advice where to go, and in effect set up a referral system.
- (v) **De La Salle University Medical Center** provides an array of services to include medical, surgical, maternal and Child care, ENT, Ophthalmology and other subspecialties, executive check up, TB DOTS, animal bite center in the ER.
- (vi) **Private practitioners** provide treatment for infections.
- (vii) **Private clinics** can do diagnostic and laboratory exams, outpatient check ups, and adult immunization.

29. **Open Forum:** During the Open Forum the following issues were discussed:



- (i) The benefit of being an organized group accredited with the local government. There was a suggestion from representatives of the municipal government for the group to be accredited by the local government as this will facilitate them to have access to assistance from the LGU. *The CCSV is registered with SEC as a private organization since 2005, but they still need to be accredited by the local government.*
- (ii) Public Employment Service Office (PESO) can provide free livelihood and entrepreneurship development training for OFW families and reintegration of returning OFWs.
- (iii) An invitation to be part of the Philippine National AIDS Council (PNAC) - a national organization that oversees the response and works in coordination with other countries and shares experiences in their work on HIV and AIDS.

“Once you are an NGO, PNAC would like to invite you to the Council as this will be a new sector. The NGOs in the Council are those that respond to HIV and AIDS.”

- (iv) Are there confirmatory hospitals on HIV and AIDS?

In Cavite there are none. The confirmatory test is done at RITM. De La Salle Hospital can do the testing and counselling and send the sample to RITM for the confirmatory tests.

30. **Closing.** In closing, DOH-CHD 4A acknowledged the big help the Project and the female spouses can contribute to the provincial AIDS Council as one is not only helped, but other families as well. **Dr. Cristobal of RHU I, thanked PRIMEX for organizing the meeting. *We in the public health sector are willing to cooperate in providing the services that you need. This is the start of a fruitful relationship.***

### III. REFERRAL NETWORK

31. For this subcomponent, the following outputs have been provided: (i) referral network scheme for the Cavite spouses (Annex G), (ii) directory of SRH service providers for Davao spouses and Cavite spouses (Annex H). During the mapping of SRH providers in Cavite, Dr. Virgil Rodil, the president of all private hospitals in the whole of Laguna and Cavite expressed his willingness to extend help in anyway he can.



**LIST OF PERSONS MET**

**A. Davao City – 10 September 2008**

- |    |                              |   |
|----|------------------------------|---|
| 1. | Atty. Melchor V. Quitain     | City Legal Officer, Office of the Mayor, Davao City |
| 2. | Dr. Josephine J. Villafuerte | City Health Officer                                 |
| 3. | Ms. Vivien P. Oledan, RN     | Public health Nurse, CHO                            |
| 4. | Dr. Salvador Entrera         | Assistant Regional Director, DOH-CHD 11             |
| 5. | Dr. Richard J. Pecson        | Director, Amosup Seamen's Hospital                  |

**B. Cavite - 22 October 2008**

- |    |                       |   |
|----|-----------------------|---|
| 6. | Dr. Cynthia Cristobal | Rural Health Physician, Rural Health Unit I         |
| 7. | Dr. Gerardo Alcantara | HIV Coordinator, Local AIDS Council, Trece Martires |

**C. Cavite – 5 November 2008**

- |     |                       |                                 |
|-----|-----------------------|---------------------------------|
| 8.  | Dir. Efren Echavia    | Provincial Director, DILG       |
| 9.  | Ms. Estelita Cadiente | Capacity Building, RHU, Carmona |
| 10. | Dr. Gerardo Alcantara | IEC, HIV Coordinator, LAC       |
| 11. | Dr. Cynthia Cristobal | RHP, RHU I                      |
| 12. | Ms. Lorna Gonzales    | DOLE, Province of Cavite        |
| 13. | Ms. Minda Yaun        | PESO, Cavite                    |
| 14. | Dr. Vilma Diez        | HIV Task Force, Cavite          |



**CAVITE HIV/AIDS TASK FORCE MEETING**  
Session Hall, Legislative Building. Provincial Capitol, Trece Martires City  
5 November 2008

**PROGRAM**

8:30 – 9:00	Registration of Participants:	<b>MS. HAYDELISA MADERAZO</b> PHO. Public Health Nurse
9:00 – 9:10	Invocation National Anthem	<b>MS. HEIZEL VIDALLO</b> PHO. Public Health Nurse
9:10 – 9:30	Welcome Address and Inspirational Messages	<b>DR. LIZA FE F. CAPUPUS, MD, MPH</b> Head, Public Health Programs
<b>Agenda</b>		
9:30 -10:00	I. Re-Echo: ADB TA: 6143-REG. Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines	<b>MS. JOSEFINA PAVICO</b> PRIMEX
10:00 – 10:20	II. Presentation of MOA Status (Transfer of Fund, grant from JPHAM)	<b>MR. ROLLE BENITEZ</b> Supervising Health Program Officer DOH-BIHC
10:20 – 11:10	III. Updates of IEC Campaign on HIV/AIDS at the Brgys. Level	<b>DIR. EFREN M. ECHAVIA</b> Provincial Director DILG-Cavite
11:10 -12:00	IV. Messages: On HIV/AIDS. Provincial Task Force Plans and Proposals	<b>DR. GERARDO ALCANTARA</b> Medical Officer III Chairman- Cavite Local HIV/AIDS Task Force
12:00 – 12:10	V. Other Matters	
	VI. Adjourned	

**MS. ESTELITA Q. CADIENTE**  
Med. Tech. III – Carmona RHU



**STAKEHOLDERS' FORUM FOR THE ESTABLISHING A SEXUAL AND REPRODUCTIVE HEALTH (SRH) REFERRAL MECHANISM FOR FEMALE SPOUSES OF OFWS**

Garden Oases Resort and Restaurant, Davao City  
16 October 2008

**PROGRAMME**

<b>TIME</b>	<b>TOPIC</b>	<b>PERSON RESPONSIBLE</b>
1:00 – 1:05	Welcome Remarks	Dr. Josephine Villafuerte CHO, Davao City
1:05 – 1:15	Introduction on the Project	Ms. Malu S. Marin PRIMEX/ACHIEVE
1:15 – 1:45	Presentation on the Results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers	Ms. Gladys Malayang PRIMEX
1:45 – 2:00	Reaction on the Presentation	Ms. Elizabeth Malonzo President, Mary Star of the Sea, Seafarers Families Association (MaSSSFA)
2:00 – 3:50	Discussion	
3:50 – 4:00	Closing Remarks	Dr. Socorro Garcia Chief, Local Health Support Division, DOH-CHD

Organized by:  
Pacific Rim Innovations and Management Exponents (PRIMEX), Inc.  
in association with  
Action for Health Initiatives (ACHIEVE), Inc.



**STAKEHOLDERS' FORUM ON ESTABLISHING A  
HEALTH REFERRAL MECHANISM FOR FEMALE SPOUSES OF OFWS**

David's Tea House, Dasmariñas, Cavite  
18 November 2008

**PROGRAMME**

<b>TIME</b>	<b>TOPIC</b>	<b>PERSON RESPONSIBLE</b>
9:30 – 10:00 AM	Registration	
10:00 – 10:05	Welcome Remarks	Hon. Mayor Jennifer Barzaga, <i>Dasmariñas, Cavite</i>
10:05 – 10:15	Introduction and Project Overview	Ms. Josefina Ma. Pavico, <i>Project Coordinator, PRIMEX</i>
10:15 – 10:45	Presentation on the Results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers	Ms. Gladys Malayang, <i>Project Implementation and Evaluation Specialist, PRIMEX</i>
10:45 – 11:00	Reaction on the Presentation	Ms. Socorro Moralina <i>President, Craftstruck Club of Seaman's Village</i>
11:00 – 11:50	Discussion	Ms. Gladys Malayang <i>Moderator</i>
11:50 – 12:00	Closing Remarks	Dr. Cynthia Cristobal <i>Municipal Health Officer, Dasmariñas, Cavite</i>
12:00 – 1:00	Lunch	

Organized by:

Pacific Rim Innovations and Management Exponents (PRIMEX), Inc.  
in association with Action for Health Initiatives (ACHIEVE), Inc.





**LIST OF PARTICIPANTS  
Davao Forum**

**A. Government Offices**

- |    |                              |  |
|----|------------------------------|--|
| 1. | Dr. Ma. Socorro D. De Gracia | Chief, Local Health Support Division, DOH-Center Health Development (CHD), Davao Region            |
| 2. | Dr. Jordana P. Ramiterro     | Medical Officer VI, Reproductive Health and Wellness Center (RHWC), City Health Office, Davao City |
| 3. | Dr. Josephine Villafuerte    | City Health Office, D.C.   |
| 4. | Ms. Nelia Cumela             | Nurse, DOH-CHD-XI  |
| 5. | Ms. Rosemarie G. Luntao      | Overseas Workers Welfare Administration (OWWA) XI  |

**B. Private Sector (NGOs and Hospitals)**

- |    |                       |   |
|----|-----------------------|---|
| 6. | Mr. Denver Talha      | Admin Staff, BIHMI  |
| 7. | Ms. Alma L. Mondragon | Executive Director, Alliance Against AIDS in Mindanao, Inc. (ALAGAD-Mindanao, Inc.) |

**C. Female Spouses of Seafarers**

- |     |                            |   |
|-----|----------------------------|---|
| 8.  | Ms. Elizabeth M. Malonzo   | President, Mary Star of the Sea Seafarers Families Association (MSSSFA) |
| 9.  | Ms. Alberta I. Malano      | VP, MASSSFA   |
| 10. | Ms. Elizabeth J. Balan     | Treasurer, MSSSFA   |
| 11. | Ms. Emily Gabo             | Asst. Treasurer, MSSSFA   |
| 12. | Ms. Myrna S. Gallego       | Asst. Treasurer, MSSSFA   |
| 13. | Ms. Rosalina M. Cabundocan | Auditor, MSSSFA   |
| 14. | Ms. Maria Fe Tomambid      | MSSSFA  |
| 15. | Ms. Jocelyn D. Peña        | MSSSFA  |
| 16. | Ms. Aurlia Quinut          | MSSSFA  |
| 17. | Ms. Cecilia J. Bahan       | Veritas Allottees Circle (VAC), Davao City                              |
| 18. | Ms. Leticia T. Teh         | VAC   |
| 19. | Ms. Rossana R. Yambao      | VAC   |

**D. Consultant Team**

- |     |                                  |                                |
|-----|----------------------------------|--------------------------------|
| 20. | Ms. Malu S. Marin                | Team Leader, RETA 6143         |
| 21. | Ms. Gladys Malayang              | PIES, RETA 6321                |
| 22. | Ms. Josefina Ma. Ferriols-Pavico | Project Coordinator, RETA 6143 |
| 23. | Ms. Irene Chia                   | Documentor                     |



**LIST OF PARTICIPANTS**  
**Cavite Forum**

**A. Government Offices**

- |     |                               |  |
|-----|-------------------------------|--|
| 1.  | Mr. Francisco Barretto        | Sanguuniang Bayan (SB), Committee on Health,<br>Municipality of Dasmariñas |
| 2.  | Mr. Teofilo Lara              | SB, Municipality of Dasmariñas   |
| 3.  | Dr. Cynthia M. Cristobal      | Rural Health Physician, RHU I, Dasmariñas, Cavite                          |
| 4.  | Ms. Imelda Herda              | NA II, RHU I, Dasmariñas   |
| 5.  | Dr. Gerardo Alcantara         | LAC, Trece Martires  |
| 6.  | Ms. Estelita Q. Cadiente      | MHO, Carmona   |
| 7.  | Dr. Jocelyn Caballes          | DBB Municipal Hospital   |
| 8.  | Dr. Gerry Montana             | Medical Officer III, General Emilio Aguinaldo Municipal<br>Hospital        |
| 9.  | Ms. Minda V. Yaun             | PESO-OPG, Cavite   |
| 10. | Mr. Dominador T. de Pano      | LGOO V, DILG, Cavite   |
| 11. | Dr. Feliciano M. Velasco, Jr. | DOH-CHD 4-A, Extension Office, Cavite                                      |
| 12. | Dr. Jesse Fantone             | Secretariat, PNAC  |

**B. Private Sector (NGOs and Hospitals)**

- |     |                              |  |
|-----|------------------------------|--|
| 13. | Ms. Amelani A. Banca         | De Lla Salle University Medical Center |
| 14. | Dr. Jacqueline R. Salagubang | OG-Gyne, Asia Medical Hospital         |

**C. Female Spouses of Seafarers**

- |     |                      |                 |
|-----|----------------------|-----------------|
| 15. | Ms. Socorro Moralina | President, CCSV |
| 16. | Ms. Reizel Bañez     | CCSV            |
| 17. | Ms. Shirley Setenta  | CCSV            |
| 18. | Ms. Hailani Gavino   | CCSV            |
| 19. | Ms. Nancy Salazar    | CCSV            |

**D. Consultant Team**

- |     |                                  |                                |
|-----|----------------------------------|--------------------------------|
| 20. | Ms. Gladys Malayang              | PIES, RETA 6321                |
| 21. | Ms. Josefina Ma. Ferriols-Pavico | Project Coordinator, RETA 6143 |
| 22. | Ms. Normie Ibe                   | Secretariat                    |
| 23. | Mr. Bong Cardíño                 | Support Staff                  |



PHOTODOCUMENTATION  
Davao Forum



Dr. Josephine Villafuerte, City Health Officer of Davao City and Co-chair for the Davao City AIDS Council, opens the forum and welcomes everyone



Ms. Malu Marin, Team leader, provides the Project Overview



Ms. Gladys Malayang presents the Results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers



Ms. Elizabeth Malonzo, MSSSFA President, responds to the findings presented in the Study



Dr. Socorro Garcia, Chief of Local Health Support Division, DOH-CHD XI, gives the Closing Remarks



Participants of the Stakeholders' Forum for Establishing a Sexual and Reproductive Health (SRH) Referral Mechanism for Female Spouses of OFWs in Davao City

PHOTODOCUMENTATION  
Cavite Forum



On behalf of Dasmariñas Mayor Jennifer Berzaga, Mr. Teofilo Lara, Sangguniang Bayan Member of Committee for Health, opens the forum and welcomes everyone



Ms. Josefina Pavico, Project Coordinator, provides the Project Overview

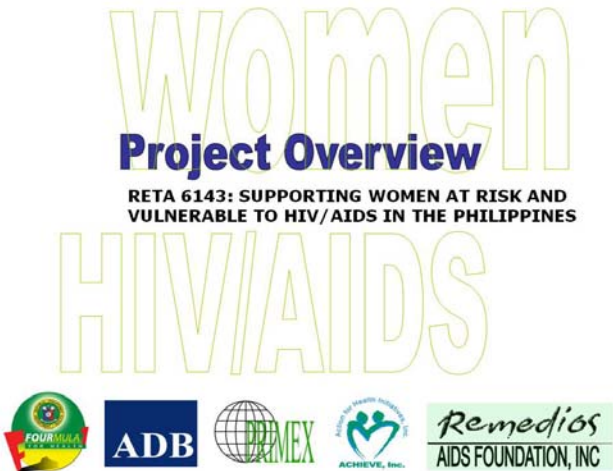


Ms. Gladys Malayang and Ms. Socorro Moralina in deep discussion on the Results of the Study on HIV Risk Perceptions of Female Spouses of Seafarers



Dr. Cynthia Cristobal, RHU I, gives the Closing Remarks




PRESENTATIONS

	<h3>Project Background</h3> <ul style="list-style-type: none"> <li>2007 - The Asian Development Bank (ADB) through the Department of Health (DOH), executed Regional Technical Assistance (RETA) 6321, Subproject 5, "Strengthening Country Responses to HIV/AIDS among Vulnerable Groups"</li> </ul> <p>Component 1: Injecting Drug Users (IDU) Component 2: Overseas Filipino Workers (OFW)</p> <ul style="list-style-type: none"> <li>Implementors: Pacific Rim Innovations and Management Exponents (PRIMEX), Inc., in association with Action for Health Initiatives (ACHIEVE), Inc. and Remedios AIDS Foundation</li> </ul>
<h3>Component 2</h3> <ul style="list-style-type: none"> <li>Phase I – Conduct of the Research             <ul style="list-style-type: none"> <li>Situation Analysis and Response Report (SAR) on Migration and HIV and AIDS in the Philippines</li> <li>Knowledge, Attitudes and Practices (KAP) of Seafarers</li> <li>Qualitative Study on Risk perceptions of female spouses of seafarers</li> <li>Case Studies of Seafarers Living with HIV</li> <li>Study on the Full Migration Cycle</li> </ul> </li> <li>Phase II – Capacity Development for Service Providers and Implementors</li> </ul>	<ul style="list-style-type: none"> <li>Gender Issues arising from RETA 6321 of both components</li> <li>Absence of response or implementation component for Component 2 that directly involves the communities affected</li> <li><b>RETA 6143: Supporting Women at Risk and Vulnerable to HIV in the Philippines</b></li> </ul>
<h3>RETA 6143</h3> <ul style="list-style-type: none"> <li><b>Component 1:</b> HIV prevention for female spouses of seafarers;</li> <li><b>Component 2:</b> Qualitative study of the personal and structural determinants of the risks and vulnerabilities of female Filipino seafarers to HIV infection and other reproductive health problems; and</li> <li><b>Component 3:</b> Qualitative study on the gender-specific vulnerabilities of women who inject drugs in Metro Cebu and Zamboanga City.</li> </ul>	<h3>Component 1: HIV prevention for Female spouses of seafarers</h3> <ol style="list-style-type: none"> <li>Community-based Education and Awareness Raising for Female Spouses</li> <li>Conduct of Advocacy Activities to establish an SRH Referral system</li> <li>Production of IEC/BCC Materials</li> </ol>

<p style="text-align: center;"><b>Community-based Education and Awareness Raising for Female Spouses</b></p> <div style="border: 1px solid black; padding: 5px;"> <ol style="list-style-type: none"> <li>1. Conduct of seminar workshops on gender, sexual and reproductive health, STI/HIV prevention among female spouses of seafarers</li> <li>2. Conduct of Peer Educators' Training</li> <li>3. Conduct of Peer Education/Outreach Activities</li> <li>4. Review/Production/Distribution of IEC/BCC materials for female spouses</li> </ol> </div>	<p style="text-align: center;"><b>Conduct of Advocacy Activities to establish an SRH Referral system</b></p> <ol style="list-style-type: none"> <li>1. Conduct of stakeholders forum with health service providers, LGUs, spouses organizations, etc.</li> <li>2. Establish an SRH referral system for female spouses of seafarers, in order to facilitate their access to SRH services</li> </ol>
<p style="text-align: center;"><b>Objectives</b></p> <p>The intent of the referral mechanism is to enable female spouses of seafarers to have access to SRH services and information, especially with regards to STI/HIV prevention.</p>	<p style="text-align: center;"><b>Thank you!</b></p>



**“HOME ALONE”: A QUALITATIVE STUDY ON HIV AND HIV RISK PERCEPTIONS AMONG PARTNERS OF SEAFARERS**

<p>Fighting HIV in Asia and the Pacific (RETA 6321): Strengthening Country Response to HIV Among Vulnerable Groups</p> <p><b>“HOME ALONE”</b></p> 	 <p><b>A QUALITATIVE STUDY ON HIV AND HIV RISK PERCEPTIONS AMONG PARTNERS OF SEAFARERS</b></p> 	<p><b>National HIV Situation</b> (as of August 2008)</p> <p><b>Total Reported Cases — 3,399</b> (cumulative 1984-August 2008)</p> <ul style="list-style-type: none"> <li>■ Total August 2008 – 41</li> <li>■ Total January – August 2008: 338</li> <li>■ Total Reported Cases 2007: 342</li> </ul> <p><b>Total OFW Cases - 1149</b></p>																							
<p><b>Study Objectives</b></p> <ol style="list-style-type: none"> <li>1. to describe the level of knowledge on STI and HIV; its prevention and treatment practices</li> <li>2. to describe the perceptions on vulnerabilities of self and partners</li> <li>3. to describe attitudes and experiences on STI and HIV risk practices.</li> </ol>	<p><b>Study Methodology</b></p> <ul style="list-style-type: none"> <li>• Two sites: Dasmariñas, Cavite and Davao City</li> <li>• Respondents were grouped according to the rank of their seafarer husbands as follows:             <ul style="list-style-type: none"> <li>– seafarer spouses married for five or less years</li> <li>– seafarer spouses whose husbands are from the rank and file (ratings position)</li> <li>– seafarer spouses whose husbands have officer positions</li> </ul> </li> <li>• Focus group discussions and key informant interviews were the methods used in gathering the data. The FGDs used a General Interview Guide approach coupled with participatory methods.</li> </ul>																								
<p><b>Notes</b></p> <ul style="list-style-type: none"> <li>• Issues raised cut across the different parts of the cycles of migration</li> <li>• The terms “partners,” “wives,” “spouses” are used interchangeably in the presentation</li> <li>• Two KIIs were also done with a woman’s experience of acquiring STI from the seafarer partner and a relationship between a seafarer and a gay prostitute.</li> </ul>	<p><b>Profile of the Respondents</b></p> <table border="1"> <thead> <tr> <th>Profile</th> <th>Women partners &lt; 5 years</th> <th>Women partners to Ratings</th> <th>Women partners to Officers</th> </tr> </thead> <tbody> <tr> <td>Ages</td> <td>22-34</td> <td>34-55</td> <td>43-58</td> </tr> <tr> <td>Mean Years as partners</td> <td>3.5 years</td> <td>20 years</td> <td>25 years</td> </tr> <tr> <td>Mean No. of children</td> <td>1.8</td> <td>2.6</td> <td>3</td> </tr> <tr> <td>Educational Attainment</td> <td>High school and some college</td> <td>Mostly some college</td> <td>Mostly college graduates</td> </tr> <tr> <td>Employment</td> <td>Housewives; small businesses</td> <td>Housewives, some employed</td> <td>Housewives, more employed</td> </tr> </tbody> </table>	Profile	Women partners < 5 years	Women partners to Ratings	Women partners to Officers	Ages	22-34	34-55	43-58	Mean Years as partners	3.5 years	20 years	25 years	Mean No. of children	1.8	2.6	3	Educational Attainment	High school and some college	Mostly some college	Mostly college graduates	Employment	Housewives; small businesses	Housewives, some employed	Housewives, more employed
Profile	Women partners < 5 years	Women partners to Ratings	Women partners to Officers																						
Ages	22-34	34-55	43-58																						
Mean Years as partners	3.5 years	20 years	25 years																						
Mean No. of children	1.8	2.6	3																						
Educational Attainment	High school and some college	Mostly some college	Mostly college graduates																						
Employment	Housewives; small businesses	Housewives, some employed	Housewives, more employed																						



<p style="text-align: center;"><b>Summary of Findings</b></p> <ul style="list-style-type: none"> <li>• <i>Knowledge of HIV and AIDS</i></li> <li>• <i>Practices and Experiences on Prevention and Treatment</i></li> <li>• <i>Attitudes and Practices towards Vulnerabilities and Exposure to Risky Behavior</i></li> <li>• <i>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</i></li> </ul>	<p style="text-align: center;"><b>Knowledge STI, HIV and AIDS</b></p> <ul style="list-style-type: none"> <li>• The younger women showed a higher knowledge of STI and HIV. Older middle-aged partners of officers showed less familiarity with the various basic aspects of STI, HIV and AIDS.</li> <li>• For all wives in the FGDs, avoiding sex with different partners was mentioned as a preventive measure to HIV and STIs, with the younger wives providing the acronym “ABC” to stand for “abstinence, be faithful, and condom use.”</li> </ul>
<p style="text-align: center;"><b>Knowledge STI, HIV and AIDS</b></p> <ul style="list-style-type: none"> <li>• While more wives in each group believed that condom use can reduce the risk of STI and HIV, each of the groups had one or two members who were not very sure (“it is not an assurance; it depends on the condom brand because some kinds easily break”).</li> <li>• A few wives in the Ratings and the 5-or-less-year married groups felt they could never be sure of their partners who claim they are safe. (“For seamen, it is every port, report; every place, replace”).</li> <li>• A few wives suggested regular medical check-up for males for early detection (“<i>pag mayroong naramdaman, magpa-check-up agad—when he feels something is not right, he should have a check-up right away</i>”).</li> </ul>	<p style="text-align: center;"><b>Practices and Experiences on STI/HIV Prevention and Treatment</b></p> <ul style="list-style-type: none"> <li>• <b>On Condom Use between Seafarer and Partner</b> <ul style="list-style-type: none"> <li>– While most of the seafarers’ wives were aware that using condoms can lower the risk of catching STIs, HIV, their actual use for this purpose was very low.</li> <li>– Condoms are used mainly for family planning. Although they are aware that condoms lower the risk of acquiring STIs and HIV, women correlate condom use to extramarital affairs (“I felt he was treating me like a prostitute”).</li> <li>– Condom use also brought the usual complaints of discomfort, decreased physical pleasure and condom defect. (“irritating during sexual intercourse”; “it is like wearing boxing gloves”; “it’s like being choked”)</li> </ul> </li> </ul>
<p style="text-align: center;"><b>Practices and Experiences on STI/HIV Prevention and Treatment</b></p> <ul style="list-style-type: none"> <li>• <b>On Seafarer’s Condom Use While Away</b> <ul style="list-style-type: none"> <li>– The wives were not always sure that their husbands use condoms with other women, but they held an implicit wish that if the men, in fact, have sex, they do this while wearing condoms.</li> <li>– While the older wives do not discuss this with their husbands, the younger wives seemed more open with their spouses about the possibilities of casual inter-crew relationships (“<i>nagpe-play sila</i>”) in passenger crew ships and casual paid sex in ports of call of tankers.</li> <li>– A young wife of a new seafarer shared that her husband had told her he had used condoms with other women. In fact, the medically-educated young wives of new seamen said that they had advised their husbands to use condoms “because it’s okay.”</li> </ul> </li> </ul>	<p style="text-align: center;"><b>Practices and Experiences on STI/HIV Prevention and Treatment</b></p> <ul style="list-style-type: none"> <li>• <b>On STI Experiences</b> <ul style="list-style-type: none"> <li>– In Davao, one spouse said she got sick (“makati masyado, much itching”) and saw a doctor who also advised her to get a regular checkup and pap smear. When she confronted her husband, he denied he had given her the infection and refused to see a doctor. She added that as a result of the incident, she favored the use of condoms.</li> <li>– In Cavite, three of the wives reported having been infected with STI, one involved a Ratings’ wife, who is already on steroids for kidney ailment from STI she got from her “playboy husband.” The other wife also got it from her spouse who was not aware he was infected until their visit to a doctor who prescribed antibiotics and condom use (which they followed).</li> <li>– The women are aware of the risks they face, and those who had not experienced having STI can only hope that their luck holds up (“so far, <i>wala pa</i>—it has not happened yet”).</li> </ul> </li> </ul>



<p style="text-align: center;"><b>Practices and Experiences on Prevention and Treatment</b></p> <ul style="list-style-type: none"> <li>• On HIV testing of their Partners             <ul style="list-style-type: none"> <li>– The wives were all aware of a policy for their spouses to be tested for HIV <i>before</i> they board their vessels, but this is not strictly followed for the rank-and-file seafarers. The test requirement for them depends upon the countries of destination or on the policies of the principals (e.g., Latin America is not strict).</li> <li>– The results of the pre- and post-trip tests are not made known (it was not clear at the FGDs if such results are requested by the men). Neither is there counseling for the men.</li> <li>– The partners do not get to know the test results, or their husbands give them very general information about the medical check-up (“Fit for work <i>ako</i>; <i>pasado ako</i>—I passed”). They are not sure either that their spouses receive any counseling (“<i>meron ata.</i>”).</li> </ul> </li> </ul>	<p style="text-align: center;"><b>Practices and Experiences on Prevention and Treatment</b></p> <ul style="list-style-type: none"> <li>• <b>On Attendance at Seminars on STI, HIV and AIDS</b> <ul style="list-style-type: none"> <li>– None of the wives had attended seminars or discussions on the prevention of STI, HIV within recent months, but they have brochures and leaflets from past seminars. The wives in Cavite had not attended seminars either except for the wives of officers where they were exposed to information on HIV from the company education with their spouses.</li> </ul> </li> </ul>
<p style="text-align: center;"><b>Attitudes and Practices towards Vulnerabilities and Exposure to Risky Behavior</b></p> <ul style="list-style-type: none"> <li>• The officers’ wives seemed to know that their own risk level is related to that of their husbands. They were not sure of their risk level because they were not sure of their husbands’ faithfulness (“no matter how beautiful a wife is, you can’t be sure about her husband”; “every wife should be prepared for possible infection from her husband”) also (“I’m high risk because he is high risk...he’s just human”; “I’m high risk because he told me he had other women”).</li> <li>• The younger wives however saw themselves at low risk (“I know myself well—there is no other man”) but with regards to their spouses, at higher risk than they, or really high. They only know too well their spouses’ vulnerability to sexual practices while at sea.</li> </ul>	<p style="text-align: center;"><b>Attitudes and Practices towards Vulnerabilities and Exposure to Risky Behavior</b></p> <ul style="list-style-type: none"> <li>• Some wives in the Ratings’ group and the young wives married 5 or less years were open in admitting that women may also have sexual activities with other partners while their spouses are away (“<i>matas ang tuleso sa mga asawa ng seamen</i>—seamen’s wives are subject to much temptation”) and there are men around who look at them as sex-starved women and, they are quick to note, also loaded with cash. In their earthy language, the young wives concluded “It is better to just scratch the itch.”</li> <li>• Some wives mentioned a hopeful kind of trust that their men remain faithful husbands (“He said that he does not need sex when he is away—<i>eh, di hindi</i>; he told me that he can put up quite well with loneliness; he said it depends on the man to yield or not to yield, and I feel that he really does not respond to other women”).</li> </ul>
<p style="text-align: center;"><b>Attitudes and Practices towards Vulnerabilities and Exposure to Risky Behavior</b></p> <ul style="list-style-type: none"> <li>• Although the wives were aware of the natural temptations for sex outside marriage in their husbands’ lives, including a few cases of homosexuality of crew and other male passengers, they did not approve of it (“it’s not really okay; <i>masakit siempre</i>—of course it pains me [to think of it]”).</li> <li>• They felt distressed about the alleged male inclination not to be faithful (“when a married man leaves home, <i>binata na yan</i>—he becomes single), and tried to explain this male predilection (“they cannot control their urges”). They expressed muted feelings of helplessness and anger when confronted with the husbands’ confessions.</li> </ul>	<p style="text-align: center;"><b>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</b></p> <ul style="list-style-type: none"> <li>• <b>Distance Communication</b> <ul style="list-style-type: none"> <li>– Modern technology—satellite calls, internet, cell phones—have enabled communication between seafarers and partners to become more frequent and regular.</li> <li>– The wives from both Davao and Cavite reported that their spouses feel less anxious about the families they leave behind because daily/regular communication is now possible, and the wives know more those details about their spouses’ jobs: (“He said his job as a welder is really risky”; “He said he spends his off-time at the ship’s karaoke room”).</li> </ul> </li> </ul>



<p style="text-align: center;"><i>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</i></p> <ul style="list-style-type: none"> <li>• <b>Difficulties of Separation</b> <ul style="list-style-type: none"> <li>– The wives said that they were separated from their husbands from 7 – 9 months. They experience role and emotional difficulties in their husbands' absence. Playing the dual role of father and mother, being responsible for all kinds of decision, balancing the budget, and child care and discipline are daunting. They have a support system of relatives, neighbors and friends which make the situation bearable.</li> <li>– Important decisions like how to deal with discipline, teen-age problems of delinquency and pre-marital pregnancy of their children weigh heavily on them because they cannot consult their husbands first. When their husbands blame them for what happened, it becomes a double burden. All these are emotionally draining, coupled with anger and hurt by doubts about their husbands' faithfulness.</li> </ul> </li> </ul>	<p style="text-align: center;"><i>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</i></p> <ul style="list-style-type: none"> <li>• For the younger wives, loneliness is a real problem. While they may have others around to help them, they feel a need to be with their spouses when they or their children are ill or have problems.</li> <li>• The same loneliness is a problem for their husbands, and the wives know that this leads to temptation. But while the wives implied that they can understand and forgive their husbands' casual liaisons, they consider a serious extra marital affair differently ("It was the most painful experience in my life when I found out that he had a woman in Malaysia"; "It would have been better if I didn't find out").</li> </ul>
<p style="text-align: center;"><i>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</i></p> <ul style="list-style-type: none"> <li>• <b>Home Leave</b> <ul style="list-style-type: none"> <li>– Home leave for the women meant juggling the demands of adjusting to having the spouses with them all the time. Compared to the older officers' wives who were not as expressive during the FGD, the younger wives unabashedly admitted their eager anticipation of their spouses' return. A number of them traveled to Manila to meet them. They claim shyness at first and the need to be comfortable with their husbands again ("I was shy at first, but it was different in the hotel").</li> <li>– They prepare for their spouses' return. If employed, they take a leave from work for the duration of their spouses' home leave (e.g., 1-3 months). They serve their men—cooking their favorite dishes, making the home attractive and comfortable for the relatives and friends who are sure to visit.</li> </ul> </li> </ul>	<p style="text-align: center;"><i>Other Factors Contributing or Mitigating Vulnerabilities and Risk Exposure</i></p> <ul style="list-style-type: none"> <li>• <b>Benefits of Seafaring Employment</b> <ul style="list-style-type: none"> <li>– the greatest benefit of having a seafarer partner is the economic benefits that the family receives. They cited a better future for the children, ownership of a house, a general improvement in life ("If we lived together all the time, we would have nothing to eat"), and savings in the bank.</li> <li>– but in the same breath, the wives emphasized the negative aspects of their lives: "<i>masarap na mahirap din</i>—it is good but it is also difficult," the emotional distresses and dilemmas being the price they pay. "<i>Sana hindi nalang seaman ang asawa ko kasi hindi kami magkasama, mahirap ang mag-isa</i>—I wish my husband were not a seaman because we cannot be together, it is difficult to be alone."</li> </ul> </li> </ul>
<p style="text-align: center;"><b>Conclusions</b></p> <p>This study has shown that women spouses of seafarers although economically secure are more vulnerable to the risk practices of their spouses leading to STI and HIV. The women in the study know and are aware of possible high risk-taking behavior and practices of their seafarer partners. There is an acceptance of this behavior but also at the same time a denial that it could not happen to them personally.</p> <p>Their vulnerabilities stem from their inability and disempowerment to negotiate for safer sex, their lack of knowledge on STI, HIV and AIDS, their multiple roles as a family decision-maker and their lack of social support in those times when their spouses are not around.</p>	<p style="text-align: center;"><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>• <b>On education and information</b> <ul style="list-style-type: none"> <li>– Older women need more information on HIV and STIs. Education and information strategies for older women need to be developed to address this need.</li> <li>– Among younger women, addressing some existing myths and misconceptions is also needed. Certain aspects of HIV (like HIV testing) need to be explained and shared among all of the women.</li> <li>– Seminars and workshops organized by employment agencies or companies can also be extended to wives and partners of seafarers.</li> <li>– Provide gender awareness training and practical applications on negotiations and communications. Provide opportunities for women and men to recognize their vulnerabilities in terms of gender-based relationships and look for methods on how best to address these vulnerabilities.</li> </ul> </li> </ul>



<p style="text-align: center;"><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>• <u>On Approaches to Interventions</u> <ul style="list-style-type: none"> <li>– Provision of health and other services need to take into consideration the social structures existing within the women partners of seafarers. Wives of the ratings seafarers are distinctly identified separate from the Officer's wives. Interventions therefore should include either a way of overcoming these social barriers and incorporate the leadership and mentoring roles that Officer's wives have over the rank and file women.</li> <li>– Address the need to de-stigmatize and have non-discriminatory practices for those diagnosed with HIV. Support groups and referral systems among the women can be formed for specifically this purpose.</li> </ul> </li> </ul>	<p style="text-align: center;"><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>• <u>On Services and Programs</u> <ul style="list-style-type: none"> <li>– Implement measures to improve husband-wife communications on safer sex, sexual behaviors and practices, etc.</li> <li>– Conduct education activities about condoms and safer sex; also market condoms in such a way as to lessen the stigma associated with prostitution rather market condoms as a way of 'protecting the one you love'.</li> <li>– Provide quality reproductive health services that are gender-sensitive and responsive to the specific needs of the partners of seafarers. Reproductive health services should include the whole constellation of services that addresses the health needs of women partners, i.e. family planning, maternal and child care, STI and HIV, cancer screening, violence against women, and male involvement.</li> </ul> </li> </ul>
<p style="text-align: center;"><b>Research Team</b></p> <ul style="list-style-type: none"> <li>• Gladys R. Malayang, Researcher/Writer</li> <li>• Lorna Makil, Writer</li> <li>• Beth Malonzo, Coordinator, Davao</li> <li>• Cyril Dalusong, Coordinator, Cavite</li> </ul>	



**A MODEL FOR SRH REFERRAL NETWORK**

Facility Level	Location	Services Provided	Referral Process
<b>Level 1 - BHS</b>			
<b>Level 2 - RHU</b>	RHU 1 and 2 - Poblacion Zone 2 - Santa Cruz, Bagong Bayan, (DBB)	<ul style="list-style-type: none"> <li>• Maternal and Child health services</li> <li>• Prenatal and Postpartum checkup</li> <li>• Family planning</li> <li>• Social Hygiene Clinic</li> <li>• Pap Smear</li> <li>• Cervical Cancer Screening</li> <li>• Education activities</li> </ul>	Referral system through the Barangay Health Station of Sampaloc 3
<b>Level 3 – Provincial, District</b>	General Emilio Aguinaldo Hospital - Family Planning Unit		One-stop Shop for STI and HIV – Family Planning Unit
<b>Level 4 – Tertiary Care</b>	La Salle Hospital – HIV testing; HACT Team		
<b>Private Clinics</b>			
<b>Private Hospitals</b>	Asia Medic Hospital – doctors practicing in Cavite	Outpatient, general medical services (45-beds)	

Referral Process:

1. Establish contact/meeting or agreement with the health facilities where you will be sending clients
2. Accomplish the Referral Slip completely
3. Provide directions, addresses, and names of contacts in the referral units
4. Follow up the actions taken by the referral units (adapted from DOH 1997 Clinical Standards Manual)

**Appendix 7:**  
**SEXUAL AND REPRODUCTIVE HEALTH (SRH)**  
**DIRECTORY**

## SEXUAL AND REPRODUCTIVE HEALTH (SRH) DIRECTORY

## A. Cavite

## 1. Government Offices

ORGANIZATION		CONTACT PERSON (Full Name)	POSITION/ TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
	Cavite Local Aids Task Force	Dr. Gerardo Alcantara	Provincial Coordinator	Trece Martires Hospital	Mobile No:09189009577 Fax No.. (046) 4190123
MHO	Municipal Health Office	Dr. Cynthia Cristobal	Municipal Health Officer	Rural Health Unit 1, Dasmariñas, Cavite	Telefax No.: (046) 416 0279
DBBCMh	Dasmariñas Bagong Bayan (DBB) Community Medicare Hospital (formerly DBB Municipal Hospital)	Dra. Jocelyn Caballes	Chief of Hospital		Telephone: 8532076 Fax No. 8531639
RHU 2	Rural Health Unit 2	Dr. Minerva Caseñas	MHO	Rural Health Unit 2 DBB Dasmariñas, Cavite	Telefax No. 046 416 5638
	Silang Main Health Center	Dra. Luz Aurique-Pang	MHO	Silang, Cavite	Telephone: 4142925 Fax No. 5110203
	Tanza Health Center	Dra. Ruth Punzalan	MHO	Tanza, Cavite	Telephone: 4376939
	Bacoor Health Center	Dra. Encarnita Camama	MHO	Bacoor, Cavite	Telephone: 4347866 4172253
	General Trias Rural Health Unit	Dr. Abe Escario	Municipal Health Officer	General Trias, Cavite	Telephone - 5091250

## 2. Non-Government Offices

ORGANIZATION		CONTACT PERSON (Full Name)	POSITION/ TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
Amosup	AMOSUP Seaman's Hospital			Cabildo corner San Jose St. Intramuros, Manila	Tel No : (02) 527-8116 to 20 loc 109 Email Address : shosp_mnl@amosup.org, admin_shm@amosup.org
AHMC	Asian Hospital & Medical Center	Dr. Socorro Caedo- Lim	Coordinator	Filinvest Corporate City, Alabang. Muntinlupa	Telephone: 771 9000
DLSUMC	De La Salle University Medical Center	Sr. Francesca San Diego	Vice Chancellor, Hospital Operations	Congressional Ave., Pasong Lawin, Dasmariñas, Cavite 4114	Trunkline +63(046) 416- 0226 /416- 1234 loc 105 Fax - 046 416 0310
	DLSU-Dr. Rodolfo Poblete Memorial Hospital	Dra. Cristina Hernandez	Medical Director	Alfonso, Cavite	Telephone: 046 415 0190 Fax No. 046 415 1286
SPH	St. Paul Hospital (formerly Dr. Jose P. Rizal National Memorial Hospital and Research Center)	Sr. Arcelita Sarnillo	SPC Hospital Administrator	DBB Dasmariñas	Telephone: 046 416 0328 Fax No. 046 416 3872



ORGANIZATION		CONTACT PERSON (Full Name)	POSITION/ TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
KFPFCC	Korean-Philippines Friendship Project Care Center	Dr. Cecille Francisco	Chief of Hospital	General Emilio Aguinaldo Memorial Hospital Compound Trece Martires, Cavite	Telephone: 046 4191713 to16
BH	Bautista Hospital	Dr. Edwin Poblete	Medical Director	375 P. Burgos Ave. Caridad, Cavite City	Telefax: 046 431 0330
CMC	Cavite Medical Center	Dr. Dante Mark Udasco	Medical Director	Dalahican, Cavite City	Telephone; 046 431 1611 046 431 1711 Fax No. 046 504 4496
MDH	Molino Doctors Hospital	Dra. Alma Talavera	Medical Director	Nat'l. Rd, Molino 2 Bacoor, Cavite	Telephone: 046 477 0830 Fax No. 046 4771661
SDMC	St. Dominic Medical Center	Dra. Myrna Estrada	Medical Director	Aguinaldo Hi-way Talaba, Bacoor, Cavite	Telephone: 046 417 2525, 046 4172539, 046 4172520 Fax No. (046) 417 6454
SMMC	St. Michael Medical Hospital	Dr. Virgil Rodil	President	220 Molino 2 Bacoor, Cavite	Telephone: 4771707 8500330 Fax No. (02)5298872 Mobile: 09179965642
AM	Asia Medic	Dr. Sharon Lacson	President	Anabu 2 Imus, Cavite	Telephone: 046 5156523 asia_medic@yahoo.com
IFH	Imus Family Hospital	Dr. Leopoldo Orantia	Medical Director	Justinville 2, Palico Imus, Cavite	Telephone: 046 970 6768 Fax No. 046 4716403
	Medical Center	Dra. Macrina Isabel Hayag	Medical Director	Imus Diversion Rd., Palico 4, Imus, Cavite	Telephone: 8091646 4722220 Fax: 4723982 mike_de_vera19@yahoo.com
OLPMC	Our Lady of the Pillar Medical Center	Dr. Ramoncito Livelo	Medical Director	Tansui Avenue Bayan Luma Imus, Cavite	Telephone: 4723773 oldmcenter@yahoo.com
OSH	Our Saviour Hospital	Dr. Alfredo Trias	Medical Director	Rosario, Cavite	Telephone: 4383688 Fax: 4381802 - Fax
	Contreras Medical Clinic	Dra. Editha Contreras	Medical Director	General Trias Drive Rosario, Cavite	Telephone: 4381958 Fax: 4387302
	South Superhi-way Medical Center Satellite Hospital	Dra. Socorro Hidalgo	Medical Director	General Trias, Cavite	Telefax: 4330210
GTMH	General Trias Medicare Hospital	Dr. Sesinand Talosig	Medical Director	General Trias, Cavite	Telephone: 8871044
WCLI	Wellcare Clinics and Lab., Inc.	Dr. Allan Hernandez	Area Representative	Main St. Plaza Gov. Drive General Trias, Cavite	Telephone: 5090944 Fax: 4166530
				Groundfloor Waltermart Aguinaldo Hi-way Dasmariñas, Cavite	Telephone: 4165202 Fax: 4166530
GTMPH	General Trias Maternity and Pediatric Hospital	Dr. Rico Torres	Medical Director	Tejero, General Trias, Cavite	Telefax 4378111 Telephone: 5091325





ORGANIZATION		CONTACT PERSON (Full Name)	POSITION/ TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
JMLIC	Jahna Maternity and Lying-In Clinic	Mr. Jacinto Dominguez	Clinic Administrator	52 San Agustin, Dasmariñas, Cavite	Telephone: 4160531/4165380 Fax No. 4165308
	Theramedica	Dr. Roald Galope	Medical Director	Bulihan, Silang, Cavite	Telephone: (02) 5208752 (046) 8901626
DGMC	Divine Grace Medical Center	Dr. Ismael Mercado		Bypass Rd.Brgy Tejero General Trias,Cavite	Telephone: 4372227-8



## B. Davao

## GOVERNMENT OFFICES

ORGANIZATION		CONTACT PERSON (Full Name)	POSITION TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
DMC-WCPU	Davao Medical Center-Welcome Center Protection Unit <b>Medical, surgical, psychological and HIV &amp; AIDS counseling, education</b>	Regina Ingente, MD	Executive Director	Davao Medical Center Bajada, Davao City	Landline: (082) 227-2731 Fax No.: E-mail :
IGDD	Integrated Gender and Development Division <b>Gender, RH &amp; LGBT Monitoring, education campaign, trainings</b>	Lorna Mandin	Officer-in-Charge	Mezzanine Flr., City Hall Bldg., City Hall Drive, San Pedro St., Davao City	Landline: (082) 226-8011 Fax No.: Email : elaybee@yahoo.com
CHO	City Health Office <b>Medical, HIV &amp; AIDS counseling, family planning services, trainings, Health monitoring</b>	Jeff Y. Fuentes	Population Program Officer II	3/F Makati Bldg. Magallanes St., Davao City	Landline: (082) 225-3859 Mobile : 0906-4204122 Email : <a href="mailto:the_styx007@yahoo.com">the_styx007@yahoo.com</a>
PopCom-XI	Population Commission-XI <b>Trainings and Education campaign, family counseling</b>	Maduh A. Damsani	Regional Director	DMC Compound, Davao City	Landline: (082) 305-5611 to 12 Fax No. (082) 227-1027 Email : popcom11@yahoo.com
RHWC	Reproductive Health and Wellness Center /City Hygiene Clinic <b>Counseling, Medical consultation/Smear, Referral and Laboratory Examination</b>	Jordan p. Ramiterre,MD.	Chief Physician	Jacinto St., Davao City	Landline: (082) 222-4187 Fax No.: (082) 225-3460 Email : <a href="mailto:ipram07@yahoo.com">ipram07@yahoo.com</a>
SP-CWCFR	SP- Committee on Women, Children and Family Relations <b>Policy advocacy and implementation</b>	Atty. Angela Librado	Chairperson	Door 5, 2 <sup>nd</sup> Floor, SP Building, San Pedro St., D.C.	Landline: (082) 222-0855 Loc. 403 Fax No.: (082) 222-0855 Loc. 403 E-mail : <a href="mailto:aalibrado@justice.com">aalibrado@justice.com</a>

## NON-GOVERNMENT OFFICES

ORGANIZATION		CONTACT PERSON (Full Name)	POSITION TITLE	COMMUNICATION LINE	
ACRONYM	FULL NAME/SERVICES			FULL MAILING ADDRESS	OTHER MODES
FPOP	Family Planning Organization of the Philippines <b>Family planning services</b>	Christopher M. Peñales	Chapter Program Manager	#301 Lions Club Bldg., Candelaria St., Ecoland, Davao City	Landline: (082) 300-7970 Fax No.: (082) 300-7970 E-mail : <a href="mailto:fpop_davao@yahoo.com">fpop_davao@yahoo.com</a>
IWAG DABAW INCORPORATED	IWAG Dabaw Incorporated <b>STI, HIV &amp; AIDS education, Training, gay organizing.</b>	Eddie Batoon	Advocacy & Networking Coordinator	Door # 2 De Campo Bldg. Suazo Extension, Davao City	Landline: (082) 300-9048 Fax No.: (082) 300-9048 E-mail : eddie_batoon@yahoo.com
IPHC-DMSF	Davao Medical School Foundation-Institute of Primary Health Care <b>Training, Medical consultation, Referral</b>	Mariper M. Mercader	Executive Director	MTRC Bldg., DMSF Compound, Circumferential Road, Bajada, Davao City	Landline: (082) 226-2344 Fax No.: (082) 221-3527 E-mail : iphc.dmsf@yahoo.com
POGS	Philippine Obstetrical and Gynecological Society, Inc. <b>Medical consultation, referral and Lab Exam</b>	Dr. Darleen S. Estuart	President-POGS Southern Mindanao Chapter	14 Sampaguita St., San Nicolas, Dalião, Toril Davao City	Landline: 0917-7017798 Fax No.: E-mail :
DPF	Development of People's Foundation Organizing, <b>ASRH/RH, VAWC and Gender Training, Policy Advocacy, and Campaign</b>	Ms. Rosena Sanchez	President	DPF-Development of People's Foundation Km. 5, Rivera Village, Bajada	Landline: (082) 227-7714 Fax No.: (082) 227-7714 E-mail : <a href="mailto:dpf@skynet.net">dpf@skynet.net</a>
COW	Center for Overseas Workers <b>Counseling &amp; referral</b>	Sr. Diana Cabasagan, RGS	Executive Director	Door 7 Santos Apt., Gov. Duterte St., Davao City	Landline: (082) 227-8065 Fax No.: (082) 227-8065
	Davao Teen Center-FPOP <b>ASRH counseling, education, campaign and training</b>	Jamail Lunar, Macla	Youth Coordinator	G/F Lions Bldg., Candelaria St., Ecoland, Davao City	Landline: (082) 300-7970 Fax No.: (082) 300-7970 Email : <a href="mailto:davaoteencenter@gmail.com">davaoteencenter@gmail.com</a>
TALIKALA	TALIKALA, Inc. <b>Prostituted women organizing, training, education and campaign including counseling</b>	Jeanette Ampong	Executive Director	# 2 Sputnik St. Dona Vicenta Village, Davao City	Landline: (082) 300-0048 Fax No.: (082) 300-0048 Email : talikaladavao@gmail.com
ALAGAD	Alliance Against AIDS in Mindanao <b>Care &amp; support for persons with HIV &amp; AIDS, Counseling, Capability building program, organizing and policy advocacy and campaign</b>	Alma L. Mondragon, RN	Executive Director	557 Kamuning St. Juan Luna Subd., Davao City	Landline: (082) 297-3394 Mobile: (082) 297-3394 Email: alu_mon@yahoo.com
MWG	Mindanao Working Group on Gender Sexuality & Reproductive Health <b>GAD Research, Training and policy advocacy</b>	Atty. Romeo Cabarde	Training Officer, Mindanao Youth Task	Social Research Office, Ateneo de Davao University, Jacinto St., Davao City	Landline: (082) 224-2955 Fax No. (082) 224-2955 Email : meong_rtcj@yahoo.com



ORGANIZATION		CONTACT PERSON (Full Name)	POSITION TITLE	COMMUNICATION LINE		
ACRONYM	FULL NAMESERVICES			FULL MAILING ADDRESS	OTHER MODES	
BWC	Brokenshire Women Center Counseling, Maternal <b>Package for pregnant women, medical consultation</b>	Belinda Nadela	Physician Coordinator	Brokenshire Hospital, Davao City	Landline: (082) 305-3525 Fax No.: (082) Email :	
DMSFI	Davao Medical School Foundation Inc. <b>Education, counseling and training and medical consultation</b>	Fides Ababon	Physician Course Coordinator	Rm 411, 4/F Davao Doctors Hospital Medical Tower, E. Quirino Ave., Davao City	Landline: (082) 225-1459 Fax No.: (082) 222-8587 Email : drafaith@gmail.com	
UCCP-PKFI	United Church of Christ in the Phil-Pag-ugmad sa Kabataan Foundation <b>Children education Development</b>	Leah Genson	Executive Director	UCCP-Pag-ugmad Foundation, Bonifacio St., Davao City	Landline: (082) 227-4656 Mobile : Email : leahgenson@yahoo.com	
TCCR	Tambayan Center for Abuse Children <b>Counseling for Street Children, Training, organizing, advocacy and campaign</b>	Joy Antflor Jaime	Street-based Therapist	# 63 Artiaga St., Davao City	Landline: (082) 222-1025 Fax No.: (082) 222-1025 Email : antflor@yahoo.com	
MaSSSFA	Mary Star of the Sea Seafarers Family Association <b>Education, Advocacy and networking, counseling and referral</b>	Elizabeth M. Malonzo	President	Brokenshire College, Davao City	Landline: (082) 222-4085 Fax No.: (082) 222-4085 Email : nendotie@yahoo.com	



**Appendix 8:**

**A QUALITATIVE STUDY OF THE PERSONAL  
AND STRUCTURAL DETERMINANTS OF THE  
RISKS AND VULNERABILITIES OF FEMALE  
FILIPINO SEAFARERS TO HIV INFECTION AND  
OTHER REPRODUCTIVE HEALTH PROBLEMS**

## A QUALITATIVE STUDY OF THE PERSONAL AND STRUCTURAL DETERMINANTS OF THE RISKS AND VULNERABILITIES OF FEMALE FILIPINO SEAFARERS TO HIV INFECTION AND OTHER REPRODUCTIVE HEALTH PROBLEMS<sup>1</sup>

### I. INTRODUCTION

1. Although data from the Philippine Overseas Employment Agency (POEA) indicate that only 3% of the 230,022 seafarers deployed in 2006 were females, this number represented 15.5% of all those employed in passenger and cruise vessels.<sup>2</sup> Within the seafaring industry, therefore, are jobs that are now being increasingly occupied by women. In fact, global and national trends over the past decades have shown the gradual but continuous rise in number of females in what were originally male-dominated occupations, including the seafaring industry. This development is mainly due to the relentless efforts of women's groups all over the world, in collaboration with some State parties and partners from donor agencies, to eliminate all forms of gender-based discrimination.<sup>3</sup> These efforts have expanded the opportunities for poor women to have better access to income and other economic opportunities. The generally favorable performance assessment of female workers across the industry groups in the Philippines, especially their dedication to work despite having multiple roles and responsibilities, has, in fact, given them a competitive edge over males especially in the services (e.g., food, health, social work), transport (e.g., passenger cruise), and communication sectors.<sup>4</sup>

2. Of the 6,436 females in the seafaring industry in 2006, 5% were non-officers, while less than 1% (25) were officers mainly in cargo vessels. The majority (93%) were deployed in passenger or cruise vessels, mainly as bar and restaurant waitresses, crew stewards, casino dealers, and massage attendants. Flags of ships with substantial Filipino female crew in 2006 include the Bahamas (with 8.7% out of the total 29,355 personnel), Bermuda (6.5% out of a total of 4,135 personnel), and Panama (2.5% out of a total of 54,749 personnel).<sup>5</sup>

3. However, the entry of women into male-dominated fields of work has had negative impacts as well. Their presence is rejected by some male peers, and the work environment is generally insensitive to their specific needs as females. They are also most likely to suffer from discrimination and various forms of abuse. The most recently concluded study of ACHIEVE, with funding support from Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), showed that being sexually abused is a major concern of female seafarers.<sup>6</sup> As such, some have coped by dressing up "like males" by not using cosmetics or fragrant shampoos to wash their hair so as not to unduly get the attention of male workers. Others lock and set an alarm in their cabins at night as well as carry a teargas to prevent unwanted sexual advances. The possibility of rape, sexual molestation, and other sexist practices on board makes women seafarers extremely vulnerable to HIV infection and other health problems.

4. From January 1984 to December 2008, the Department of Health - National Epidemiology Center (DOH-NEC) reported 3,589 HIV Ab seropositive cases, of whom 1,089 (30%) were women. The leading mode of transmission was through unprotected sexual intercourse (89%).<sup>7</sup>

<sup>1</sup> This Study was conducted by Dr. Carolyn I. Sobritchea, Principal Investigator, and Ms. Raquel T. Ignacio, Research Assistant.  
<sup>2</sup> POEA. 2006. *OFW Global Presence: A Compendium of Overseas Employment Statistics, 2006*. <http://poea.gov.ph/2006Stats>. Accessed on 8 June 2008

<sup>3</sup> UNDP. 2003. *Human Development Report, 2003: Millennium Development Goals: A Compact Among Nations to End Human Poverty*. New York: Oxford University Press, page 203.

<sup>4</sup> TESDA Women's Center and Japan International Cooperation Agency, 2005. *A Study of Employment Opportunities for Women in TWC's 12 Trade Areas*. Manila.

<sup>5</sup> POEA. 2006. *ibid*.

<sup>6</sup> Sobritchea, Carolyn I., Ma. Theresa U Batangan, and Rolando G. Talampas. 2008. *A Qualitative Study of the Risks and Vulnerabilities of Filipino Seafarers to HIV and an Assessment of Current Intervention Policies and Programs*. Draft Report. ACHIEVE, Inc. and GFATM.

<sup>7</sup> DOH-NEC. May 2008. *Philippine HIV and AIDS Registry*. [http://www.doh.gov.ph/files/NEC\\_HIV\\_May-AIDSreg2008.pdf](http://www.doh.gov.ph/files/NEC_HIV_May-AIDSreg2008.pdf).



5. Women are at greater risk than men of being infected with HIV, and they suffer more from its effects due to physical, cultural, and economic reasons. Inequality in decision making at home and in the public domain prevents them from having equal access to knowledge and skills that can enable them to negotiate for safer sexual relations and confront the many sources of stigma and discrimination.

6. Gender inequality is among the primary determinants of physical and sexual violence, economic dependence, inadequate education, and lack of access to empowering skills and knowledge.<sup>8</sup> The epidemiological and biological predisposition, especially of younger females, to HIV infection and the likelihood that they may transmit it to their sexual partners because the symptoms are often less noticeable and may go untreated for long periods of time, justify the need to do an immediate study of their risks and vulnerabilities in the context of seafaring work. It is important to set in place protective measures before reproductive health problems mount and the number of infected individuals increase.

### A. Study Objectives

7. This study was carried out as part of the project, **Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines**, financed by the Asian Development Bank (ADB) through its **Gender and Development Cooperation Fund (GDCF) established under Regional Technical Assistance (RETA) 6143**, which supports initiatives to promote gender mainstreaming in ADB operations, gender capacity development, and strategic partnerships.

8. It is a pioneering effort to describe and analyze, in a more comprehensive manner, the gender dimensions of the risks and vulnerabilities, especially to HIV infection, of female seafarers. It was carried out mainly for the purpose of identifying appropriate actions that will help prevent the spread of HIV among them, to their sexual partners and children, within their occupational group, and in the larger society. **Its specific objectives were:** (i) to identify the risks and vulnerabilities of female seafarers to reproductive health (RH) problems, especially to HIV infection, according to work designation, education, family background, and knowledge, attitude, behavior, and practices (KABP) about RH and HIV and AIDS; (ii) to determine the extent of their access to sexual and reproductive health (SRH) services and information; (iii) to identify the gender-related barriers as well as opportunities to promote RH and safer sex practices among the females in the seafaring industry; and (iv) to recommend measures to enhance the gender-responsiveness of current policies, education and advocacy programs, and services for seafarers and other migrant workers of the government, the private sector, the association of seafarers, and non-government organizations (NGOs).

### B. Research Design and Methodology

9. Data collection and analysis was undertaken for five months, from June to October 2008, and involved the following processes: (i) review of related literature; (ii) development and pre-testing of research instruments; and (iii) fieldwork. The collation and analysis of interview data were subsequently carried out during the whole month of November 2008, followed by the writing of the first draft of the research report. The initial research findings were presented to selected stakeholders, and the comments provided have enriched this report.

10. To enable the research team to compare the research findings with the most recently completed studies on this topic, the study adopted the analytical framework shown in Figure A8.1. This framework also guided the recently completed qualitative study of ACHIEVE on the risks and vulnerabilities of both male and female seafarers to HIV infection.<sup>9</sup> In this framework, the conceptual domains and analytical

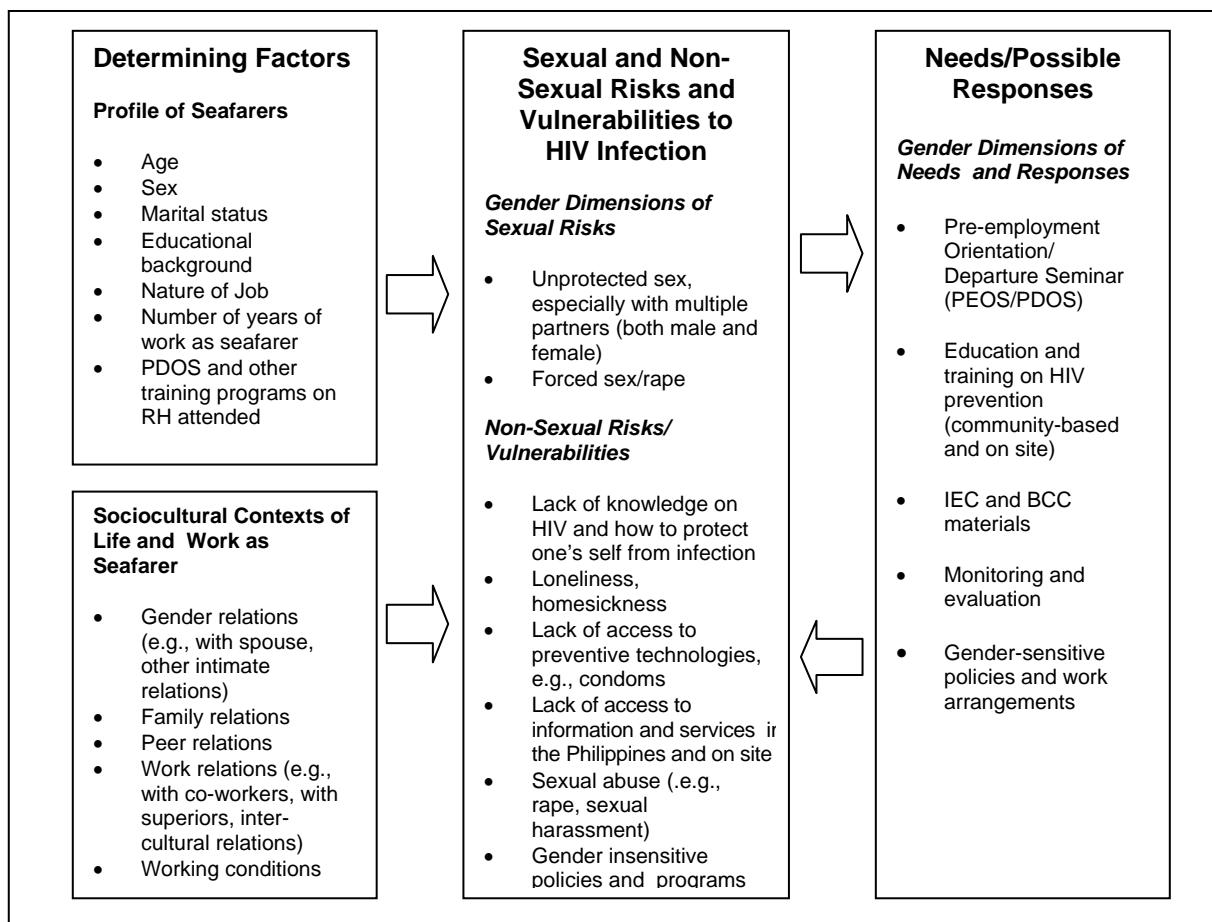
<sup>8</sup> Sobritchea, Carolyn. 2006. *Feminist Interrogations of the HIV and AIDS Phenomena in Asia*. Tokyo: Institute of Gender Studies, Ochanomizu University.

<sup>9</sup> Sobritchea *et al.*, 2008. *ibid.*



variables that were used to collect and analyze the data include the personal history or background of the study participants, the conditions of their work at sea, as well as their knowledge and attitudes about gender relations and sexual practices as these relate to risky and non-risky work and sexual behaviors.

**Figure A8.1: Analytical Framework – Determinants of Risks and Vulnerabilities Vulnerabilities to HIV Infection and Appropriate Responses**



11. The analytical framework takes into account the interplay of various socioeconomic factors, primarily the personal characteristics and sociocultural background of the female seafarers, which influence their capacity to deal with sexual and non-sexual risk conditions and vulnerability to HIV infection. Existing literature shows that many forms of gender biases and the persistence of inequality in the workplace, as well as the domestic sphere, are brought about by traditional constructions of femininity and masculinity. Very often, females and males are consigned or typecast into stereotype roles that subsequently undermine their personal interests and capacity for development. Gender issues, like the vulnerability of women to physical and sexual abuse and their lack of control over their sexuality, are factors that increase their predisposition to HIV infection.

12. Gender is an equally important variable in examining the safety and security policies of the maritime industry, the subcultural elements of life at sea, the lifestyle of seafarers, and their relationships with peers and intimate partners. This research examines, in particular, the extent to which the physical and social configurations of maritime work lessens or intensifies the risks and vulnerabilities of female seafarers to RH issues, especially HIV infection.

13. Risks, whether sexual or non-sexual in nature, generally refer to those ideas, attitudes, and behaviors of seafarers that predispose them to HIV infection and other RH problems. For example, rape, having unprotected sex, or having multiple sexual partners are among the common types of sexual risks, while injecting drug use and heavy alcohol consumption are non-sexual forms of risk to HIV infection.

14. Vulnerability, on the other hand, refers to the social, cultural, and economic contexts that expose or shield individuals from sexual and non-sexual risks. For female seafarers, this includes such factors as presence/absence of gender-responsive or gender-sensitive support mechanisms, RH and medical information and services, as well as measures to promote safety and security from accidents and other work-related problems.

### C. Study Design

15. **Review of Literature.** This entailed the collection and analysis of all available local and foreign, published and unpublished literature on the following topics: (i) number and nature of work of female seafarers over the years and across various types of vessels; (ii) their risks and vulnerabilities to HIV infection; (iii) assessments of the extent of gender responsiveness of current policies, programs, and services; (iv) gender issues (i.e., personal and structural) that affect the work and health of female seafarers; and (v) good practices (e.g., local and foreign) that make seafaring safer and more empowering for females. The review of literature guided the development and refinement of the study design, research instruments, and analysis of field data.

16. **Focus Group Discussions (FGDs).** Four FGDs were conducted mainly with female seafarers who had the following demographic and employment profile:

- FGD 1: Male and female officers with varying civil status, work designation, and age;
- FGD 2: Female ratings and officers in passenger vessels, with representation from those married and single, younger and older, and with different work designations; and
- FGDs 3 and 4: Female ratings from passenger vessels with varying civil status, employment status/designation, and age.<sup>10</sup>

17. The FGDs focused on the participants' experiences with respect to RH and gender issues in the maritime industry. The discussions also touched on the barriers and opportunities (e.g., policies and practices of the different principals, the organizations of seafarers) to prevent and control HIV infection.<sup>11</sup>

18. **In-depth (Case Study) Interviews.** To better understand the interplay of gender and non-gender related factors that put women at greater risk of HIV infection, the Study Team conducted in-depth interviews (IDIs) with nine female seafarers who had personal experiences of, or are knowledgeable about, SRH problems (see Annex B for interview schedule). The interviews focused on their own analyses, reflections, and perspectives on the causes of these problems and how they could be prevented in the future.

19. **Key Informant Interviews (KIIs).** In addition to IDIs, KIIs were conducted with key stakeholders — policymakers and program managers — to assess the extent to which existing policies, programs, and services (e.g., education, training, advocacy, and health and medical facilities) are sensitive to the situation and special needs of female seafarers (see Annex C for KII guide). Included among the

<sup>10</sup> Almost all of the FGD participants came from passenger ships because of the small number of female seafarers working in non-passenger ships.

<sup>11</sup> The discussion guides are in Annexes A-1 and A-2.





respondents were the most knowledgeable persons from the following organizations/institutions: (i) organizations with regulatory functions over the maritime industry, including training of crew members; (ii) manning agencies with relatively large numbers of female clients both in the cargo and passenger vessels; and the (iii) association of women in the maritime industry. List of Persons Interviewed and their designations is in Annex D.

20. **Validation Workshop.** The findings of the FGDs, KIs, and IDIs were collated and analyzed based on the analytical framework shown in Figure A8.1. The key findings of the study and proposed recommendations were presented to stakeholders at a validation workshop,<sup>12</sup> and the comments incorporated in this report.

#### D. Research Ethics

21. The Study Team adhered to the ethical principles that usually govern the collection, analyses, and writing of qualitative data. Informed consent was secured from all the research participants before the interviews and FGDs. They were informed of their rights as research participants, especially the option not to disclose any information which they felt uncomfortable discussing or which could threaten their security or safety. They were also told about their right to withdraw at any point of the research process.

22. In particular, the ethics of confidentiality and respect for privacy were observed during the research. No personal information which could lead to the identification of the research participants (except for those who agreed to be identified in the report) was mentioned in the report. The interview and FGD guides were developed such that the research processes were respectful of the private thoughts, experiences, and personal space of the research participants. Each interview was guided by the following processes: (i) self-introduction by the interviewer/researcher; (ii) briefing about the objectives of the study and ethical requirements; (iii) interview; and (iv) debriefing.

23. On the other hand, rigor in the research process was observed through various ways. The preparation of the research design and data collection tools was guided by the analytical framework and the review of related literature. Established methods of data generation, consultation, and pre-testing of instruments helped ensure the reliability and validity of the research findings.

## II. REVIEW OF RELATED LITERATURE

### A. Women and HIV and AIDS

#### 1. The Global Situation of HIV and AIDS and Women

24. After 20 years of international responses to the HIV and AIDS epidemic, why are HIV infection rates still on the rise? Why are the numbers of women living with HIV increasing faster than the number of men? What can be done to address the problem entrenched in inequality, denial, and stigma? These are but a few of the many questions raised by women's organizations around the world when global data in the late 1990s started to show the continuous rise in reported cases of infection, particularly in Asia and among women. Indeed, the magnitude of the problem is vast. Some 3 million infections were recorded in 2001.<sup>13</sup> This figure slightly declined, however, to 2.7 million in 2007 due to the concerted efforts of various stakeholders to decisively prevent and deal with the problem, as well as improve estimation processes. Current data show that overall, 2 million people died of AIDS in 2007, compared

<sup>12</sup> The findings of this study were presented at the Final Dissemination Workshop of RETA 6321, Subproject 5: Strengthening Country Response to HIV/AIDS among High-risk Groups in the Philippines, 15 January 2009, Astoria Plaza Hotel, Pasig City, Philippines.

<sup>13</sup> UNAIDS. 2008. 2008 Report on the Global AIDS Epidemic. [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008\\_Global\\_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp). Accessed January 23, 2009.



with an estimated 1.7 million in 2001. Women now account for half of all people living with HIV worldwide, with nearly 60% of them in sub-Saharan Africa. UNAIDS also reports that young people aged 15-24 account for nearly 45% of new infections worldwide.<sup>14</sup>

25. It was only on 27 June 2001, during the 8th plenary meeting of the UN General Assembly, that a resolution was passed declaring HIV and AIDS a “global crisis” requiring a “global action.” The resolution recognized that “*women and girls are disproportionately affected by HIV/AIDS*” and called on international organizations and State Parties to “*develop and accelerate the implementation of national strategies that promote the advancement of women and women’s full enjoyment of human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.*”<sup>15</sup>

26. Putting these statements into this UN resolution and other policy commitments of international organizations was a long and difficult journey for many human rights activists. It took many years of research, organizing, and advocacy work for them to make government and international organizations recognize that “*HIV/AIDS is not only driven by gender inequality — it entrenches gender inequality, putting women, men, and children further at risk.*”<sup>16</sup>

27. When HIV infection first became public knowledge in the early 1980s, the reported cases mainly involved men from industrialized countries. The common perception then was that the infection was contained in certain sectors or social enclaves like urban-based male homosexuals and women in prostitution. By 2007, however, there was a completely different demographic profile of people infected with HIV. The infection has spread to the entire population, affecting both the young and old, female and male, regardless of sexual orientation and civil status. It had spread fast in regions that used to have low prevalence rates, like Southeast Asia. Increase in population mobility and the high incidence of poverty in the region has negatively influenced the educational status of populations and caused the strong resurgence of cultural taboos about sexuality and reproductive health.

28. Of the 33.2 million cases of HIV infections worldwide in 2007, Asia accounted for around 5 million (estimate of between 4.1 to 6.2 million), including the 380,000 [200,000 - 650,000] people who were newly infected that year. Approximately 380,000 (270,000 - 490,000) died from AIDS-related illnesses.

29. The countries that have experienced a decline in prevalence rates in recent years include Thailand, Cambodia, and Myanmar, mainly due to their relatively successful prevention and control programs. On the other hand, countries like Indonesia (especially Papua province), Pakistan, and Vietnam are experiencing an increase in reported incidence of infection. The same is true for Bangladesh and China, except on a much slower rate.

## 2. The National Context of HIV and AIDS and Women

30. The Philippines had its first reported case of AIDS in 1984. Since then, the increase in number of infected individuals and the spread of the virus in the Philippines has been described from “low and slow” to “hidden and growing.” The early response to the problem by the Philippine government and civil society groups may account for the success in keeping the figures low and preventing the spread of the virus to the general population. The other contributory factors are (i) the large number of circumcised males, (ii) the low prevalence of injecting drug users (IDUs), (iii) the division of the country into an

<sup>14</sup> *Ibid.*

<sup>15</sup> United Nations General Assembly. “S-26/2. Declaration of Commitment on HIV/AIDS,” Twenty-sixth Special Session, Agenda item 8. 2 August 2001.

<sup>16</sup> Bridge, Emma. 2002. “Gender and HIV/AIDS: Spotlighting Inequality.” In: Brief, Issue 11, September 2002.



archipelago that limits the mobility of populations, (iv) the low prevalence of ulcerative sexually transmitted diseases (STDs), and (v) the strong cultural and religious norms on marital monogamy.<sup>17</sup>

31. Nonetheless, there is evidence to show that the incidence will increase in the coming years unless appropriate measures are taken to address the risk factors and sources of vulnerability of certain sectors of the population, particularly the female overseas Filipino workers (OFWs) and adolescents. In fact, there were around 500 newly diagnosed cases in 2008 compared to some 300 reported cases in 2007. The risk factors that have to be dealt with include the prevalence of sexually transmitted infections (STIs) among people from most-at-risk populations (MARPs) – men who have sex with men (MSM), people in prostitution (PIP), IDUs, OFWs – and the partners of all these groups,<sup>18</sup> low condom use, and gender norms that put women at greater risk of infection. The other aggravating factors are the lack of decisive measures to address the risks and vulnerabilities of adolescents and overseas migrant populations, as well as the resistance of faith-based organizations to promote condom use and sexual and reproductive health education.

### 3. HIV and AIDS, Filipino Women, and the Seafaring Industry

32. A current feature of overseas migration is its increasing feminization. When the Philippines began sending workers abroad in the early 1970s, women constituted only 12% of the total flow. In 1987, their proportion in relation to all departing workers reached 47%. In 2007, POEA reported a total of 306,383 Filipinos who were deployed abroad for the first time (new hires) and 48% of them were females.<sup>19</sup>

33. The phenomenal rise in number of female Filipino migrant workers is attributed to two major factors: (i) the continuous high demand of countries all over the world for their skills, particularly those related to domestic work, service work, and caregiving; and (ii) the inability of the local economy to generate enough jobs and adequate income.

34. In terms of occupational characteristics, OFWs are mostly into unskilled and semi-skilled work in the manufacturing, health and medical, services, seafaring, and household-based services.<sup>20</sup> In 2006, there were 128,186 females in service work, making up 42% of the total new hires deployed that year, mostly employed as domestic workers, caregivers, and night club entertainers (Table A8.1).

**Table A8.1: Deployment of Newly Hired OFWs, by Skills Category, 2006**

Skill Category	Female	Male	Total
Professional, medical, and technical workers	24,046	17,212	41,258
Administrative and managerial workers	289	528	817
Clerical workers	4,641	3,271	7,912
Sales workers	3,112	2,405	5,517
Service workers	128,186	16,135	<b>144,321</b>
Agricultural workers	91	716	808
Production workers	23,344	80,240	103,584
For reclassification	745	3,161	3,906
<b>Total</b>	<b>184,454</b>	<b>123,668</b>	<b>308,122</b>

Source: POEA, 2006. <http://www.poea.gov.ph>

<sup>17</sup> United Nations Philippines. "United Nations Implementation Support Plan to the Philippine Response to HIV/AIDS," unpublished report. In: Carolyn I. Sobritchea, 2005. "Gender and the Prevention and Control of HIV/AIDS in the Philippines," Paper read at the ISEAS Forum on Gender Issues and HIV/AIDS: Trends and Practices in Southeast Asia, December 5, 2005, Institute of Southeast Asian Studies, Singapore.

<sup>18</sup> PNAC. 2008. Follow-up to the Declaration of Commitment on HIV and AIDS United Nations General Assembly Special Session (UNGASS). *Country Report of the Philippines (January 2006 to December 2007)*. Philippine National AIDS Council with support from the UN Theme Group on HIV and AIDS.

<sup>19</sup> POEA. 2008. *2007 Overseas Employment Statistics*. <http://www.poea.gov.ph/stats/stats2007.pdf>. Accessed January 27, 2009.

<sup>20</sup> *Result on 2006 Survey of Overseas Filipinos*. <http://www.census.gov.ph/data/pressrelease/2007/of06tx.html>



35. Other than domestic work, Filipino women have increasingly been recruited abroad to work in hospitals as caregivers, in factories, and in hotels and restaurants. The Filipino males, on the other hand, make up a big proportion of those deployed in the production and seafaring sectors. In 2006, one-third of all the males deployed for overseas work were seafarers. It is interesting to note, as well, the continuous increase in number of females in the seafaring industry. They constituted 15.5% of all Filipino workers deployed in passenger or cruise vessels<sup>21</sup> and 2.8% out of the total 274,497 Filipino seafarers in all types of vessels (Table A8.2).<sup>22</sup>

**Table A8.2: Deployment of Seafarers, by Rank Category and Sex, 2006**

	Total	Male	Female	% Female
Rating	136,579	136,250	329	0.24
Officer	52,757	52,732	25	0.04
Passenger Ship/Liner Personnel	38,508	32,528	5,980	15.50
Rating not Stated	2,178	2,076	102	4.60

Source: POEA, 2007

36. The increase of female participation in the seafaring industry has been largely brought about by the growth of employment opportunities for them in the passenger and cruise vessels, particularly in the restaurant, casino, and club entertainment work. Young women with hotel or casino, even health or tourism-related training background, have taken up the challenge of applying with known agencies, such as CF Sharp and Magsaysay Maritime Corporation, to work on board cruise ships.<sup>23</sup> Table A8.3 shows the big numbers of females in such occupations as technical secretary (92%), masseuse (89%), front desk attendant (88%), and crew stewardess (74%).

**Table A8.3: Deployed Seafarers on Bahamas-Flagged Ships, by Sex and Position on Board, 2006**

	Total	Male	Female	%Female
Bar waiter/bar waitress	353	169	184	52.00
Barboy/bar utility	289	253	35	12.00
Bartender/bartendress	264	246	16	6.00
Casino dealer	237	130	107	45.00
Crew steward/ess	546	139	406	74.00
Crew utility	307	250	55	17.90
Crew utility steward	15	7	8	53.00
Cruise director	18	13	5	27.70
Cruise staff	117	89	28	23.90
Day utility	457	417	39	8.50
Day/night cleaner	473	382	91	19.0
Front desk attendant	60	7	53	88.0
Housekeeping supervisor/2nd steward	215	172	42	19.50
Masseur/masseuse	164	18	146	89.00
Messman	618	602	15	2.40
Nurse/medic	56	26	30	53.50
Overseas performing artist (singer, musician, dancer, SCP, novelty act)	269	242	27	10.00
Purser	103	67	36	34.90
Receptionist	49	13	36	73.00
Room steward/stewardess	232	165	66	28.00
Security guard	193	144	49	25.00
Stage manager	35	29	6	17.00
Steward	466	441	24	5.00
Tailor/seamstress	41	34	7	17.00
Technical secretary	14	1	13	92.80
Waiter/waitress	2,284	1,883	396	17.00

Source: POEA, 2007

<sup>21</sup> POEA. 2007. *OFW Global Presence, 2006*. A Compendium of Overseas Employment Statistics 2006 by the Philippine Overseas Employment Administration (POEA), also accessed on <http://www.poea.gov.ph/stats/2006Stats.pdf>

<sup>22</sup> *Ibid.*

<sup>23</sup> Sobritchea *et al.* 2008. *Ibid.*



37. The most recently completed study of ACHIEVE also showed that flags of ships with more Filipino female crew in 2006 include Bahamas, Panama, Italy, UK, Liberia, Bermuda, and the Netherlands, which were almost the same rank-wise with respect to male deployment, except for the inclusion of Norway's Second Registry—the Norwegian International Ship (NIS)<sup>24</sup> (Tables A8.4 and A8.5.)

**Table A8.4: Top Flags of Registry for Female Seafarer Deployment, 2006**

Country	Total	Male	Female	% Female
Bahamas	29,457	26,997	2,358	8.00
Panama	55,016	53,398	1,351	2.45
Italy	6,073	5,504	549	9.00
UK	7,824	7,288	515	6.50
Liberia	22,210	21,650	441	1.98
Bermuda	4,417	4,135	272	6.00
Netherlands	6,653	6,447	192	2.80
Japan	3,383	3,247	129	3.80
Malta	7,803	7,694	76	0.97
Norwegian International Ship Registry	7,260	7,170	54	0.74

Source: POEA, 2007

**Table A8.5: Top Flags of Registry for Male Seafarer Deployment, 2006**

Country	Total	Male	Female	% Female
Panama	55,016	53,398	1351	2.45
Bahamas	29,457	26,997	2358	8.00
Liberia	22,210	21,650	441	1.90
Malta	7,803	7,694	76	0.97
UK	7,824	7,288	515	6.50
Norwegian International Ship Registry	7,260	7,170	54	0.74
Netherlands	6,653	6,447	192	2.80
Italy	6,073	5,504	549	9.00
Bermuda	4,417	4,135	272	6.00
Japan	3,383	3,247	129	3.80

Source: POEA, 2007

38. Sailing abroad is still a man's world, especially when technical aspects of navigation and ship engine maintenance are concerned. In both ratings and officer categories, males dominate in this industry, even as the legal requirement as to gender for licensure exam was repealed years ago. The latest POEA statistical reports generated for this review clearly showed that there are very few women on board cargo and other non-passenger vessels. The majority are in passenger liner ships plying the Caribbean, the Mediterranean, and other worldwide destinations. Nonetheless, their number is expected to increase in the coming years since the number of those enrolled in maritime courses has increased in previous years.

39. There are 90 maritime schools accredited by the Commission on Higher Education.<sup>25</sup> In recent years, these schools have accounted for less than 5% of the total national enrolment at the collegiate level. They have also chalked up about 3% (11,000 -13,000) of the total graduates (MTC, 2007; CHED 2002-2004). These schools usually offer four-year baccalaureate degree courses in marine transportation (for deck officers) and marine engineering. The country's premiere school is the state-owned Philippine Merchant Marine Academy (PMMA) in Zambales, whose graduates in the 1960s and 1970s now dominate the managerial complement of the shipping and manning industries. Some, like the PMMA, are government schools, while the great majority is privately owned.<sup>26</sup>

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.



40. Supplementing the maritime colleges are the training centers, regulated by the Maritime Training Council (MTC) in connection with Philippine compliance with the International Maritime Organization (IMO) *Standards of Training Certification and Watchkeeping 1978/1995 Convention* that are for basic and upgrading courses mandated by the international shipping instruments.<sup>27</sup>

41. Some courses enable non-college graduates to enter the profession as ratings. These are the basic courses on seamanship, personal survival craft, and first aid at sea taken by those who work as hotel workers on cruise ships. The other courses are specialized (e.g., for tanker operations, simulator courses, and the like), which need to be taken by those aspiring to work on specialized vessels.<sup>28</sup>

## B. Gender Dimensions of HIV and AIDS

42. Women are at greater risk to HIV infection, as compared to men, and they suffer more from its effects due to physical, cultural, and economic reasons. Inequality in the exercise of power at home and in the public domain prevents them from having equal access to knowledge and skills that could enable them to negotiate for safer sex and confront stigma and discrimination. Gender inequality is among the primary determinants of physical and sexual violence, economic dependence, inadequate education, and lack of access to empowering skills and knowledge.

### 1. Epidemiological and Biological Predispositions of Women

43. Females, particularly those of adolescent ages, are biologically more vulnerable to the infection because of the following explanations from medical science:

- The female reproductive organ has a greater surface area of mucous membrane where the virus can enter.
- A younger woman's risks are heightened because of her immature cervix and thinner mucous membranes, which get abraded during forced or dry intercourse.
- The semen of HIV-positive men contains a higher concentration of the virus than the vaginal fluids of HIV-positive women.
- STI in women is likely to go untreated because it is not so visible or is less noticeable, and this increases their risk of contracting HIV. The presence of untreated STI infection can make that person ten times more likely to get and transmit the HIV.
- Pregnancy and childbirth, especially in poor countries and communities, increase the risks of women to anemia and birth complications, which, in turn, also predispose them, more than men, to blood transfusion.

44. The progression from being HIV positive to having AIDS is faster for girls compared to boys in many South and Southeast Asian countries since they experience higher rates of malnutrition that are, in turn, responsible for the weakening of the immune system. A study commissioned by the World Health Organization (WHO) in 2000 showed that malnutrition among children remained a major public health issue, even as it decreased from 47% in 1980 to about 33% in 2000, or that around 40 million children under five years of age grew up healthy in the last 20 years.<sup>29</sup> In 2000, the study claimed that a third of all children under five years of age were stunted, 70% of them in Asia (mainly South Central Asia), 26% in Africa, and about 4% in Latin America and the Caribbean. In nearly all Southeast and South Asian countries, there are higher rates of malnutrition among female children and adolescents. The preference

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> De Onis, Mercedes, Edward A Frongillo, and Monika Blossner. 2000. "Is Malnutrition Declining? An Analysis of Changes in Level of Malnutrition since 1980." *Bulletin of the World Health Organization*, 78 (10): 1225.



for a male child invariably influences the manner by which households allocate food, educational benefits, and other vital resources for their children.

45. **Pregnancy and Breastfeeding Concerns of HIV-Infected Women.** Current medical information suggests that pregnancy does not affect the progress of the infection in HIV-positive women who show no symptoms or are in the early stages of the infection. However, the bases for this observation were drawn from studies in industrialized countries because there has been little research on this topic in developing countries, especially when viewed in the context of high rates of anemia, micronutrient deficiency, and malnutrition among poor pregnant HIV-positive women.<sup>30</sup> The added risks for HIV-positive women are the possible complications during childbirth that may require transfusion of blood or blood products.

46. The UNIFEM study on AIDS showed that there is roughly a 15% chance of transmission through breastfeeding.<sup>31</sup> This poses a dilemma for nursing women since resorting to bottle feeding will reduce the risk of infection but expose the infant to malnutrition and diseases caused by unclean water that is mixed with milk or used for cleaning the bottle.

## 2. Gender Norms and Practices

47. Other than the aforementioned biological or physical factors are numerous cultural beliefs and practices that make women most vulnerable to HIV infection. In many rural areas of South and Southeast Asia, it is still customary for very young women to marry older men. Cultural norms likewise prevent women's access to knowledge and information related to SRH. Showing interest in sexual matters is often frowned upon and considered an act that is unbecoming of a proper or decent woman. Moreover, the high social value placed on virginity before marriage keeps many girls ignorant of sexual matters. Even those who are sexually active are discouraged from discussing sexual matters with their partners and friends. In the Philippines, for instance, women are unable to negotiate for safer sex since it is often tied to the notion of love and fidelity. Women who demand the use of condoms, for example, are suspected of not being truly committed to the partnership or are being unfaithful.<sup>32</sup>

48. There is also the widespread norm for wives to remain monogamous throughout their marriage even as their husbands may engage in extramarital relations. Studies in Africa and Asia have shown that many married women contract the disease from their one and only sex partner—their husband.<sup>33</sup> Then the social pressure to bear a child affects women's choices about protecting themselves against HIV infection. Early marriage, which is still customary in many developing countries in Asia, exposes young women to an increased risk of STIs and HIV infection, especially if their partners are older and have had more sexual exposure. Although most countries have declared 18 as the minimum legal age of marriage, 100 million girls<sup>34</sup> are expected to marry in the next decade.<sup>35</sup> Data from the UNFPA show that while girl child marriage has decreased globally over the last 30 years, it remains a common practice among the poor. In Southeast Asia, 48% (nearly 10 million) of females under the age of 18 were married in 2004. In India, the rate of girl child marriage in 2004 was 50%, 51% in Bangladesh, and 54% in Afghanistan. Not only is there a strong correlation between age of marriage and maternal mortality, early marriage restricts a girl's social mobility and access to educational opportunities.

49. Inasmuch as women are mainly responsible for home and child care, they carry the greater burden of caring for HIV-positive family members. They are exposed to the risk of infection and also have to sacrifice their own health, well-being, and economic resources for the care of a sick spouse, child, or

<sup>30</sup> WHO, 2003. "Gender and HIV/AIDS." *Gender and Health*, November 2003.

<sup>31</sup> UNIFEM, East and Southeast Regional Office. n.d. *Women, Gender and HIV/AIDS in East and Southeast Asia*. n.p.

<sup>32</sup> Sobritchea, Carolyn I., "Gender and the Prevention and Control of HIV/AIDS in the Philippines."

<sup>33</sup> UNAIDS. n.d. "Women and Their Vulnerability." *Women, Gender and HIV/AIDS in East and Southeast Asia*. n.p.

<sup>34</sup> The United Nations Convention on the Rights of the Child (CRC) defines a child as every human being below the age of 18 years unless defined differently by a State party.

<sup>35</sup> UNFPA. 2005. *State of the World Population 2005, Child Marriage Fact Sheet*.



grandchild. When called upon by circumstances to provide home care, many women are not trained in the management of AIDS patients, nor do they have access to medical supplies like gloves and face masks that can protect them against other infections. In majority of the countries, women's invisible and unpaid labor subsidizes the inadequate social protection provided by government. Since unpaid labor is not counted in formal statistics, the enormous cost to women, families, and the next generation is overlooked.<sup>36</sup>

50. The negative impacts of HIV and AIDS on older populations in developing countries have been amply described in recent studies.<sup>37</sup> In Thailand, for instance, older people use their limited financial resources and extend their working hours for the care of a sick child or an orphaned relative. Their social relations and emotional health suffer not only from the added pressure of health care, but also from the stigma and discrimination exhibited by neighbors, health workers, and relatives. UNAIDS estimated in 2007 that AIDS had orphaned 15 million children under the age of 17.<sup>38</sup> The responsibility of raising and sending them to school has been passed on to grandparents and older relatives.

51. For men, certain gender norms increase their risk of contracting the infection and transferring it to their wives and other sexual partners. Many societies expect them to be married, bear children, and produce male heirs to carry the family name. They are also expected to be much more knowledgeable than their partners about sexual matters and are tolerated for having sexual relations with women other than their legal wife or wives. A UNAIDS report based on studies in seven countries, including Cambodia, the Philippines, and Papua New Guinea, found that social constructions of masculinity encourage young men to view sex as a form of conquest. In some cases, male ignorance of sexual matters is construed as a sign of weakness, and this discourages them from seeking correct information on prevention of HIV and STI.<sup>39</sup>

52. The schools and other informal institutions of learning in many Asian countries have not effectively conveyed the information and skills that can protect both sexes from reproductive health problems, including HIV infection.<sup>40</sup> Then, too, school administrators and teachers are very often not properly informed about the seriousness of the problem and what they can do to encourage young people to develop positive SRH beliefs and behaviors.

53. The resistance of some faith-based institutions to the use of condoms and to promote women's SRH rights is among the major obstacles to the effective implementation of HIV prevention programs. In the Philippines, the fundamentalist faction of the Catholic Church has actively countered the campaigns for the promotion of condom use and sexuality education for adolescents on charges that these would only "promote" promiscuity and abortion.

### 3. Gender Norms and Practices: The Philippine Context

54. Filipino women have traditionally assumed the burden of preventing pregnancy through use of the pills, intrauterine devices (IUDs), and even through induced abortion. Many males, on the other hand, believe that condom use reduces sexual pleasure and makes them less masculine in the eyes of their partners. In short, the prevalence of the "machismo"<sup>41</sup> culture, especially in the seafaring industry, and

<sup>36</sup> UNIFEM. *ibid.*

<sup>37</sup> See for instance the study of John Knodel, Wassana Im-Em, and Chanpen Saengtienchai. 2000. "The Impacts of HIV/AIDS on Older Populations in Developing Countries: Some Observations Based on the Thai Case." *Journal of Family Issues*, 21(6):777-805. .

<sup>38</sup> UNAIDS. 2008. *ibid.*

<sup>39</sup> Gender and Health. 2003. "Gender and HIV/AIDS." n.p.

<sup>40</sup> UNAIDS. 2000. *A Report on the Global HIV/AIDS Epidemic.*

<sup>41</sup> Philippine society remains tolerant of the "double standard of morality" whereby men may engage in premarital and extramarital relations while the women are expected to be chaste before the wedding and monogamous throughout their married life.





the unequal power relations between the sexes predispose women to physical and sexual abuse and to their lack of control over their reproductive health.

55. Lack of access to information is another factor that accounts for low condom use in the country due to contradictory and often confusing messages sent by the government about its policies on family planning, reproductive health, and population and management. The most serious deterrent, however, in the country's effort to increase the use of condom by men is the strong resistance of the Catholic Church to all forms of modern contraceptives.

*"The traditional sex role expectations underscore many of the factors that make both men and women vulnerable to HIV/AIDS infection. For women, these include the cultural prescription that they should not show too much interest in sexual matters, especially when they are not yet married or once they become widows. Women are expected to take a passive role in sexual relations and defer to the sexual demands and needs of men. Filipino men, on the other hand, construct their masculinity around the notions of virility and sexual prowess manifested in the number of children they have, insistence on unprotected sex, and prevalence of extramarital relation."*<sup>42</sup>

56. In the 2002 Young Adolescent Fertility and Sexuality (YAFS) survey of the University of the Philippines Population Institute (UP-PI), the percentages of men and women engaging in unprotected sex were 70% and 68%, respectively. There has been no significant improvement in their level of awareness about HIV and AIDS – 27.8% believed that it is curable, while 60% said that there was no chance for them to be infected.<sup>43</sup>

57. The reported incidence of STIs has also remained high over the past years. For instance, the 2004 *STI/HIV/AIDS Technical Report* revealed that syphilis rates among high-risk groups ranged from 1% - 4%, and the highest growth was noted among freelance sex workers.<sup>44</sup> A 2002 survey conducted in a provincial city with many entertainment establishments showed that 35% of those working in night clubs mentioned symptoms of STIs; others admitted having been infected with gonorrhea and *Chlamydia* during the few months prior to the study. There was also an increase of STI cases among the young females and males, especially among the 18-24 age group, compared to the general population. The inability of sex workers and young women to negotiate for safer sex has to do with traditional notions of gender roles and norms in sexual relations.

58. The number of sex partners of female sex workers (FSWs) varies from 1- 80 per week based on a study conducted from 1997-2003. Some MSM reported having as many as 55 sex partners in a month. Nonetheless, the overall average number of sexual partners of these groups has remained the same at two per month over the last three years. Meanwhile, condom use was less than 30% among the MARPs and only 4% for the entire male population.

59. As mentioned earlier in this paper, a major stumbling block in efforts to prevent and control HIV is the resistance of certain faith-based groups, particularly certain sectors of the Catholic Church, for young people to have full and regular access to SRH information and services. In addition, the use of condoms and other methods of preventing STIs and unwanted pregnancy are viewed as "promoting" sexual promiscuity and abortion. Members of these groups wield considerable political clout, often causing the ambivalent stance of national government officials on various gender and RH issues. For example, the current administration has promoted the use of natural family planning methods and has left to local governments the decision on whether or not to promote the use of condoms and other RH approaches.

<sup>42</sup> Action for Health Initiatives (ACHIEVE), Inc./CARAM-Philippines. 2004. *Ibid.* p.158.

<sup>43</sup> Philippine National Aids Council (PNAC). 2005. *4<sup>th</sup> Medium Term Plan, 2005-2010*. Manila

<sup>44</sup> PNAC. 2005. *ibid.*



This has emboldened some city or village officials to pass local ordinances to prevent NGOs from operating RH clinics and to justify the removal of modern contraceptives from public health facilities.

#### 4. Social, Economic, and Other Impacts of HIV and AIDS

60. Over the years, several NGOs have tried to document the experiences of stigma and discrimination by people living with HIV (PLHIV). These studies have taken note of some of the impacts of the infection on the personal life of PLHIV, their families, and communities. What is lacking is a more decisive investigation of the gender dimensions of the problem, particularly the differing impacts on women and men of current prevention, control, and treatment programs. In 2003, the Remedios AIDS Foundation, an NGO based in Metro Manila, collaborated with Deakin University in Australia to conduct a study of HIV/AIDS-related stigma and discrimination.<sup>45</sup> A team of researchers composed of a lawyer, social worker, medical practitioner, economist, and health workers was organized to look into the discriminatory policies and practices of the justice system, the health sector, education, and family life as well as by insurance firms, housing companies, and employers. Unfortunately, the study did not specify the common and different experiences of discrimination of HIV-positive women and men. Nonetheless, the study presented significant findings including the following, among others:

- **Health sector.** Medical personnel from various health institutions refused to provide care to a positive person because of his/her status. Some private and public medical laboratories failed to inform the person of the blood test results, thereby depriving that person the opportunity to seek immediate medical assistance and counseling. There were many lapses in ethical conduct of service providers, such as ensuring the anonymity of the infected person and giving due notice or counsel to the sexual partner(s) and relatives. A number of medical schools required their incoming interns to undergo HIV blood tests even if this is against the law. Moreover, such mandatory blood testing was often not accompanied by pre-test and post-test counseling.
- **Judicial system.** The study noted the insensitive conduct of judges and lawyers, which prevented PLHIV from using judicial and legal remedies to solve their problems, like seeking redress for unpaid salaries, unclaimed insurance benefits, or illegal termination from work. There were no protocols to guide the conduct of court trials and the management of records.
- **Prison administration.** The Philippines has no policy concerning the administration of prisoners with HIV and AIDS.
- **Immigration processes.** Personnel of the immigration offices did not have a common understanding of how to implement HIV-related policies for individuals who leave or enter the country. For instance, the change of status from temporary visitor to a non-quota immigrant by marriage may or may not require the submission of a certification that the applicant is not infected with the virus. However, foreigners who wish to apply for permanent residency status need to undergo a blood test, and their application is denied once they test positive for HIV.
- **Social services.** Many social service providers were found to be insensitive to the plight of people with HIV/AIDS. They would conduct interviews or inquiries within the hearing distance of others and make discriminatory or embarrassing remarks. The procedures for securing social benefits were found to be very tedious and exhausting, especially by those who had failing health.

61. As mentioned earlier, gender inequality in decision making at home and in the public domain prevents women from having equal access to knowledge and skills that can enable them to negotiate for

<sup>45</sup> Remedios Aids Foundation. 2004. *Directory of Non-Government Organizations*. Manila.



safer sexual relations and confront the many sources of stigma and discrimination. The HIV-infected women, who participated in the aforementioned study by Deakin University and Remedios-AIDS Foundation, reported having suffered from stigma and discrimination by immediate family members, friends, co-workers, and neighbors. Some said that upon learning of their status, they were prevented from cooking the meals at home or going near their children. Others had to leave their house and stay in shelters upon the insistence of family members who feared being infected. Many friends and co-workers who learned of their status either shied away or cut off their ties completely. Many wives had problems collecting the death and other insurance benefits of their husbands suffering from, or had died of, AIDS.

### C. Policy and Program Dimensions of HIV and AIDS, Migration, and Gender

#### 1. National Policies, Strategy Framework, and Programs on HIV and AIDS Prevention, Control, Treatment, and Care

62. The early and decisive response of the Philippine government, NGOs, the academic community, and the private sector, may also account for the low number and slow spread of the virus in the Philippines. As soon as the first few cases of infection were reported by media in the mid-1980s, the government organized an interagency task force to undertake appropriate prevention and control programs. Several NGOs were formed and, to this day, continue to generate information and educational materials as well as conduct public awareness seminars. At present, there are some 87 NGOs all over the country directly involved in research, counseling, medical service, and advocacy around the issue of reproductive health and rights.<sup>46</sup>

63. In 1998, the legislature passed the *Philippine AIDS Prevention and Control Act*, which laid down the policies, implementing mechanisms, and programs for the prevention and control of the infection. The law requires the promotion of public awareness about the causes, modes of transmission, consequences, and means to prevent and control HIV and AIDS through comprehensive nationwide educational and information campaigns. The school officials, health service providers, labor unions, and employers, among others, are required to initiate these campaigns. A national mechanism, the Philippine National AIDS Council (PNAC), was established to develop and coordinate a comprehensive national prevention and control program as well as treatment and support initiatives for PLHIV. PNAC prepares plans of action and monitors the pace and quality of program implementation. The Council is composed of representatives from various government agencies and NGOs. The Council's leadership has resulted in the passage of several agency-level enabling policies to ensure the effective implementation of programs mandated by law.

64. The law also declared compulsory or mandatory HIV testing as unlawful and provides for access of PLHIV to basic health and social and medical services, including pre- and post-test counseling for individuals who voluntarily go for blood testing.

#### 2. Prevention, Control, and Treatment Plans and Programs

65. The *4th AIDS Medium Term Plan (2005–2010)* is geared towards preventing “the further spread of HIV infection and reducing the impact of the disease on individuals, families, and communities.”<sup>47</sup> It has lined up several programs meant to achieve the following objectives: (i) to increase the proportion of population with risk-free practices; (ii) to increase the access of persons infected with HIV to quality

<sup>46</sup> Sobritchea, Carolyn I. and Florence Tadiar. 2004. *Review of Philippine Policies and Programs on Migration and HIV/AIDS*. Commissioned by the Southeast Asian Ministers of Education Organization Regional Tropical Medicine and Public Health Network (SEAMEO TROPED), the BACKUP (Initiative-GTZ), the Philippine National AIDS Council and the Department of Health. The project report was used to formulate the *Joint Resolution for Strengthening Collaboration among ASEAN Countries to Prevent and Control HIV/AIDS*.

<sup>47</sup> PNAC. 2005. *ibid.* p. 9.



information, treatment, care, and support services; (iii) to improve accepting attitudes towards PLHIV; and (iv) to improve the efficiency and quality of management systems in support of HIV/AIDS programs and services. These objectives should be carried out through expanded training, education and advocacy, continuous research and monitoring, expanded care and support positives and their children, and by strengthening the institutional management support system.<sup>48</sup> While preventive interventions shall continue to target most-at-risk populations, the plan for the coming years is to reach out to the general populace, particularly adolescents and young people. Moreover, local programs shall be expanded and diplomatic measures strengthened to reduce the vulnerabilities of Filipinos working overseas.

66. **Information, Education, and Communication (IEC) Program.** Over the years, the government and NGOs, with the support of international funding organizations, have produced and widely disseminated IEC materials for MARPs, students, service providers, and policy makers. With the use of the Behavior Change Communication (BCC) approach, such IEC materials were used for one-on-one risk reduction counseling, media campaigns, community outreach, peer education, and training, as well as for advocacy forums. Moreover, the integration of HIV and AIDS into the elementary, secondary, and vocational curricula is continuously being pursued. At the same time, tertiary schools have started to develop courses linking sexuality and sexuality issues with gender and culture. With the use of their gender budget, local government agencies have also started to integrate HIV and AIDS into gender awareness seminars for community leaders and workers. On the other hand, several labor unions and federations of employers have allocated resources for the regular conduct of seminars on RH and HIV and AIDS. While these advocacy and capacity building activities have been shown to be quite effective in changing people's attitude and behavior, their coverage remains to be very limited. There is a need to reach out particularly to communities in remote areas of the country now sending many of their residents for work in urban centers and abroad.

67. Fortunately, the easy access to web resources by policymakers, service providers, and other program implementors can provide them with updated information on HIV and AIDS. Meanwhile, PLHIV have been trained to actively participate both in the development and dissemination of these IEC materials and the management of service programs.

68. **Research, Training, and Advocacy.** With the active support of many academic institutions and research-based NGOs, the Philippines has produced a wealth of research materials about the causes and manifestations of HIV and AIDS as well as the constraints and opportunities for its prevention and control. These materials are used for the development of new programs and improvement of the old ones. For example, the early establishment of the surveillance system, particularly the conduct of seroprevalence surveys among MARPs starting in the mid-1980s, the establishment of the *HIV/AIDS Registry* in 1991, and the National HIV/AIDS Sentinel Surveillance System (NHSSS) in 1993 gave decision-makers and program planners appropriate information for policy and program planning. The NHSSS-Behavioral Sentinel Surveillance introduced in 1997 continues to provide vital information on changes in demographic and geographic spread/locations of HIV.

69. Three national surveys on adolescent reproductive health beliefs and practices have so far been undertaken by the University of the Philippines Population Institute (UPPI). These studies have been used to develop advocacy, training, and education programs to promote adolescent SRH. Qualitative studies have likewise been undertaken to describe and analyze the vulnerabilities of sex workers, seafarers and their spouses, health workers, and the like. A few studies on HIV-related laws, policies, and services have been undertaken to examine the forms of discrimination against PLHIV.

70. Over the years, training has been provided to medical and health personnel, social workers and counselors, policymakers, and program implementors. PNAC reports that the contents of the training programs include topics such as basic medical information about HIV and AIDS, diagnostic approaches and ethical guidelines for management of cases, and syndromic STI management. The Department of

<sup>48</sup> PNAC. 2005. *ibid.* p.19.



Education (DepEd) has trained selected teachers at the provincial and city levels for the integration of HIV and AIDS in health and social studies courses. Meanwhile, the Department of Social Welfare and Development (DSWD) has trained hundreds of community volunteers and leaders all over the country for prevention campaigns and information dissemination as well as care and support of PLHIV. The Department of Foreign Affairs (DFA), in partnership with a local NGO, has also taken measures to capacitate its local and foreign personnel to participate in prevention programs and to assist OFWs diagnosed with HIV.

71. The NGOs, for their part, have offered a wide array of training packages which include topics on gender relations, sexuality and human development, prevention counseling, hospice care, and community organizing for HIV prevention. Special attention has been given to the integration of HIV and AIDS in training programs (i.e., pre-departure, on site, and upon return to the country) of OFWs.

72. Advocacy and training efforts aimed at eliciting media support have had many positive results. A *Media Manual for HIV/AIDS Reporting and Popularizing the IRR (Implementing Rules and Regulations) of Republic Act 8504 (the AIDS Law)* was developed in 2001 to enable the media practitioners to uphold the ethical guidelines in reporting news about PLHIV.

73. An encouraging development in the country is the serious effort of some NGOs in recent years to engage faith-based organizations in discussions of SRH issues and concerns. Given the strong resistance of Christian fundamentalist groups to accept the principles of reproductive and sexual rights and allow their members to exercise such rights, NGOs have adopted creative strategies to overcome this barrier. Some groups have mobilized student organizations in sectarian schools to discuss SRH concerns. Other groups have encouraged and mobilized progressive religious leaders to openly state their views on HIV and AIDS and popularize deconstructions of religious texts that privilege liberating interpretations. The Bangsa Moro Women's organization in Southern Philippines, for example, has led in efforts to advocate for women's access to information, knowledge, and services that would promote reproductive health and gender equality. Through painstaking advocacy efforts, the organization got their Muslim leaders to issue a statement that family planning and women's access to life-saving reproductive health services is in keeping with Islamic precepts.

### **3. Services for Prevention, Treatment, Care, and Support and Monitoring and Evaluation (M&E)**

74. The service components of the country's HIV and AIDS response include the facilities aimed at prevention and early detection or monitoring of risky behavior and those that deal mainly with the treatment, care, and support of PLHIV. For prevention services, the health facilities have focused on the promotion of STI treatment and care using the syndromic management approach and counseling. Tertiary and secondary hospitals located in areas with large numbers of MARPs have expanded their human and material resources for HIV testing. For these purposes, NGOs have been tapped for the aggressive promotion of condom use and safer sex negotiation counseling.<sup>49</sup> There is an ongoing campaign to popularize voluntary counseling and testing (VCT). To make VCT accessible, 11 treatment hubs (three in Metro Manila, San Fernando City [La Union], Baguio City, Legazpi City, Cebu City, Bacolod City, Iloilo City, Davao City, Zamboanga City) where PLHIV can access free ARV and 32 public VCT centers with trained VCT counselors and proficient medical technologists were established under the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) project.<sup>50</sup>

75. RA 8504 also requires the creation of an information system to be jointly operated and managed by the different government agencies. This provision of the law has not been fully implemented, thereby making it extremely difficult to monitor and evaluate both the outputs and results of programs.

<sup>49</sup> Sobritchea, Carolyn and Maria Theresa Ujano-Batangan. 2004. Communicating Reproductive Health to the Youth: Good Practices by Philippine NGOs. Demographic Research and Development Foundation, Inc. in cooperation with the David and Lucille Packard Foundation, Quezon City.

<sup>50</sup> Country Report of the Philippines (January 2006 to December 2007). *ibid.*



Nonetheless, the programs with external funding support are able to monitor the performance of programs and provide vital information on gaps and good practices. An HIV/AIDS M&E system has been recently developed by PNAC. However, the system is not yet fully operational due to severe lack of resources. The results indicators also need to be strengthened to include gender and other RH variables.

#### D. Strategies to Address HIV and AIDS, Migration, and Gender Issues

##### 1. Promoting Gender Equality as a Key to HIV Prevention, Control, and Treatment

76. Despite the abundance of studies showing that gender inequality underlies the faster spread of the diseases among women and their children and the many negative impacts on them of the problem, not enough attention has been given to this matter. At a top-level meeting of world leaders in 2001, Paula Donovan, UNIFEM Regional Gender and HIV/AIDS Advisor for Africa, argued that:

*“The failure of states to fulfill their obligation to provide the highest possible standard of health has forced women to fill a gaping hole as best as they can. By refusing to provide adequate help, the same international community that ratified the Convention on the Elimination of All Forms of Discrimination Against Women has driven women and girls out of schools and job training and leadership roles in the public arena, and back to the home. The same global community that united behind the Beijing Declaration and Platform for Action of the Fourth World Conference on Women has allowed women and girls, including the very old, the very young and the sick, to take on full-time jobs as health care and hospice workers, foster parents and social workers—and to do that grueling work with no pay, no benefits, no protection, no resources.”<sup>51</sup>*

77. Many women’s groups involved in HIV prevention and treatment work have noted numerous forms of discriminatory practices against women both as recipients and givers of care and support. These include the following:

- Sexual and ethical injustices of prenatal testing for women.<sup>52</sup>
- Some countries in Asia require regular blood testing and pregnancy tests for overseas migrant workers, including women in domestic and entertainment work. Once tested positive, they are immediately deported and denied access to work benefits, counseling, and health care.<sup>53</sup>
- Women rarely have access to condoms, acyclovir as a herpes prophylaxis, anti-fungal treatment for thrush, and support to treat other sexually transmitted infections because these issues are often not considered as part of the comprehensive health care packages.<sup>54</sup>
- The cost of HIV and AIDS treatment is often so prohibitive and beyond the reach of poor families in developing countries. While the price of treatment may be uniform for all those who need it, women’s unequal economic power compared to men makes access to treatment more difficult for them.
- The insensitivity of health and social workers to the plight of HIV-positive women by often blaming them, for example, discourages many from having regular health check-ups and medication. The spiritual or religious views of counselors and their lack of readiness to talk

<sup>51</sup> UNIFEM. *ibid.*

<sup>52</sup> Welbourn, Alice. “Women with HIV/AIDS: Commonwealth Casualties,” The Commonwealth Health Ministers Reference Book 2006. [http://www.icw.org/tiki-view\\_articles.php](http://www.icw.org/tiki-view_articles.php).

<sup>53</sup> Marin, Maria Lourdes S., Amara T. Quesada, and Carolyn I. Sobritchea. For Good: Life Stories of Filipino Migrant Workers Living with HIV/AIDS. Quezon City: Action for Health Initiatives (ACHIEVE), Inc./CARAM-Philippines, 2004.

<sup>54</sup> Welbourn, Alice. 2006. “Women with HIV/AIDS: Commonwealth Casualties.”



about sexual matters also present serious problems in terms of their ability to communicate enabling messages.

- The bulk of financial and technical support is on treatment rather than prevention. Although this is not unique for women, the relative inattention to HIV infection in women has resulted in a constant struggle for resources to find and care for women with HIV infection. Prevention efforts usually take a lower priority and are the first to be cut when resources are diminished.<sup>55</sup>
- Although women are the major caregivers of family members with AIDS or those suffering from opportunistic infections (OIs), they are not given enough training and information on how to provide such care and to protect themselves from the infection. Men are much less likely to be blamed by the community or their families when they themselves get infected or when the care they provide to a sick family member is perceived to be weak or inadequate.
- Community-Home Based Care (CHBC) approaches that are currently being integrated into national AIDS program strategies lack measures to promote the role of men as caregivers in the family and community.<sup>56</sup>

## **B. Some Proposed Measures to Reduce Risks of Women to HIV Infection and its Negative Effects**

78. Given the aforementioned sources of women's vulnerability to HIV infection and their negative effects on their social and economic situation, several measures have been put forward by individuals and groups worldwide. These include the need to strengthen the gender equality components of current policies and programs through protection and promotion of women's fundamental human rights. Reforms of existing national and international policies must focus on improving women's economic independence, access to information about their SRH and legal status. But the success of these measures has largely depended on the effectiveness of interventions to enhance women's participation in decision making so that they themselves can influence the framework and contents of HIV prevention, control, and treatment programs. Equally important is the need to change the attitude and behavior of males to engage in responsible sexual behavior and to share in the responsibility of protecting themselves, their partners, and their children from HIV and AIDS and STIs. Since empirical data already show that male violence against women contributes to the spread of HIV in direct and indirect ways, strong measures must be instituted to eliminate this problem through education and training, as well as strong legislation. While many countries in the Asia Pacific region have already passed laws to protect women against gender violence, these laws are often inadequate to respond to many forms of physical, economic, psychological, and sexual abuse.

79. Since the risk of HIV infection is also closely linked to migration and human trafficking, it is extremely important to strengthen current global and national policies and programs to promote safe migration and eliminate human trafficking.

80. Tuberculosis is a major cause of death among PLHIV. An estimated one-third of PLHIV are co-infected with this disease. Without proper treatment, 90% of those infected with HIV will die within months of developing active TB.<sup>57</sup> What this observation underscores is the need to strengthen public health programs taking gender equity principles into consideration.

81. A policy paper prepared by the Emerging Social Issues Division of UN-ESCAP in Bangkok made several recommendations to ensure that current HIV and AIDS programs are sensitive and responsive to

<sup>55</sup> Guinan, Mary E. and Laura Leviton. 1995. "Prevention of HIV Infection in Women: Overcoming Barriers." *Journal of American Medical Women's Association*.

<sup>56</sup> UNIFEM. *ibid*.

<sup>57</sup> Development Gateway. <http://www.developmentgateway.org/hiv>.



the needs of women.<sup>58</sup> It is important to reiterate here the suggestions of the women themselves whose voices and aspirations have been amply documented by the studies cited in this paper. They include the following, among others:

- Provide information and counseling before and after blood testing about mother-to-child transmission and breastfeeding.
- Expand the dissemination of counseling and information services beyond prenatal and family planning clinics for easier access of unmarried and childless women.
- Intensify efforts to eliminate all forms of violence against women through legislation and its strict enforcement. While many countries have passed legislation against domestic violence or spousal abuse, sexual harassment, and rape, other countries have yet to pass effective measures to eliminate human trafficking and abuses committed against commercial sex workers. Decisive and effective actions against these problems can reduce the risk of women to HIV.
- Provide adequate community-based support services for the care of AIDS patients so that their medical and health care and everyday needs will not weigh heavily on their families, particularly the female members. Since caregivers are at risk of being infected, they should be given adequate prevention training and information.
- Ensure that the human rights of HIV-positive women are protected by strengthening the ethical guidelines for medical and health care services, research, training, and advocacy. The norms of confidentiality, privacy, informed choice, and participatory actions must be observed at all times. International treaties on human rights signed by nearly all member countries of the United Nations and enforced through national laws and policies ensure the fundamental human rights of women to access to health care, the right to freedom from discrimination, the right of freedom of reproductive choice, including the right to bear children, and the rights to work, education, social security, and dignity. All HIV and AIDS policies and programs must ensure that these rights are respected, protected, and fulfilled.
- Involve both men and women in the prevention of mother-to-child transmission programs. The husbands can go with their wives during antenatal check-ups to enhance their role as caregiver in the family.
- Underscore the need for continuous research on the gender-related causes and impacts of HIV and AIDS. Existing monitoring indicators go beyond providing sex-disaggregated data. In particular, there is a need for more data coming from developing countries on the sociocultural factors that affect the transmission of HIV during childbirth and through breastfeeding. The other areas for future research include the impacts of ongoing community-based prevention programs, counseling services and sexuality education, the development of microbicides and other effective female-controlled methods of preventing HIV that do not prevent pregnancy and do not involve the use of a condom.<sup>59</sup>

### C. Grounding HIV and AIDS Programs on the Principles of Gender Equality, SRH, and Rights

82. The strategy framework for the HIV and AIDS programs of both government and NGOs is increasingly being anchored on the principles of gender equality, SRH, and rights. This simply means that serious efforts are being carried out at the moment to strengthen the country's response to include not

<sup>58</sup> UNESCAP, Emerging Social Issues Division. "Gender and HIV/AIDS in Asia and the Pacific Region." Gender and Development Discussion paper, Series No. 18, n.p.

<sup>59</sup> Gender and Health. 2003. "Gender and HIV/AIDS." 2003. n.p.





only the biomedical perspective but also the sociocultural and political factors, the individual, and structural causes of the modes of transmission, and impacts of HIV and AIDS.

83. Patterns of gender relations, constructions of gender identity and role expectations, as well as sexuality and reproductive health beliefs, are all closely linked to the prevention and control of HIV. The sexual attitudes and behaviors of both men and women influence their receptivity to calls for safer sex and other actions to prevent being infected. In particular, the persistence of gender inequality in decisionmaking at home, the economic dependence of women on their husbands, and the pervasive influence of cultural values that tolerate male sexual "indiscretions," put women at greater risk to HIV infection. A study conducted by an NGO on the links between labor migration and HIV/AIDS, for example, showed that the wives of seafarers were unable to negotiate for safe sex and demand marital fidelity from their spouses because of economic dependence.<sup>60</sup> Many had to live with the vices of their husbands, i.e., their drinking, gambling, and "womanizing." Those infected by their husbands had to deal with the trauma of discrimination from family members and neighbors and from having to attend to the medical needs of their husbands and their own.

84. How is the gender and rights-based approach being increasingly integrated into HIV and AIDS plans and programs? Many NGOs do this by (i) bringing into their programs the prevention of STIs and domestic and sexual violence, (ii) conducting gender sensitivity seminars, and (iii) anchoring the discussion of HIV and AIDS on notions of human sexuality. Tan (2005) asserts that "*sexuality moves from intentions to acts. Beneath those contraceptive prevalence rates and episodes of unprotected sex are decisions and choices drawn from a constellation of meanings, a process where sex is constantly being interpreted and reinterpreted, sometimes in ways that may be contradictory.*"<sup>61</sup> In grounding HIV and AIDS programs on sexuality and reproductive health concepts, it becomes necessary to interrogate sexual meanings from diverse locations of actors, how meanings are expressed in everyday life and interactions, and their macro contexts. It is also important to examine the constructions of gender identities and sexual orientations and of notions of love, lust, romance, pleasure, and desire in order to locate specific sources of power and disempowerment by both women and men.

85. For government, the integration of gender principles and concepts into RH and HIV and AIDS programs is pursued through the gender and development (GAD) approach introduced by the National Commission on the Role of Filipino Women (NCRFW). Congress passed a law in 1996 requiring all of its national and sub-national agencies to allocate 5% of their resources (known as the gender budget) for use in programs that can address the gender issues in health, governance, and labor in the economy and in culture. The use of the gender budget must be in accordance with the gender mainstreaming policy guidelines, which include the installation/development of the following: (i) sex disaggregation of reports and data; (ii) skills in gender analysis, planning, and monitoring; (iii) enabling structures and mechanisms (i.e., creation of a Gender Focal Point and a Technical Working Group for Gender); and (iv) results-based M&E system.<sup>62</sup> The NCRFW advocates for the inclusion of women's empowerment approaches (i.e., leadership training, skills enhancement workshops for safe sex negotiation, reducing the demand for sex trafficking and prostitution) in HIV and AIDS and related RH programs.<sup>63</sup>

<sup>60</sup> Ybañez, Riza Faith, Sahlee Bugna, and Dyra Sanga. 2000. *Labor Migration and HIV/AIDS*. Kalayaan Inc. and CARAM-Asia.

<sup>61</sup> Tan Michael. L. 1998. *Sex and Sexuality*. University Center for Women's Studies, University of the Philippines, and United Nations Population Fund, Women's Health Research Consortium Project, p. 10

<sup>62</sup> National Commission on the Role of Filipino Women. 2002. *Gender Mainstreaming and Institutionalization in the Budgeting Process*. Manila.

<sup>63</sup> National Commission on the Role of Filipino Women. 2001. *Framework Plan for Women, 2001-2003*. Manila.



### III. RESULTS AND DISCUSSION

#### A. Profile of Research Participants

86. As mentioned earlier, the data used to examine the causes and manifestations of risks and vulnerabilities of female seafarers to reproductive health problems, particularly HIV infection, came from various data collection strategies – from four FGDs, nine in-depth (case study) interviews, and five KIs, mainly with policymakers and programs managers of institutions directly involved in promoting the welfare of workers in the maritime industry.

87. Except for two male officers, all those who participated in the study are females (34 in FGDs and 9 in IDIs), mostly single, belonging to the early and middle reproductive age groups (20 to 40 years old), and with tertiary or college-level education (Table A8.6). The data suggest a strong similarity of the demographic profile of female seafarers with female OFWs. They represent a good mix of young and old, single and married, and with and without college education. It must be noted, however, that the majority of the women in this study come from younger age groups, are single, and had finished tertiary schooling. All these factors greatly influence the capacity of seafarers, especially women, to access and use reproductive health information, services, and personal skills to deal with risks and vulnerabilities to HIV infection.

**Table A8.6: Characteristics of Research Participants**

Characteristics	FGDs	IDIs (Case Studies)
<b>Total number</b>	36	9
<b>Number by sex</b>	2 (male); 34 (female)	9 (female)
<b>Age</b>		
20-24	8	5
25-29	8	1
30-35	10 (9 female; 1 male)	1
36-40	7 (female)	1
41-45	1 (male)	0
46-50	1 (female)	0
51-55	0	0
56-60	1 (female)	1
<b>Civil status</b>		
Single	17 (16 female; 1 male)	8
Married	15 (14 female; 1 male)	1
Separated	1 (female)	0
Living in with partner	2 (female)	0
<b>Number of children</b>		
0	21 (20 female; 1 male)	6
1	5	1
2	7 ( 6 female; 1 male)	2
3	2 (female)	0
No answer	1 (female)	0
<b>Highest education attainment</b>		
High school graduate	3 (female)	1
Vocational	4 (female)	1
College level	10 (female)	2
College graduate	17 (15 female; 2 male)	6
No answer	2 (female)	0
<b>Occupation</b>		
Officer		
3rd Mate	0	1

Characteristics	FGDs	IDIs (Case Studies)
Chief Engr	1 (male)	0
3rd Engr	0	1
4th Engr	0	1
Electrical Engr	1 (female)	0
Chef	1 (male)	0
Security Officer	1 (female)	
Ratings		0
Cabin/room Stewardess/accommodation	9 (female)	2
Junior Waitress	2 (female)	0
Bar Stewardess	4 (female)	0
Buffet Steward	1 (female)	0
Bartender	1 (female)	0
Security Guard	4 (female)	0
Restaurant Hostess	1 (female)	0
Massage therapist	10 (female)	1
Pantry Attendant	0	1
AB	0	1
Engine Cadet	0	1
<b>Type of vessel</b>		
Passenger ship	34 (33 female; 1 male)	4
Cargo ship (bulk, carrier, tanker, etc.)	2 (1 female ; 1 male)	5
<b>Number of years of service in current position</b>		
< 1 year	3 (female)	1
1 year	9 (female)	2
2 years	0	3
3 years	4 (female)	0
4 years	2 (female)	0
5 years	3 (female)	1
6 years	1 (female)	0
11 years	1 (female)	0
12 years	2 (1 female; 1 male)	1
14 years	1 (female)	0
15 years	0	0
20 years	1 (female)	0
First timers	7 (female)	0
No answer	3 (2 female; 1 male)	0

88. The employment profile of the research participants also shows the diversity of jobs presently available to women. In general, they are jobs that are commonly perceived or stereotyped as requiring feminine skills and personality traits. These include the cleaning of cabins, bar hosting, kitchen work, and body massage. Very few females (six from non-passenger ship; one from passenger ship) are into technical and managerial positions, partly because of the low rate of women who enter and finish maritime-related college and technical courses.

89. Again, there is a mix of females who are relatively new in seafaring work and those who have been on board for many times over the years. Less than one-third (15) had either a year or less than a year of maritime work during their last contract, while seven identified themselves as “first timers.” Very few of the women (10) have worked on board cargo and passenger ships for more than five years. Comparing these data with their ages, it is apparent that most of the research participants have had previous land-based work before they opted to become seafarers. In fact, many were initially employed as hotel and restaurant personnel or in massage parlors. This trend is likely to continue because of the big gap in salary between land- and sea-based restaurants or food services, hotel, and body massage work.



## B. Sociocultural and Economic Contexts of Female Seafaring

90. Understanding the social, cultural, and economic contexts of female seafaring is important in developing measures, particularly policies and programs that can prevent labor abuses and eliminate their risks to reproductive health problems and sexual abuses.

91. **Reasons for Becoming a Female Seafarer.** When asked about their motivations or reasons for becoming a seafarer, the answers of many FGD and IDI participants had to do with a strong desire, especially of the married ones, to augment their income so that they can improve the economic condition and quality of life of their family. Those who were single spoke of their responsibility, as a surrogate parent, to send their siblings to school. Others, meanwhile, mentioned the need to give financial support to aging parents or poor relatives.

92. The married women seafarers were particularly aware of the need for them to help augment the income of their husband, even if doing so meant being away from their young and growing children.

93. It is worth noting that some of the women who had seafarer fathers and brothers discouraged them from getting into the same occupation. Melissa (not her real name), for instance, narrated that in 1993, she went with her seafarer father to a manning agency. The fleet manager was a friend of her father and asked her to apply. Her father did not allow her to do so. She waited for her father to leave for his next contract, and then returned to the manning agency to file her job application. This was how she got started as a seafarer. Edna (not her real name), for her part, was also repeatedly dissuaded by her seafarer brother from applying for a sea-based job. It was her mother who saw a television job advertisement, one morning, and encouraged her to apply. Perhaps, the resistance of males to get their female family members into seafaring is borne out of their personal knowledge of the risks and dangers to females of maritime work.

**Table A8.7: Reasons for Becoming a Seafarer (multiple responses; n=83)**

Reasons/Motivations	Frequency	
	FGD	IDI
To have a higher income and improve the economic condition and quality of life of the family.	24	4
Encouraged either by relatives, friends, classmates, and/or co-workers to apply for a seafaring job.	19	5
To be able to send children and/or siblings to school	7	0
To travel, see foreign places, and learn about other cultures	5	2
Applied for work out of curiosity; the opportunity was there	5	0
Graduate of a maritime degree	1	5
To build a house and start a business	2	0
To disprove the notion that women are not capable of becoming seafarers/Breaking stereotypes		1
Other reasons (able to come home every 8 months to be with the family compared to land-based overseas work; influenced by personal experience of seeing childhood friends who had money and chocolates because their fathers were seafarers)	3	0

94. The availability of scholarships provided by maritime institutions/schools is one of the major motivations for enrolling in maritime degrees, especially for those who have come from poor and middle class families. Five of the nine IDI participants, for instance, claimed that they finished their education from the Maritime Academy of Asia and the Pacific (MAAP) because of the scholarship that was given to them upon admission into the school. They all came from the province and were recruited by MAAP while they were about to finish high school to take the entrance examination and qualifying medical tests. Upon admission, they applied and eventually qualified for scholarship. One of them (23 years old, single, Third Mate) said that she passed the entrance examination of the University of the Philippines (UP), but opted instead to go for maritime training not only because of the scholarship provided by MAAP, but also because her family could not afford to shoulder the cost of her transportation and stay in the UP campus. Another IDI participant (22 years old, single, engine cadet) noted that being a scholar in a maritime



school is much more affordable than going to regular tertiary schools. Since they are required to stay on campus throughout the duration of their studies, her father did not have to worry about her allowance for commuting. Their stay in the dormitory, as well as the expenses for the meals and training materials, were all covered by the scholarship grant.

95. **Life Inside the Academy.** Being a female in a maritime school does not generally confer any special treatment or attention. Since very few women have, in fact, enrolled in maritime courses over the years, the curricular requirements are the same and applied uniformly to both sexes. Although some schools have instituted policies to help the female students deal with their RH concerns, like being exempted from physical drills during their menstrual period, some of the study participants said that they did not avail of such privilege. They studied and performed all the curricular requirements just as hard as their male peers. As aptly put by one of the female cadets, *“lahat ng ginagawa ang lalaki, ginagawa naming.”* (We did everything that was required of our male classmates.) The other female participants, however, said that they availed of such privilege or “special treatment” and insisted that “even if they enrolled in a male-centered educational institution, they were still female and entitled to behave like one.”

96. The daily routines in the Academy were described as being similar to those done in military schools. They woke up at about 4:30 each morning, did physical exercise, took their meals at a fixed time, went to class, strictly observed the evening study period, and went to bed. Some of the female cadets found the physical exercises, like push-ups, very strenuous at first, but through time, they claimed to have adjusted well to this and other school regulations. The school, they said, imposed sanctions or penalties on those who did not comply with the rules and daily routines. In order to prepare them for the long period of stay at sea, the students are restricted from leaving the school premises and from taking home leave. They had to overcome the feeling of being “homesick.”

97. **Reactions of Male Students to the Presence of Female Peers.** The attitudes and reactions towards the presence of female classmates by the males were varied. While some welcomed and easily adjusted to their having female classmates, others were less accepting. Such variations in male reactions to female students are best reflected in the following stories shared with the research team by the female cadets:

**From a 23-year old, single Third Mate:** *“Noong una po, noong first year kami, ano sila: “Uy babae, ganyan, special treatment yan.” Lyon ‘yong pinakamahirap na part doon noong first year kami sa MAAP. Medyo hindi pa kami okay noon, pero noong makilala na nila kami, eventually, they treated us like their own sisters. Inaalagaan nila kami. Iyong mga lalaki kasi ang tingin sa babae, hindi nila kayang mag-seaman, “hindi magtatagal iyan sa pagbabarko.” Lyon ‘yong isang factor kaya na-challenge kami. Halos lahat kaming babae ganyan. Kaya namin mag-barko. (When I was in first year, the males were initially unfriendly to us. Later, however, they started treating us like their sisters. They took care of us. But still, some of the males believed that we would not be able to hurdle the work of a seafarer. This attitude is what challenged us to study hard.)*

**From a 22-year old, single Engine Cadet:** *“Yung may meron, hindi kami pinasama.. pwedeng hindi kami sumama sa jogging, ganun. So isa yun sa mga kinaiinisan at saka kinaiinggitan ng mga kaklase naming lalaki. Na sana dapat meron din silang ganon, na sana dapat meron din silang excuse na hindi sila sasama sa mga exercise, sa mga activities na mahihirap. Kami kahit papaano, merong consideration. Yun yung mga kaano namin na, ang hirap ipaintindi sa mga lalaki. Kahit na yung iba may kapatid na babae, pero ang hirap ipaintindi. Tapos pag sabihin natin na nagkasakit ka dun, syempre maeexcuse ka sa formation, kasi may recommendation yung doktor na, hindi pwedeng sumama sa jogging or sa physical activities kasi may sakit, naiinggit sila. Tapos hindi nila naiintindihan,*



*sabi namin kahit papano, kahit pumasok kami sa mundo ng lalaki, babae pa rin kami. Yung katawan namin, babae pa rin.*" (Those who would have their menstruation were exempted from the morning exercise of jogging. This is one of the things that our male peers disliked. They envied us. They wanted to have some kind of privilege, too, for not joining the daily exercises and other strenuous activities. It was hard to make them understand our situation as women. Even those who have female siblings had difficulty understanding us. Then there were times when we would get sick and we would ask, with a doctor's certification, to be excused from the "formation." Our male classmates would be envious. They refused to understand that even if we entered a "male world," we remained physically female.)

*"...Parang naiinis sila na ganito, mundo na nga ng lalaki pinapasok ninyo tapos meron pa rin kayong special treatment."* (Our male classmates resented the fact that we were breaking into a "man's world" and were given special treatment.)

98. **Notions of Femininity and Masculinity.** Cultural beliefs and norms about femininity and masculinity, acquired in childhood and adolescent years, often influence the manner adults would shape their relationships with the same and opposite sexes. More importantly, they determine a person's capacity to protect himself or herself from sexual risks and vulnerabilities.<sup>64</sup> This study probed into the ideas about sexuality and femininity that the female seafarers acquired in early life. The Study Team wanted to find out whether such beliefs and norms can explain their current perceptions, attitudes, and behavior about gender relations. It is interesting to note that the nine case study participants who answered this question gave very similar responses.

99. Nearly all came from families that hardly talked about sexuality-related topics and issues. They claimed to have been brought up in traditional ways, "*where women should not talk openly and actively acquire information about sexual matters.*" Most of what they presently know about sexuality and reproductive health were acquired later in life from peers, through the media, and sparingly, from the classroom. Minda, for example, is a 38-year old, unmarried, cabin steward with two children. She narrated having studied in a Catholic school and spending her early life "*just staying home and going to school.*" She did not receive any form of sexual education from her parents or from her teachers. She had a boyfriend at the young age of 20, which resulted in a pregnancy. Since she was taught that having an abortion is a sin, she decided to keep the child. A few years later, she had another boyfriend who left her with a second child. Her second pregnancy happened while she was on board; she was 26 years old then. She was able to keep her pregnancy secret for six months and was able to finish her contract. She eventually broke up with the father of the child due to their differences and because he was not a good man ("*masama ang ugali*"). After giving birth to her second child, she started to use contraceptives to avoid getting pregnant.

100. Some stereotyped beliefs about gender identities and roles acquired in early life seem to have influenced the manner female seafarers deal with everyday life at sea. Some examples to bolster this observation are the following:

- Males are believed to be "naturally" polygamous. They will court their female crew mates even if they are married and have sexual relations with sex workers even while maintaining sexual relations with a female crew mate or a partner in the Philippines. This belief tends to foster a tolerant attitude among female seafarers about the sexual behavior of their partners.
- Women who are sexually abused can be blamed for what happened to them because they did not behave "properly." For example, the lack of sympathy by some female seafarers for crew members who were raped or sexually harassed, is justified by their accusation against the victim that the crime could have been prevented if the latter did not go out "drinking" with the

<sup>64</sup> An extensive discussion of constructions of sexuality by Filipino adolescent males and females and sexual risks is found in: Tan, Michael, Ma. Theresa Ujano-Batangan, and Henrietta Cabado-Espanola. 2001. *Love and Desire: Young Filipinos and Sexual Risks*. Quezon City: University of the Philippines Center for Women's Studies.



male crew mates or did not engage in “seductive” conduct. A case of sexual assault was dismissed, according to a case study participant, because of the findings of the investigators that the “woman wanted it.” The interview with Fr. Savino Bernardi, Executive Director of the Apostleship of the Sea, highlights the common perception of many, including the women themselves, about the female ideal role as “upholders of morality.” He emphasized that it is the women’s primary responsibility to protect themselves from harm by “being morally upright and by resisting all forms of temptation.”

- An experience of sexual abuse should be kept secret because it can cause shame to one’s family, especially to one’s spouse. This belief underlies the refusal of some female seafarers, who had been raped or sexually harassed, to report the offense.

### C. Perceptions of Labor Conditions and Nature of Relationships among Ship Personnel

101. The perceptions of the women who participated in this study about the condition of their work at sea varied according to the nature of their job. Those who worked as cabin stewardess of cruise vessels found their work to be so tiring and tedious since they usually work for more than 12 hours daily. The work schedule of some is from 6 AM to 2 PM. They rest for a few hours and then resume work from 6 PM to midnight. For others, the work schedule is from 6 AM to 6 PM, with a short break for lunch and rest. “Cabinists” are expected to clean between 17 to 21 rooms or cabins daily. Their workload doubles when one group of passengers docks and another group comes on board. They have to speed up their work to ensure that all the cabins are ready for occupancy once more. The period or cycle of cruising varies from 7, 14, to 21 days. For the seven- and fourteen-day cruises, the cabin stewardess gets between two to eight hours of work off.

102. The same schedule of work applies to the women assigned in the dining room, kitchen, and cocktail lounge. Although their job is not as tiring as the cabinists, they also spoke of the need to be attentive and responsive, at all times, to the many and varying demands of passengers of various nationalities and cultural backgrounds. They are always at risk, they said, of being sexually harassed or ridiculed for their conduct and looks.

103. The female cadets of cargo vessels, on the other hand, described their work not only physically, but also emotionally, demanding. They have to strictly conform to the daily work routines, regardless of being female, while having to deal emotionally with an all-male company. So as not to invite unwanted romantic or sexual attention from the male crew members, some female cadets said that they have to “dress, talk, and behave” like men. As some of the interviewees said:

**From a 23-year old, singer, Fourth Engineer:** *“Mas maganda siguro iyong hindi ka nagpapabango sa barko, hindi ka nagsa-shampoo. Kasi iyong mga lalaki pag maka-amoy ng babae, di ba ganon po sila Eh iyong mga lalaki daw pag yong makaamoy ng amoy ng babae parang iba na iyong pumapasok sa isip nila. Mas maano daw kasi sila sa babae mas madaling ma-arouse.”* (It is better not to use perfume or sweet smelling shampoo while on board to avoid attracting the men and sexually arousing them.)

*“Hindi talaga ako nagpapabango. Tapos hindi ako nagso-shorts, pants lang palagi, then T-shirt, nagli-lady sando pa ko doon sa loob. Iyong talagang wala kang ipapakita na babae ka or kung babae ka man ipakita mo pa rin na disente ka.”* (I really do not use perfume when on board. I do not wear shorts. I always wear long pants and t-shirts and even an undershirt. I have to make sure that my body is fully covered. This is how to convey the message that I am a decent woman.)

**From a 22-year old, single, Engine Cadet:** *“Hindi na ako nagshoshort, nagjojogging pants ako ng maluwag, tapos t-shirt ko puro maluluwag. Sabi nila, kaya, may instances din dun na nasabihan akong tibo. Sabi ko, ok lang masabihan akong tibo. Kasi yun nga, yung damit ko is loose, tapos yung pants ko is loose.”* (I do not wear shorts. I wear loose ones like jogging pants and t-shirts. This is the reason why I am sometimes suspected of being a lesbian.)



104. When asked to give a word that would sum up the nature of their work, many said that “life at sea for a female seafarer is boring.” One said that her life is “boring” since all she does is work for 12 hours a day and then afterwards, stay in the cabin with her husband. She sometimes participates in some recreational activities with the crew or plays video games in the cabin with her husband. Another said that life at sea is “boring” since all she does is work, sleep, and watch television in her cabin. The married women, in particular, said that they always had to deal with feelings of loneliness and homesickness when on board the ship.

105. Despite their common perception of the boring nature of their work, everyone admitted that there are ample recreational activities for both passengers and crew members. There are facilities for physical exercise, body massage, television, and film viewing as well as for listening to music and live performances. When docked in ports, the women go shopping, dine in Filipino restaurants, make long distance calls, or send internet messages to their families and friends. Alcohol drinking is a regular form of pastime especially among male crew members. According to the FGD participants, some women participate in these “drinking sessions,” sometimes done in male cabins. These are occasions, they said, when female seafarers run the risk of being raped or sexually harassed (Table A8.8).

**Table A8.8: Recreational Activities and Forms of Pastime (multiple responses; n=44)**

Responses	Frequency	
	FGDs	IDIs
<b>On board</b>		
Stays in the cabin; sleeps	8	3
Participates sometimes in activities for the crew	3	0
Plays video games /card games	1	1
Videoke	0	3
Watches TV/DVD/listen to music	4	2
Uses the internet	1	2
Goes to gym or spa	1	0
Goes to theater/disco	0	2
Hangs out with fellow Filipino crew	0	3
Goes to the gym/sports ?	0	2
<b>On shore</b>		
Hear mass	1	0
Shop	1	2
Other activities at port - eat Filipino food, internet, call families in the Philippines, visit seaman’s center, etc.	0	3

106. The common health problems encountered at sea include seasickness, diarrhea because of unclean drinking water, and allergies caused by the “sea water and condition of the cabin.” Some also mentioned developing gastric ulcers and acquiring such infectious diseases as tonsillitis, colds, and flu. Being infected by these ailments does not excuse the crew from performing their duties. As one FGD participant said, “*Dun kasi may sakit ka o wala, kailangang magtrabaho.*” (You have to work even when sick.) Another participant said that if a person is still sick after three days of medication on board, she or he will have to be sent back home.

107. Those who participated in the IDIs complained about the worsening labor condition of seafarers. Compared to their situation years back, they said that the quality of food on board now is so poor, especially when compared to what is served to passengers. In the past, the uniforms of the cabin stewardess were paid for by their employer. Now, they have to cover this expense, including their return flight to the Philippines. Given the passage by international maritime regulatory organizations of more safety and security measures, they have to attend more training programs and medical tests that require more expenses on their part.

108. Work relations among Filipinos are generally cordial. A few, however, mentioned the tendency of some, especially the males, to spread rumors about the conduct or behavior of their female peers.





Massage therapists, for example, are often rumored and believed to be engaged in prostitution. As an FGD participant said: “*They think we give extra services. We really don’t do that. We are really scared if (name of ship captain) finds out. And I do not want to do it.*” Another female FGD participant admitted that “*rumors are our biggest problem.*” She added:

*Tsismis talaga ang pinaka problema dun. Unang beses ko lumabas, may kasama akong Pilipino din. Nagpunta kami sa crew bar. Tapos pag-uwi namin magboyfriend na kami. Pilipino din ang nagtsismis nun. (Gossip is the main problem there. The first time I went to the crew bar, I was with a male crew member. Right after we left, we were already accused of being together. It was another Filipino who spread the rumor.)*

#### D. Other Gender Issues

109. Numerous gender issues were mentioned by both the ship officers and ratings who participated in this research. They claimed that the generally masculine or male-centered nature of work on board cargo and passenger vessels make it extremely difficult for women to perform their work. The lack of gender-sensitive provisions in most international policy guidelines for maritime service, including the *Maritime Labour Convention of 2006*, is a major barrier, some argued, to protecting women seafarers from safety and security issues brought about by their biological needs and social characteristics.

110. Among female ship officers, the most serious problem is their lack of female company on board cargo vessels. It is the usual practice at present to have just one or two female cadets in a cargo vessel consisting of some 30 personnel. This practice or arrangement exposes women to the dangers of rape, sexual harassment, and sexual assault. They have to behave in a masculine manner in order to deflect the sexual advances of male crew members.

111. Moreover, the females interviewed for this study claimed that there is no toilet for the exclusive use of females (outside their cabins) in cargo vessels. Maritime industry leaders and policymakers noted that it would be very difficult to advocate for this facility because of its cost implications and possible negative effect, they claimed, on the “physical stability” of the ship. Ship owners, they said, would surely go against any proposal to install a toilet specifically for females considering the potential loss of income for doing it and the fact that the number of females entering maritime education has not increased over the years.

112. Moreover, women cadets wear the same kind of uniform worn by the males when working in the boiler room or the section where the ship engines are located. The uniform has big openings on the side of the body, thereby exposing the hips and legs of the women who wear it. To remedy this situation, the female cadets have to wear additional clothing underneath this uniform, thus causing so much physical discomfort.

113. In non-passenger vessels, the females have to endure the negative attitude of male co-workers. They would sometimes receive snide remarks or criticisms about their failure to perform at par with the male crew members. Other male crew members would refuse to follow the instructions given by their female officers.

**From a 22-year old, single Engine Cadet:** “*Hindi nila ako matanggap nung una, kasi sabi nila, ang mundo ng seaman, panlalaki lang talaga...Hindi ganun kaganda yung pag-ano nila sa akin, pagwelcome... parang inoobserbahan nila, ‘kakayanin kaya nitong batang to?’ Ang dami na nilang experience sa pagbabarko. Tapos, pag may konti ka lang pagkakamali, iki-criticize ka nila talaga, sasabihin sabi sa iyo e, ‘ang hirap ng buhay dito.’ Parang idi-discourage ka nila. Pero may mga instances na tutulungan ka naman nila, pero hindi ganun ka-close. Unlike yung mga ka-age ko lang or yung mga malalapit lang ang age sa akin,*



*kesa yung mga matatanda mas iba.” (The men could not accept me at first. They would say that I intruded into their world. They did not treat me well. They observed whether I could perform the tasks assigned to me. I would be criticized for minor infractions. It is as if they wanted to discourage me from continuing with my work. But there were times too, when they would help me. The males who were of my age were more accepting than the older ones.)*

**From a 23-year old, single Third Mate:** *“Third Mate na kami minsan mapifeel mo na nadi-discrimanate ka kasi babae ka. Iyong iba kasi, tulad ko fresh graduate, 2 years as seafarer. Iyong iba doon 10 years nang nagsi-seaman and then mas mababa iyong ranggo sa akin. Hindi lang ako ang nakakaramdam. Pati iyong ibang taga-MAAP din kasi officers na din sila. Pero naha-handle na lang namin. (Even if I am a Third Mate, an officer, I sometimes feel being discriminated against for being a female. I am especially resented by lower ranking and longer staying male seafarers. Other female officers (from MAAP) also go through this experience. We just try to cope.)*

*“Sa decision-making pagdating sa barko, kasi deck ako, so iiwas-iwas. May mga times na mag-uutos ka tapos magsa-suggest siya na ‘Third baka pwedeng ganito.’ Magalang naman pero ang sa akin, I’m the officer, kung may mabulilyaso sa barko, ako iyong maa-ano, so ako talaga iyong masusunod. Nagsa-suggest siya pero sinasabi ko, ‘hindi mas maganda na lang iyong ganito.’ Hina-handle ko naman siya nang maayos na kukuhanin ko iyong opinion niya para lang hindi siya mapahiya, ‘o sige, maganda nga iyong ganyan.’ (There are times when my orders are defied because I am an officer. The males would try to insist on their point of view and ways of doing things. I try to be diplomatic and accommodate their suggestions so as not to embarrass them.)*

**From a 23-year old, single Fourth Engineer:** *Parang naawa sila “anong nangyari sa ‘yo?’ Kasi pag may nakita silang babaeng umiiyak, ano na agad. Pero sa atin naman kasi umiiyak talaga tayo pagka sobrang galit, sobrang saya, ganon tayo. Sa kanila hindi. Iyon lang misinterpretation lang.” (The male seafarers easily take pity on the females they see crying. But they do not know that we women cry when we are happy or sad or angry.)*

114. The females in passenger vessels, on the other hand, talked about their long hours of work (10-14 hours a day) to complete the tasks of cleaning the cabin or serving in the cocktail lounges and dining rooms. Because of fear of being rumored or talked about as having romantic or sexual relations with co-workers, many restrict their movements and opt to stay in their cabins during “off-duty” periods. They would lock their rooms at night and remove the telephone from the hook to avoid unwanted calls from passengers and crew members.

115. The other gender issues mentioned by the women seafarers include the following:

- Risk of cabin female attendants being raped or sexually harassed by male passengers, especially when they are drunk.
- Female security guards find it difficult, sometimes, to pacify drunk or unruly passengers. The common perception that females are weak makes it difficult for them to enforce ship regulations. Their physical safety is especially compromised when there are brawls or fights among male passengers. A female security guard narrated in one of the FGDs that, *“it is sometimes difficult to handle fights among passengers. We respond to the situation and we sometimes get hurt. There are about 3,500 passengers and 1,000 crew members and there are only 13 security guards in the ship.”* The typical perception that women belong to the weaker sex perhaps explain why passengers do not often heed the call of female security

guards to stop their brawl or fight. This explanation is offered by a male officer who said that male security officers are better able to enforce peace and order especially among cruise passengers.

- Some ship officials “court” or ask for “sexual favors” with the female employees, especially the bar attendants and cabin stewardess. When they are rebuffed or rejected, they hit back by giving the latter “a hard time.”
- Some ships or principals strictly enforce the termination of contract and immediate return to the country of a female employee once she is found pregnant. However, the male crew member who got her pregnant is not equally sanctioned.
- Boyfriends of female seafarers sometimes engage in multiple and simultaneous sexual relations and this is reason, they said, why women can get infected with STIs, including HIV. Male seafarers would often go out “on a binge” with their male crew mates whenever their ship is docked, especially in ports located in East and Southeast Asia, and have relations with unprotected sex workers.

116. Some of the research participants argued that, indeed, “*there is no safe place in the ship for women.*” As Nene said, “*lahat ng place dun, hindi ka safe, kahit kabina mo, hindi ka safe.*” (All the places in a ship are not safe. You are not safe even in your own cabin.) Drinking alcohol with male crew members, especially when done in their cabins, poses the greatest risk for female seafarers. One said that whenever this happens, it is most likely that the women will not be able to return to their own cabins afterwards, alluding to the fact that consensual or forced sexual relations will most likely happen.

**Box 1: Narratives of Sexual Abuse and Related Experiences from FGDs (not real names)**

Lenny: *I have heard of a male manager who likes this particular girl so he keeps sexually harassing her.*  
 Donna: *There are managers who ask for sexual favors.*  
 Lita: *Sometimes the passengers ask for extra services (sexual services) so you have to be strong to stop it and report the incident right away.*  
 Marita: *I had an experience before where a male guest asked for a “hand massage/job” but I resisted. I reported the incident to my manager. Good thing the guest did not insist. The guest gave me a tip of 500 dollars. My manager then accused me of doing the hand job.*  
 Digna: *Someone would call me in my cabin and say, “I wanna have sex with you and I will pay you.”*  
 Rowena: *A 70-year old Australian passenger made a suggestive remark to a female seafarer. The man said to his friend while in front of the female seafarer that one would know if a woman has already given birth by looking at her bum. When the female seafarer passed by the Australian, he whistled and stared at her bum. He did this for about ten times.*  
 Marie: *A Filipino official once asked a stewardess to go to his cabin and give him a massage. The stewardess was sexually harassed and she filed a complaint against him. The manager was sent home.*  
 Cynthia: *Women are prone to sexual harassment. In our case, we are security guards. If the captains like us and want us to be their girlfriend and we reject them, they give us a hard time. The Chief assigns all the heavy work to us until we give up. Many women give in to avoid being given a hard time.*

117. Many FGD participants recalled previous cases of rape, gang rape, and sexual harassment. In many instances, the victims, they said, did not file a complaint because of shame and fear that they would tarnish the reputation of their husband or boyfriend. Others feared the emotional burden of having to live with the knowledge that once a complaint is filed, everyone in the ship would know and talk about the case. As an FGD participant noted:

*“Minsan kasi pag babae ka, pag may naiwanan ka rito sa Pilipinas, minsan di sila magsusumbong kasi yung kahihyaan ang iniisip nila. Kasi pag may nangyaring ganun, buong fleet, buong barko alam na yun eh. Kaya kung mahina-hina ka, di ka na lang magsusumbong, tatahimik ka na lang.”* (When you are a woman and you have a boyfriend or a husband in the Philippines, you will not file a complaint when someone sexually abuses

you because you are concerned about causing shame to your partner. Once a woman files a complaint, the entire fleet or ship would know about it. So if you are not strong-willed, you will just keep quiet.)

118. However, the other research participants insisted that there are adequate policies on board that now protect female workers from rape and sexual harassment. There are procedures and mechanisms now imposed especially by Western or Europe-based principals to ensure the prevention and speedy resolution of gender-related issues like sexual harassment and sexual assault. Other FGD participants also underscored the importance of self-discipline and determination not to engage in risky sexual behavior or not to predispose oneself to situations that will make them vulnerable to romantic or sexual assault. As Mina noted, *“They (referring to abusers) cannot do anything to you against your will since security measures and officers are present.”* Many principals now enforce strict rules on alcohol drinking. They regulate the time and amount of alcohol drinking, thereby reducing the incidents of fights and risky sexual behaviors.

### Box 2: Women’s Expressions of Strength and Resilience from FGDs

- *“Kailangang malakas ka talaga.”* (You just have to be strong.)
- *“Kailangan alam mo kung paano umescape.”* (You should know how to escape.)
- *“Sasabihin ko may camera kahit wala.”* (I tell them there is a camera even if there is none.)
- *“Hindi na training ma’am (ang kailangan) kasi kung massage therapist, alam na ang weak points (ng sexual abuser).”* (We do not need training because as massage therapists, we already know where the weak points of the potential abuse.)
- *“Alam mo dapat sa sarili mo na kaya mong protektahan ang sarili mo.”* (You just have to assure yourself that you can protect yourself.)
- *“Kailangan lang alam mo ang mga polisiya.”* (You just have to know the policies.)

119. Other than those already mentioned in the earlier sections of this report, like wearing male clothes and not using perfumed hair shampoo, female seafarers devise various strategies to avoid being sexually abused. Some carry a teargas whenever they are out of their cabin while others lock their cabins at night and devise and install an alarm system in their cabin door.

### E. Unmet Reproductive Health Needs

120. Because of their youth, the female seafarers perceived themselves to be generally healthy. The health problems they experienced on board included common diseases like flu and tonsillitis, seasickness, and painful/irregular menstruation. Others mentioned being inflicted with allergies, diarrhea, or having suffered from hair loss due to the poor quality of water used for bathing or washing parts of the body.

121. Majority of the FGD participants complained about the lack of regular access to reproductive health information and services. In terms of health and medical services, they mentioned the following issues:

- Difficulty in communicating with the medical personnel due to language barriers. Some said that *“there are no Filipino doctors on board to understand our health concerns.”* Others claimed that sometimes, the doctors prescribe the wrong medicine.
- Health and medical service providers do not give reproductive health information like how to prevent pregnancy, when to go for STI tests, or what to do when one has painful menstruation.
- The clinic is open for a limited period of time only during the day.
- Tests and medication for STIs and other RH problems are not provided by some principals.

- Only condoms are given for free to the crew members. In some ships, the women are given only one packet of contraceptive pills. They have to purchase the rest. In other ships, however, either no pills are given for free or all pills are free.

122. **Out of the 34 female FGD participants, three personally experienced being pregnant while on board. Five said that they knew of others who became pregnant while on board, and two of them were immediately sent back home when the ship captain learned of their condition. Three of the research participants also said that they had female crew mates who had an abortion.**

123. **Six of the female FGD participants and one of the in-depth interviewees said that they have been using contraceptive pills, while the others have been using condoms (2) and natural family planning methods (2).**

124. Numerous RH issues were mentioned by the FGD, KII, and IDI participants, including unwanted pregnancies, abortion and abortion complications, and STIs. Having an abortion is allegedly resorted to by women who had their pregnancy outside of marriage. This is usually done when the ship docks in ports of countries where abortion service is legal and available. Otherwise, it is done clandestinely with the use of abortifacients and unsafe methods of pregnancy termination. A participant of the 4<sup>th</sup> FGD mentioned that he once heard of a co-worker who had an abortion. A male co-worker and a close friend of hers recommended the use of an abortifacient. He bought the medicine for her. The woman took it and subsequently had the fetus aborted. After a month, she decided to return to the Philippines. Another FGD participant narrated a case of abortion complications. The woman had to be airlifted and taken to a hospital in New Orleans because she lost consciousness and was bleeding profusely.

#### **F. Extent of Awareness about Reproductive Health Matters**

125. It is disturbing to note, for instance, that when the Study Team asked some questions to assess the extent of knowledge of the FGD participants about human sexuality, very few were able to give correct answers. Many were not aware of the ovulation cycle or when it is safe or unsafe for a woman to have sexual intercourse. Others did not know the causes and symptoms of STIs or how they can be prevented. The low level of awareness, especially of the young females, points to the urgent need to integrate sexuality education, not only HIV-related information, into school curricula and pre-departure training programs.

126. Perhaps because most of the FGD and IDI participants are relatively young and new in the seafaring industry, many had very limited knowledge about STIs, including HIV and AIDS. While some said that they really did not know much about the nature and cause of HIV infection, others linked the disease to “having sexual intercourse with women in prostitution,” “having multiple sexual partners,” “not using condom,” and “not being hygienic.” A few described the symptoms of HIV infection as “losing weight, feeling weak, and getting easily tired.”

127. Adherence to beliefs like washing oneself thoroughly after having sex to prevent HIV infection underscores the need to step up current efforts to improve the access of female seafarers to RH information and services. Nonetheless, some of the women also claimed that the best measures against STIs are monogamy, fidelity, and “self-control.” Others mentioned praying, masturbation, “phone sex with husband,” and frequent communication with loved ones back home as ways to cope with sexual urges and to prevent having sexual relations with a crew mate. The thought of taking a blood test again for contract renewal purposes, is what keeps the others from engaging in unsafe sexual practices.

128. The research participants mentioned the following as their sources of information about STIs and HIV: (i) school; (ii) pre-departure orientation, from IEC materials given by the manning agencies and principals; and (iii) from on-board seminars given by the ship doctor.



129. The common perception of those who participated in this study is that there is widespread use of modern and natural methods of preventing pregnancy among sexually active female seafarers, regardless of civil status. These include the pills, “injectable,” ligation, withdrawal, and condom use. Some, however, admitted a dislike for condom use for the main reason that “it lessens the sense of pleasure,” of either the female or the male partner. Two FGD participants, in fact, said that they would ask their partners not to use condoms so that they could better enjoy the sexual contact. One participant admitted that she does not know how to use condom. Some of the women called for more vigorous campaign to encourage males to use condoms. They said that some men do not like to use condoms and therefore get frequently infected with STIs.

130. On the other hand, those who prefer natural methods of birth control, like withdrawal, are afraid of the possible ill effects of modern contraceptives on their health. For example, the use of pills by single females is believed to cause the thinning of the uterus and the subsequent inability to become pregnant once they marry and decide to have children. One said that she would combine the use of withdrawal with prayers and massage of the abdomen to prevent being pregnant.

### G. Factors that Predispose and Protect Women Seafarers from HIV Infection

131. Other than the risk of being possibly raped or subjected to forced sexual relations on board, another factor that predisposes women to HIV infection is the accepting attitude of some to the “polygamous” nature of males and to the inevitability of being attracted to a co-worker presumably due to the “nature of life at sea.” Female seafarers, in fact, generally take a pragmatic view of sexuality and reproductive health issues. Many consider it “normal” and inevitable that crew members will get romantically and sexually involved with each other regardless of their civil status. Being at sea for long periods of time and away from their husband or boyfriend predisposes some of the women to enter into a sexual partnership with a ship mate. Such accepting attitude towards having a sexual partner on board was justified by some research participants in the following manner:

- *“Kasi para sa akin, mas maganda magkaroon ng karelasyon dun, pampabilis ng panahon.”* (For me, it is good to have a romantic/sexual relationship because it helps you forget the time spent on board.)
- *“May inspirasyon, mawala ang lungkot mo.”* (Having a sexual/romantic partner can inspire you to work better and helps ease the loneliness.)
- *“Ako aminado, married yun pero pag uwi dito, wala na.”* (I admit that my boyfriend on board is married, but our relationship ended as soon as we returned home.)
- *“Sa barko kasi, madali lang makipag boyfriend lalo na kung lagi kayong gumigimik.”* (It is really easy to find a boyfriend on board especially if you always go out and have fun with your crew mates.)
- *“Pang-alis ng stress. Talagang nahuhulog po talaga dun, kasi wala naman pong magbabawal sa iyo e, tapos kabina, sarili nyo pa yung kabina. Wala namang pakialaman yung mga tao dun e. Depende talaga sa ‘yo kung bibigay ka o hindi, kasi ikaw ang kawawa.”* (I engage in sexual relationships to reduce emotional stress. It is easy to have a romantic or sexual relationship on board because there are no restrictions there, and no one pays attention to what you do.)
- *“Kasi syempre, minsan wala kang kausap, di ba. Mga barkada ko meron ding mga ka-relationship, kumbaga, parang naano ka na rin. Para ka namang mukhang tanga, makikijoin ka sa kanila di ba?”* (I get into sexual relations out of loneliness. My peers are into it as well so you would look stupid if you don’t go along with them.)

132. Those who are married or who have a relationship with another seafarer accept the fact that their husband or boyfriend can have relations with other women or men on board too. What they usually do,



they said, is just to admonish their partner to observe safer sex. As mentioned earlier, there are women who like and do not like the use of condom. The latter are, therefore, at greater risk of contracting STIs, especially HIV. Nonetheless, some said that they try to minimize the risk by having regular medical check-ups, including HIV blood testing. However, the women don't subject themselves to voluntary testing. The medical check-up they go through is one of the requirements before going on board. The participants said that they know that they don't have HIV or STI because the result of the medical exam said, "*fit to work*." Others said that they pressure their partners to stay monogamous and submit to blood testing.

## H. Policy and Institutional Initiatives to Promote the Gender Responsiveness of the Maritime Industry

133. In addition to the collection of qualitative data on the risks and vulnerabilities of female seafarers to HIV infection, the Study Team also interviewed key personnel of organizations charged with policy development and enforcement in the shipping industry. This was meant to assess the extent to which these organizations have helped and promoted the safety and security of female seafarers.

### 1. The *International Maritime Convention of 2006* and Related International Instruments for the Protection of Seafarers

134. The International Labor Organization (ILO) adopted the *International Maritime Convention in 2006*, and is presently regarded as the "bill of rights" for maritime workers worldwide. It provides the standards and rules for the workers, employers, and governments involved in the shipping industry. The Convention particularly sets out the rights to decent conditions of work for the more than 1.2 million seafarers today through the consolidation and updating of more than 65 international labor standards over the last 80 years.<sup>65</sup>

135. The provisions of the Convention include the conditions of employment, accommodation, recreational facilities, food and catering, health protection, medical care, welfare, and social security protection. Except for the rule on maternity leave benefit, all the entitlements of workers are the same for both males and females. The language of the Convention is very gender-neutral, thereby ignoring the differing needs and capacities of the sexes to perform their roles and responsibilities. Other reproductive health concerns of female seafarers include their need for regular access to sexuality information and medical services relating to pregnancy-related problems and other reproductive health concerns.

136. The occurrence of various discriminatory practices against women workers shown by this study underscores the need for a comprehensive gender analysis of the Convention. The conditions of employment, for example, must include guidelines that can prevent the occurrence of gender-based abuses and violations. The provisions that define the enforcement mechanisms at all levels must be strengthened to include gender-sensitive guidelines on the investigation and management of cases like rape, gang rape, and sexual harassment.

### 2. The International Maritime Organization (IMO)<sup>66</sup>

137. IMO is a specialized agency of the United Nations with 168 Member States and three Associate members. It was established, through the passage of an international convention adopted in Geneva 1948, "*to develop and maintain a comprehensive regulatory framework for shipping and its remit today includes safety, environmental concerns, legal matters, technical cooperation, maritime security, and the*

<sup>65</sup> *The Maritime Labour Convention*, [http://www.ilo.org/global/What\\_we\\_do/International\\_Labour\\_Standards](http://www.ilo.org/global/What_we_do/International_Labour_Standards)., accessed 10 December 2008.

<sup>66</sup> The bulk of data in this section of the report came from the website of IMO and from the interview with Atty. Brenda Pimentel, IMO Regional (Asia) Coordinator of IMO. Supplementary information about gender equality programs of the shipping industry was sourced from the website of the Women's Maritime Association.



*efficiency of shipping.*<sup>67</sup> In its 60 years of existence, IMO has endeavored to enforce safety and security standards in shipping mainly through policy and program advocacy. IMO presently implements various programs to enhance<sup>68</sup> the compliance of State parties to agreed standards that aim to prevent accidents and impose regulations for ship design, construction, equipment, operation, and manning. In recent years, IMO has also passed international agreements for the prevention of pollution by ships and standards of training for seafarers and on rules concerning distress and safety communications, search and rescue, as well as oil pollution preparedness, response, and cooperation.

138. In 2005, IMO committed to pursue the UN Millennium Development Goals “*not just in terms of the service it provides to the maritime community itself, but also in the wider context of the international agenda set by the United Nations, and in particular by (addressing) the special maritime needs of Africa.*”<sup>69</sup>

139. Over the years, IMO has implemented various programs to enhance the entry and participation of women in the shipping industry. In 1988, it implemented the first strategy plan for the integration of women in the maritime sector. This was followed by the 1997 action program for achieving the UN commitment to gender equity and development. At present, IMO promotes the MDG goal of gender equality through support for short-term fellowships, and “*knowledge sharing through the establishment of formal regional associations for women in the port and maritime sectors.*”<sup>70</sup>

140. The most recent and direct support to the maritime industry of the Philippines by the IMO Regional Office was the establishment, in 2007, of the Women in Maritime Philippines (WIMAPHIL), which aims to enhance the participation of women in the maritime industry through policy advocacy and training. It collaborated with UNAIDS Philippines a few years back in organizing seminars on HIV and AIDS for women seafarers.<sup>71</sup> One of its current programs is to encourage females to enroll in maritime education.

141. According to Atty. Brenda Pimentel, IMO Regional Coordinator, it may be very difficult to convince ship owners to adopt special measures for female seafarers like designating a comfort room in cargo vessels for their sole use because of the cost implications and the possibility that the ship will not even hire a female cadet in the future. She noted a decline in number of women entering maritime schools. Atty. Pimentel also observed that there are manning agencies now which refuse to hire female seafarers because of the additional cost of paying the maternity leave benefits and the return flight to the Philippines in case they are found pregnant while on board.

### 3. The Maritime Training Council (MTC)<sup>72</sup>

142. MTC was established on 1 May 1984 to pursue the Philippines' commitments to IMO's 1978 *Convention on Standards of Training, Certification, and Watchkeeping for Seafarers (STCW '78)*. Amended in 1995, the Convention is now more commonly called as STCW '95. On 11 January 1984, the Philippines submitted its Instrument of Accession to the Convention to IMO.

143. The Council is attached to the Department of Labor and Employment (DOLE) for administrative and policy supervision. It is headed by the DOLE Secretary who acts as Chairperson and is composed of

<sup>67</sup> “Introduction to IMO.” [http://www.imo.org/About/mainframe.asp?topic\\_id=3](http://www.imo.org/About/mainframe.asp?topic_id=3).

<sup>68</sup> Inspection and monitoring of compliance are the responsibility of member States. However, IMO has promoted the use of the Voluntary IMO Member State Audit Scheme to ensure the implementation of international agreements and covenants.

<sup>69</sup> IMO.n.d. *Technical Co-operation: IMO's Response to the 2005 World Summit*.

<sup>70</sup> *Ibid.*

<sup>71</sup> From the interview with Ms. Carla Limcaoco, President of WIMAPHIL.

<sup>72</sup> The data in this section of the report came mainly from the MTC website and from the interview with MTC Acting Executive Director and Head of the Maritime Office of DOLE, Mr. Noriel P. Devanadera.





the following member-organizations: Maritime Industry Authority (MARINA), Philippine Coast Guard (PCG), Bureau of Higher Education (now the Commission on Higher Education [CHED]), POEA, Welfare Fund Administration (now the Overseas Workers Welfare Administration [OWWA]), and Professional Regulation Commission (PRC). A representative from the private sector (one each from maritime employers and seafarers, respectively) also sits on the Council. A Secretariat, headed by an Executive Director, assisted by a deputy, handles the day-to-day operation of MTC.

144. The functions of MTC, as prescribed in Letter of Instructions (LOI) No. 1404 are as follows:

- Develop, formulate, and prescribe standards of training for seafarers as prescribed by the Convention;
- Issue certificates of proficiency or competency to seamen who meet the training requirements of the Convention;
- Assist the Ministry of Education, Culture, and Sports (now the Department of Education) in regulating and supervising the establishment and operation of seamen training centers throughout the country;
- Liaise and coordinate with international organizations, particularly with IMO, as regards the training, upgrading, and qualifying of seafarers;
- Formulate rules and regulations to implement the STCW of 1978 and to attain the objectives of LOI 1404;
- Prescribe and collect fees from the seamen training centers subject to clearance by the National Tax Research Center (NTRC) and to be remitted to and will constitute part of the Seafarers Welfare and Fund;
- Undertake special programs/projects in furtherance of the objectives of training and upgrading of seafarers; and
- Study, evaluate, and recommend to the Ministry of Education, Culture, and Sports the number and maximum enrolment of nautical schools to ensure that the graduates will have reasonable opportunity to be employed aboard ship after their graduation.

145. In subsequent years, the composition and functions of MTC were expanded to enhance its capacity to respond to the emerging challenges to human resource development of the shipping industry as well as the fast changes in the global economy and physical environment. In 1997, Executive Order (EO) No. 396 was issued, "*Providing for the Institutional Framework for the Administration of Standards of Training, Certification, and Watchkeeping for Seafarers in the Philippines.*" This was followed in 1999 by Executive Order 149 creating under the MTC an Executive Committee headed by MARINA to assist the Council in its policy-making task. Included in the Committee are regular council members and the DOH and the National Telecommunications Commission (NTC). In 2002, another administrative policy was passed, expanding the membership of the Council to include DFA and the Office of the President (OP). The Council's functions were also expanded to include the following, among others:

- Ensure that all legal and administrative measures taken and provided by the concerned government agencies and instrumentalities are appropriate and compliant to the Convention, as amended;
- Ensure that the evaluation of the quality standards of the government instrumentalities involved in the administration of the certification system, training courses and programs, and examination and assessment carried out by or under the authority of the government instrumentality concerned, including the qualification of instructors and assessors, are conducted in accordance with Paragraph 2 of Regulation I/8 of the Convention, as amended;
- Be responsible to other State Parties with respect to the Philippine compliance to the Convention, as amended, including compliance with Regulation I/10; and



- Communicate to the IMO information required under Regulation I/7 of the Convention, as amended.

146. According to Mr. Noriel Devanadera, MTC Executive Director, the Council does not have any policy guideline, coordination mechanism, and program to promote gender equality and address the gender issues in the maritime industry. He noted the “very insignificant” number of females in the industry as the possible explanation for the lack of attention to the needs and concerns of the female workers. It is a policy of the Council, he said, not to make any distinction between women and men. The competency standards apply equally to both sexes. He also noted that all the members of the Council, like CHED, ensure that their policies and programs do not discriminate against women. Director Devanadera, however, favored the protectionist policies for women of the industry. He said that “*there is a natural disadvantage for women to do commercial vessel work... especially when they marry and get pregnant and when they experience some reproductive ailments.*” He added that this is the reason why many female graduates of maritime education have opted for land-based jobs.

147. Numerous ships are now being built, and would start operating starting in 2012. Since the Philippines is among the top suppliers of maritime labor, the Council has focused its work on organizing job fairs across the country and facilitating the provision of incentives by schools and principals for those interested to enroll in maritime-related courses. MTC has also promoted the development of a “bridging course” program where certification tests can be taken by students after passing short-term, intensive courses.

148. **Gender in Maritime Education.** The 2003 study published by the Seafarers International Research Center (SIRC)<sup>73</sup> described the results of two surveys conducted worldwide of how ratings and women are trained for jobs at sea. The surveys revealed the serious shortcomings of the training of women for seafaring skills. They include the finding that “*out of 17 marine training institutions surveyed, only 10% of the 6,500 trainee seafarers were women, and only four of the institutions had an equal opportunity policy.*” Moreover, the studies found that there were instances of fraudulent certification and improper issuance of watchkeeping certificates, which had undermined efforts to maintain the highest competency standards of human resources.

149. In the Philippines, there are about 90 schools recognized by CHED, which offer tertiary-level courses in maritime work, such as bachelors degrees in marine transportation and marine engineering. A cursory review of their curricular programs shows that, while there is adequate credit unit allocation for general education courses (e.g., 56 units out of 140 units), there is very limited emphasis on the sociological and cultural aspects or dimensions of seafaring. These topics are very important for students to learn, given the complex social, health, and economic issues that confront the seafaring industry. Only three units, in fact, of social science are offered, which is a course on general psychology, with inputs on alcohol and drug prevention, STD, HIV, and AIDS prevention (Table A8.8). When asked about where they learned about human sexuality and reproductive health knowledge, the FGD participants, especially the cadets, could hardly recall what was taught to them in school.

**Table A8.8: Summary of Total Number of Units of the BS Marine Transportation Curriculum**

Courses	Lecture Hours	Laboratory Hours	Credit Units
General Education Courses	52	12	56
Core/Professional Courses	54	48	70
Non-Academic Courses	0	8	(14)
Sub-total	106	68	140
Shipboard Training	1 year	-----	40
<b>Total Credit Units</b>			<b>180</b>

<sup>73</sup> <http://www.itfseafarers.org/resistance.cfm>. accessed July 21, 2008.



150. Schools for seafaring in the country generally accept female students. For example, the MAAP has been recruiting female students since its establishment in 1998. According to its President, Vice-Admiral Eduardo Santos, the Academy “believes in gender equality – women could become good officers like men, and this has been the mission of MAAP – to develop excellent officers, men and women alike.” The Academy has instituted policies against discrimination on the basis of race, sex, color, religion, regional origin, age or handicap, and against sexual harassment and sexual misconduct. It has created mechanisms for the filing and investigation complaints, as well as clear guidelines for demerits/suspension/expulsion due to such prohibited acts as alcohol drinking, gambling, use of firearms, hazing, marriage (during the duration of the training), and contracting STIs.

151. Female students have their separate living quarters or dormitory, and there are restrictions on the entry of males into this area. The same policy holds true for the entry of females into the male dormitory.

152. While the Academy gives special treatment to women based on biological considerations, like exemption from training during menstrual period, such policy is not acceptable to the female students themselves. As Vice Admiral Santos said, “women within the academy are competitive and disdain special treatment...”

#### IV. CONCLUSIONS AND RECOMMENDATIONS

153. Results of the literature review showed that despite many policy and program constraints and weaknesses, the Philippines responded early to contain the rise and spread of HIV. The most daunting challenge at the moment, therefore, is to sustain current initiatives, replicate the good practices, and, most importantly, contain the spread of the infection. **There are a number of promising approaches that need to be pursued.** These are the (i) full integration of the gender equality and reproductive rights approach into the HIV and AIDS national plans and monitoring system; (ii) mainstreaming of HIV and AIDS into the framework of poverty reduction; (iii) strengthening and/or development of appropriate policies and programs to protect the reproductive health and reduce the risks to HIV and AIDS of overseas workers, especially female domestic workers, health service providers, entertainers, and seafarers; (iv) giving special attention to sexuality and reproductive health needs and concerns of adolescents and young people and, most significantly, (v) provision of adequate treatment, care, and support for PLHIV.

154. Of late, many multilateral development organizations have strongly advocated for the use of the human rights approach to development work. This study strongly endorses the adoption of such a framework in protecting and promoting the status of females in the seafaring industry. In particular, **there is a need to strengthen the integration of the gender equality and human rights principles into policies and programs on HIV and AIDS prevention and control.** There is a dearth of information about the gender dimensions of seafaring.

155. DOH, in 2002, passed a policy mandating all health services throughout the country to provide adolescent and youth health service programs that include sexuality and reproductive health counseling and access to appropriate medical care and services. This has led to the establishment of community-based Teen Centers in some provinces and cities across the country. With good practices drawn from the experiences of NGOs that pilot-tested various education, counseling, and organizing programs for adolescents, it is hoped that these **Teen Centers would eventually provide the services adolescents and young people so badly need to develop appropriate health-seeking behavior and promote their sexual health.** It is important as well that tertiary education and technology training, particularly the maritime schools comply with existing government policies about the integration of HIV and AIDS information into their curricula.

156. A policy paper prepared by the emerging Social Issues Division of UN-ESCAP made several recommendations to ensure that the current HIV and AIDS programs in various countries are sensitive and responsive to the needs of women. **It is important that these recommendations are implemented at once.** They include such measures as the provision of information and counseling about reproductive



and sexual health, strict enforcement of labor laws, and provision of guidelines to prevent sexual and physical abuse – one of the major determinants of women’s inability to protect themselves from STIs.

157. While the Philippines has indeed managed to control the rise and spread of HIV during the past two decades, it has to double its efforts in the coming years to ensure that the figures do not increase dramatically, and that the negative impacts of the infection are negligible. This should be done through continuous advocacy and capacity training and by expanding the prevention framework to include gender, sexuality, and reproductive rights issues and principles. **More importantly, there is a need to strengthen support for overseas workers and pay attention to the sexual and reproductive health of adolescents and young people.**

158. The results of this study indicate the presence **in the shipping industry of many gender issues that make women more vulnerable to abuse and RH problems**, compared to their peers in land-based work. Work-related gender biases, such as the lack of a toilet for females in cargo vessels, and the “gender neutral” language of labor, safety, and security policies all ignore the special needs of women due to their different biological functions and characteristics.

159. The study found that, while some principals or ship owners have very strict rules governing interpersonal relations between passengers (in cruise vessels) and ship personnel, and among the crew members themselves, there are also those which hardly enforce rules on code of employee conduct. In most cases, health and medical benefits are not sensitive to the reproductive health needs of women. Some manning agencies and principals do not provide regular services for pregnancy tests, STI testing, and treatment. There is a wide variation, as well, in the current capacity of principals and manning agencies to raise the awareness of seafarers about HIV and AIDS. While some have institutionalized HIV and AIDS prevention and control programs, others have not done so. What this observation implies is that **the risk and vulnerability of female seafarers to RH problems, therefore, vary greatly depending on the policies and practices observed by the principals and manning agencies which hire them.**

160. This research validates the findings of earlier studies<sup>74</sup> about the presence in the seafaring industry of individuals, females and males, who both practice and do not practice safer sex, who are able and unable to protect themselves from RH risks and vulnerabilities. **Development interventions must, therefore, seriously account for such differences and diversities.** Homogenized or the “one size fits all” interventions, be they policy, program, or services for HIV prevention and control, will likely fail to deliver the desired results.

161. **The most significant finding of this study is the presence of many policies and practices within the shipping industry, in both the cargo and passenger vessels, that ignore, if not condone, the gender biases and discriminatory practices.** It is important that these issues be addressed immediately, given the increasing number of women employed in passenger or vessels. The vulnerability of women to HIV infection, as this study shows, is brought about by the male-centered nature of the shipping industry that fosters, among others, discriminatory practices and conditions that put them at risk of being sexually abused.

162. **The specific recommendations of the research participants and the study team are as follows:**

- **Strengthen current advocacy efforts to promote the gender-responsiveness of existing diplomatic agreements (e.g., through IMO) and international covenants (e.g., through ILO).** This will entail a comprehensive gender analysis of the *Maritime Labour Convention*,

<sup>74</sup> See PRIMEX and ADB. 2008. Study on Knowledge, Attitudes, and Practices (KAP) of Seafarers and their Links to HIV Risks and Vulnerability. Metro Manila; ACHIEVE. 2005. Health at Stake: Access to Health of Overseas Filipino Workdgers. Quezon City; Sunas, Lorela P., Ricardo J. Mateo, June Lopez, Jose Ramoncito Navarro and Consorcia Lim-Quizon, n.d. The Vulnerabilities of Filipino Seafarers to HIV/STIs. Metro Manila: USAID, WHO and the Field Epidemiology Training Program, UP.



2006 to identify the gender gaps and possible amendments, especially to the provisions on condition of employment; accommodation, recreational facilities, food, and catering; and health protection, medical care, welfare, and social security protection. There is a need to ensure the equal access of female seafarers to income, health, and medical benefits now enjoyed by land-based female workers, as enshrined in international human rights instruments like the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* which is currently ratified by 184 countries.

- **Review and improve existing training, education, and advocacy materials to account for the additional risks and vulnerabilities of women seafarers.** Many of the IEC materials for HIV prevention and control programs are not gender-sensitive. They do not explain, for example, how inequality in power between males and females can put the latter at greater risk of infection. Analyses of the causes and manifestations of HIV infection hardly account for its link with such issues as rape, physical abuse, unwanted pregnancy, and other RH problems experienced by women.

163. **Develop gender-appropriate IEC messages.** Moreover, it is recommended that the kinds of information and messages, the modes of communication, and competency requirements of trainers should fit into the varying experiences and needs of male and female seafarers. To realize this objective, it is necessary for trainers and advocates to first go through gender sensitivity seminars and skills training on the use of non-sexist communication language and images. The use of sexist language or the privileging of masculine perspective and images in advocacy and training materials will not be effective in influencing the female users. Female seafarers will be responsive to certain kinds of communication and learning approaches and messages depending on their age, marital status, and emotional needs.

164. **Strengthen the capacity of women's organizations within the maritime industry to effectively promote the labor and reproductive health rights of female workers in the maritime industry.** There are a number of women's groups within the maritime industry, which can take the lead in advocacy efforts to promote gender equality measures. They include, for example, WIMAPHIL and the women's committees of the unions of seafarers. They can be given trainer's training and other capacity building activities to promote the gender responsiveness of the maritime industry. These organizations can be capacitated as well to develop counseling programs and provide legal support services for female seafarers who have been sexually abused or illegally terminated.

165. **Conduct more intensive research to examine in greater detail the existing international maritime labor and safety/security conventions and agreements as well as local policies for possible discriminatory provisions.** Such research must provide data that should validate or challenge alleged protectionist measures such as immediate termination of contract of women found pregnant while on board or the pre-employment requirement of pregnancy test and blood test for possible HIV infection.

166. **Undertake a comprehensive assessment of the impacts of HIV prevention training modules integrated into the curriculum of maritime schools.** Such study can pave the way for curriculum revision that can perhaps expand the coverage of the module to include topics on human sexuality, gender relations, and reproductive health.

167. **Strengthen the capacity of oversight and regulatory offices.** Finally, the Study Team affirms the recommendation of the research participants for measures to strengthen the capacity of oversight and regulatory offices to monitor the performance of manning agencies and training institutions. Many of their complaints have to do with the violation of work contracts, especially the provision of health and medical benefits. There is a need for stricter enforcement of rules that would protect women from rape, sexual harassment, and other forms of abuse.



**Annex A-1****FGD GUIDE: IDENTIFICATION OF GENDER ISSUES IN SEAFARING  
AND CURRENT RESPONSES**

**Participants:** Male and female officers with varying civil status, work designation, and age

**Process:**

- I. Introduction of participants and Research Team  
Briefing on the project objectives and activities
- II. Orientation to Gender and Development and related concepts (e.g., gender issues, gender bias discrimination, and their manifestations and causes)
- III. Focus group discussions
  1. Gender issues in policies of manning/crewing agencies (hiring, promotion, firing, welfare benefits, salary, assignment)
  2. Safety and security issues of women
    - a. Physical safety (e.g., comfort room, cabin, etc.)
    - b. Safety and security during work
    - c. Safety and security during off duty
    - d. Health security
  3. Current policies and programs to protect women seafarers from harm
    - a. Code of conduct of officers
    - b. Code of conduct of employees
    - c. HIV preventive policies
  4. Recommendations to address gender issues identified by participants

**Annex A-2****FGD GUIDE: IDENTIFICATION OF REPRODUCTIVE HEALTH AND SEXUALITY ISSUES****Participants:**

- Session 1: Female ratings and officers in passenger vessels, with representations from those married and single, younger and older, and with different work designations
- Sessions 2 and 3: Female ratings from passenger vessels with varying civil status, employment status/designation, and age

**Process:**

- I. Introduction of participants and Research Team  
Briefing on the project objectives and activities
- II. Orientation on reproductive health and sexuality (concepts)
- II. Focus group discussions
  1. Concept of self as female seafarers
  2. Reproductive health issues and concerns
    - a. Menstruation
    - b. Pregnancy
    - c. Family planning
    - d. VAWC
    - e. STI and HIV
  3. Sexuality issues
    - a. Sexual desire
    - b. Romantic attraction
    - c. Partnership—same sex, multiple partnership, sequential partnership, bisexual
  4. Responses/coping to RH and sexuality issues (including vulnerability to HIV and STI)
  5. Recommendations to address issues on RH, sexuality, and HIV and STI

**IN-DEPTH INTERVIEW SCHEDULE**

Interview No.: \_\_\_\_\_  
Interview Code : \_\_\_\_\_  
Interviewer: \_\_\_\_\_

**RETA 6143 Component 2 : Qualitative Study of the Personal and Structural Determinants of the Risks and Vulnerabilities of Female Filipino Seafarers to HIV Infection and other Reproductive Health Problems—IN-DEPTH INTERVIEW GUIDE**

Time start: \_\_\_\_\_  
Time end: \_\_\_\_\_

**INTERVIEW GUIDE****I. Introduction**

1. Interviewer
  - a. Greet the participants
  - b. State your name and organizational/institutional affiliation
2. Participant
  - a. Ask the participant to state name and other personal information indicated in this form.
3. Process
  - a. State the objective of the interview.
  - b. Assure the participant that there are no right nor wrong answers and that the responses will be kept in strictest confidence.
  - c. Ask the participant if she has additional questions regarding the interview. Answer the queries of the participant.
  - d. Request permission to tape the interview.
  - e. Recording of the interview will only commence once the interview process starts.





**KEY INFORMANT INTERVIEW (KII) GUIDE****Process:**

- Introduction of the interviewer
- Briefing on the project (objectives and activities)

**KII Guide Questions:****For maritime institutions:**

1. About the interviewee (position, function, work background, etc.)
2. About the organization (year founded, mandate, programs on seafarers, etc.)
3. Reasons for recruiting female students
4. Ensuring accommodation, security and safety of female students
5. Enabling conditions that make maritime institutions conducive to learning for female students (curriculum, award system, etc.)
6. Challenges faced by female students
7. Existing policies that protect/address issues of female students, e.g., sexual abuse, gender biases, etc.
8. Recommendations

**For organizations:**

1. About the interviewee (position, function, work background, etc.)
2. About the organization (year founded, mandate, programmes on seafarers, etc.)
3. Problems faced by female seafarers (safety, security, work-related, etc.)
4. Gender issues in the seafaring industry
5. Existing policies that protect female seafarers or policies that are discriminatory against female seafarers
6. Recommendations

**LIST OF PERSONS INTERVIEWED (KII)**

**1. Vice Admiral Eduardo Mar Santos, AFP Ret.**  
President  
MAAP

**2. Atty. Brenda Pimentel**  
Regional Coordinator  
International Maritime Organization

**3. Mr. Noriel Devanadera**  
Director  
Maritime Training Council

**4. Ms. Carla S. Limcaoco**  
President  
Women in Maritime Philippines

**5. FR. SAVINO BERNARDI, Cs**  
Director  
Apostleship of the Sea



**Appendix 9:**  
**GENDER-SPECIFIC VULNERABILITIES OF**  
**FEMALES WHO INJECT DRUGS (FIDUs) IN**  
**METRO CEBU AND ZAMBOANGA CITY**

## GENDER-SPECIFIC VULNERABILITIES OF FEMALES WHO INJECT DRUGS (FIDUs) IN METRO CEBU AND ZAMBOANGA CITY<sup>1</sup>

### I. INTRODUCTION

1. This study on gender-specific vulnerabilities of female injecting drug users (FIDUs)<sup>2</sup> in Metro Cebu and Zamboanga City commenced in June 2008 as part of the Project, ***Supporting Women at Risk and Vulnerable to HIV/AIDS in the Philippines***, financed by the Asian Development Bank (ADB) through its ***Gender and Development Cooperation Fund (GDCF) established under Regional Technical Assistance (RETA) 6143***, which supports initiatives to promote gender mainstreaming in ADB operations, gender capacity development, and strategic partnerships.

2. The study was aimed at identifying gender issues and concerns confronting female IDUs and assessing the social and historical roots of their problems in order to provide gender-specific inputs, develop gender-responsive harm-reduction policies and guidelines, and support initiatives that promote gender mainstreaming, gender capacity development, and strategic partnerships. The study was envisaged to contribute to the mainstreaming strategy of ADB in promoting gender equality and women's empowerment and complement ongoing activities of RETA 6321 (Fighting HIV/AIDS in Asia and the Pacific), Sub-Project 5: Strengthening Country Response to HIV/AIDS among High-risk Groups. In particular, it aimed to strengthen the gender-specific outputs of the said Project and provide gender-specific recommendations for the national HIV/AIDS and harm reduction programs and policies.

3. This report is a compilation of 17 cases of female injecting drug users in two cities in the Philippines: Cebu and Zamboanga. It describes the situations faced by women who inject drugs and discusses the implications of injecting drug use on gender relations between male IDUs and their female counterparts, or women IDUs and their male partners. It determines emerging concerns of women to enable the identification of potential areas for policy revision and the development of operational guidelines for harm reduction. It is hoped that the data in this study can be used by government agencies and non-government organizations (NGOs) to modify the focus and tone of behavior change communication strategies. Questions on who does what, where, when, who decides, how often, and who controls are addressed to facilitate gender analysis and/or enable an assessment of gender differences.

### II. RATIONALE FOR THE STUDY

4. For many years now, much of the HIV/AIDS education and prevention campaigns has been focused on male IDUs, maybe because they represent a larger proportion compared to the estimated 10% of female IDUs. However, despite this relatively low proportion of women among the IDU population, policymakers and program implementers need to recognize that women are not isolated individuals, and they interact with other at-risk groups. The conduct of an in-depth study on gender issues in injecting drug use is therefore necessary for a better understanding of the dynamics and context of injecting drug use, particularly among women. To date, no study has yet been done specifically to clarify and address issues among women who inject drugs. The data obtained this study will be used to guide the development of gender-appropriate harm reduction intervention programs and policies. Gender-specific and localized risks need to be addressed because behavioral dynamics vary greatly not only across society, culture, and cities, but also across genders. Therefore, any attempt to encourage positive behavior change among the IDU population also requires a thorough understanding of the constraints and other factors influencing the risk behaviors of women.

<sup>1</sup> This study was conducted by Dr. Fiscalina Amadora-Nolasco, Principal Investigator, and National Research Consultant for Female IDU Study. Technical guidance was provided by Dr. Vicente Salas, HIV Specialist/Team Leader, and Dr. Jose Narciso Sescon, Deputy Team Leader for Component 1, RETA 6321, Subproject 5.

<sup>2</sup> These are women who inject drugs for non-medical/non-prescribed purposes.



4. The spread of HIV infection in Asia has been linked to poverty, high levels of preventable diseases, inadequate resources for health, rapid urbanization, commercial sex, and the prevalence of sexually transmitted diseases (cited in Amadora-Nolasco, 2000). No such society can avoid the epidemic (Whiteside and FitzSimons, 1994). Drug use among women in Asia is often considered a minor problem largely because the number of women classified as IDUs is estimated at 10% or less (Reid, 2002). However, this figure will tend to increase; hence, the need to keep an eye on the situation.

5. The challenge, therefore, is to be able to explore the various aspects of injecting drug use among women. Finding out how to reach IDUs in a culturally appropriate way is the challenge facing government and health care practitioners in the Philippines today (Amadora-Nolasco et al., 2002). In many countries, the combination of involvement in illicit drugs, crime, violence, and sex work has had adverse effects on families and the social situation of women (Ahmed, 1998 as cited in [www.youandaids.org/themes/injecting\\_druguse.asp](http://www.youandaids.org/themes/injecting_druguse.asp)).

6. This research was carried out on the assumption that if harm reduction initiatives and policies are specifically tailored to women's circumstances, they are more likely to adopt change to healthy behaviors. It was, therefore, imperative to also try to understand and consider actual situations within which women IDUs live and work. As Wiebel (1990) put it, "policy makers who want to make good decisions concerning complex issues must have accurate, reliable information."

7. The UN Office on Drugs and Crime (UNODC) reported that the intersection of unsafe injecting drug use and unsafe sexual practice is a significant factor in the increased risk for HIV infection of drug injecting females. As men and women are differently affected by HIV, an understanding of these gendered differences will be critical to developing effective responses, specifically because women users are viewed quite differently from men users by the wider society ([www.youandaids.org/themes/injecting\\_druguse.asp](http://www.youandaids.org/themes/injecting_druguse.asp)).

8. HIV and AIDS programs for IDUs with insufficient gender sensitivity can increase the scope and magnitude of injecting drug use in known IDU sites, which, in effect, could result in an increase of public health and development issues faced by communities, government, and NGOs. Programs and policies that do not consider gender may not produce successful results considering the reality that female concerns are integral and should be considered in policy development and program planning. UNAIDS (1999) declared that the impact of society's defined gender roles on protective health behavior of women emphasizes the significance of empowerment approaches, especially for women vulnerable to HIV. Empowerment approaches assume that health behaviors are not isolated events but are embedded within social, cultural, and economic surroundings; hence, health behaviors are not under the volitional control of individuals (UNAIDS, 1999). On condom use, for instance, several studies have reported that the woman herself does not make the decision about condom use – rather, it is her partner who makes the decision (Amadora-Nolasco, 2001).

9. The strategic emphasis on gender influences is based on the need to assess and deal with women's unequal position in society. It sees gender as a cross-cutting issue which influences injecting and sexual behaviors, drug use patterns, sharing and cleaning practices, and interactions with the larger population in a broader socio-cultural environment.

### III. REVIEW OF LITERATURE

10. Gender influences HIV/AIDS risk behavior (Auerbach, 1994; Amaro 1995), most especially when a woman is poor and/or dependent on her male sexual partner. It is presumed that men making decisions regarding condom use and needle sharing/cleaning, for example, have an influence on women's adoption or non-adoption of positive behaviors to prevent HIV/AIDS infection.



11. As with other HIV vulnerable groups, IDUs represent a diverse community with varied life histories and conditions, and must be dealt with in its complexity, including gender differences. Although injection risks are presumed to be the same for both sexes, their sexual practices may be different and difficult to change. Studies have shown that self-protection for women may be affected by abusive partners, economic factors, and norms within sexual relationships (Wingood, 1996; Bunnell, 1996; van der Straten 1998).
12. A study conducted by Gomez (1993) reveals that the fear of their partner's violence predicts whether women use condoms (cited in UNAIDS, 1999). Other investigations also revealed differences in intervention efficiencies between target populations and between different types of interventions (UNAIDS, 1999), and messages have been found to be more effective when these are directed towards a specific group.
13. As a result of women's increasing involvement in all forms of drug-related problems, they are likely to suffer more severe consequences than men. Women IDUs are more at risk of HIV infection over male IDUs mainly because of their generally subordinate status in society. Women may be possibly introduced to drug use by their sexual partners who inject their drugs for them. If they rely on others to inject them, overdose due to unawareness of dosage is possible and they could be at risk to HIV ([www.youandaids.org/themes/injecting\\_druguse.asp](http://www.youandaids.org/themes/injecting_druguse.asp)).
14. A woman who uses drugs for whatever reason and who is infected by HIV seldom receives the sympathy and support that she needs (Deany, 2000 as cited in [www.youandaids.org/themes/injecting\\_druguse.asp](http://www.youandaids.org/themes/injecting_druguse.asp)). Data globally affirm that not only are many women monogamous already, but it is unsafe for them to assume that they are safe in their monogamous situation (Heise *et al.*, 1995).
15. In general, women drug users are likely to have a drug injecting male sexual partner. A husband or a boyfriend or even a male member of the family possibly introduced the woman to drugs. Usually, women have access to drugs because of their male sexual partners. They prefer to share needles and be injected by someone else. If their male partner is an active drug user, then women may undergo difficulty in avoiding drug use or even accessing drug treatment (ASEAN Secretariat, 2007).
16. Female injecting drug users differ from their male counterparts in terms of background, reasons for using drugs, and psychosocial needs. HIV/AIDS programs, however, are unable to reach out to this group because services are designed for men. Further, the UNODC reports that gender-sensitive services addressing the specific needs of female injectors hardly exist in most countries. They are more likely to be stigmatized by society, compared to male injectors, because their activities are considered to be doubly deviant: drug injecting violates social norms, and a female who injects drugs violates societal expectations of her as a woman and nurturer of family. Females have greater difficulty abstaining from drug use, particularly if her male drug-injecting partner continues and supports injecting, and may even discourage her from seeking prevention and treatment services. Hence, gender inequality, social exclusion, stigma, and discrimination all act together to increase the vulnerability of female injecting drug users to HIV (United Nations Office on Drugs and Crime, [www.unodc.org](http://www.unodc.org)).

#### A. The Global Experience

17. In the developed world, such as the United States of America, the United Kingdom, and Australia, the proportion of IDUs who are women is often as high as 25%. In China, most drug users are men, but the number of women using drugs is increasing. In Yunnan and Guangxi provinces, women make up 16-25% of all drug users in treatment and tend to be younger than male drug users. Other countries in Asia where there are significant numbers of women IDUs include Nepal, India, Pakistan, Bangladesh, Indonesia, Vietnam, Thailand, Sri Lanka, Philippines, Taiwan, Japan, and Malaysia (ASEAN Secretariat 2007, [www.aseansec.org](http://www.aseansec.org)).



18. In the County of San Diego, USA, most of the IDU cases are male, but the proportion of female IDU cases has increased significantly ( $p=0.005$ ) from 1981 to 2000. When all AIDS cases are considered, females are significantly ( $p<0.001$ ) more likely to be IDU than males ([www.sdhivaid.org](http://www.sdhivaid.org)).

19. Risky behaviors continue to sustain serious AIDS epidemics in Asia. Injecting drug use is the strongest initial driver of HIV infection, even if the number of people injecting drugs is relatively small. The majority of drug injectors are sexually active and, in some countries, a large proportion of them buy or sell sex. At the heart of Asia's epidemic lies the interplay between injecting drug use and unprotected sex (AIDS Epidemic Update, 2005).

20. Findings obtained by the National AIDS Demonstration Research Projects pointed out that sharing of drugs with the use of equipment was much easier to change than sexual practices. The project showed reduction in sex practices, but less dramatically than for drug risk practices (Wibel et al., 1996).

21. Programs to reduce the use of non-sterile needles and sexual risk-taking among drug injectors are crucial, as well as strategies to reduce the sexual transmission of HIV involving sex workers, their clients, and other sexual partners. Hein *et al.* (2004) (as cited in AIDS Epidemic Update, 2005) state that "*punitive campaigns to combat 'social evils' tend to drive drug injectors and sex workers beyond the scope of outreach programmes and can inadvertently entrench risky behaviors.*" Generally, even when the overall proportion of sex workers who inject drugs is low, the proportion of female drug users who sell sex tends to be high (MAP Report, 2005).

22. In urban Indonesia, injecting drug use appears to be a growing phenomenon and is increasingly also recorded in non-urban areas. HIV prevalence among IDUs has been recorded at extremely high levels in Jakarta, West Java, and Bali (Ministry of Health, Indonesia, 2003).

23. Studies have shown that most injectors know where to get sterile needles, yet close to nine in ten (88%) of them still use non-sterile injecting equipment (Pisani, 2003, as cited in AIDS Epidemic Update, 2005).

24. In Myanmar (Burma), two states (Kachin State and Northern Shan State) have been found to have an estimated 300,000 IDUs out of a total population of 40 million, with a male to female ratio of about 9:1. Opium and heroin are the most commonly used drugs, and injection is preferred to smoking drugs, as it is less costly and gives a stronger effect ([www.kit.nl/exchange/html/1997\\_2\\_myanmar\\_reaching\\_out.asp](http://www.kit.nl/exchange/html/1997_2_myanmar_reaching_out.asp)).

25. In Thailand, there is evidence that HIV is spreading largely among the spouses, partners of clients of sex workers, and IDUs. It is estimated that in 2002, 50% of infections was the result of heterosexual transmission in cohabiting partnerships: 20% due to injecting drug use, 15% transmitted from mother to child, and 15% associated with commercial sex ([www.avert.org/aidssoutheastasia.htm](http://www.avert.org/aidssoutheastasia.htm)).

26. In China, the first AIDS case was reported in Beijing in 1985. The most frequent modes of HIV transmission have been injecting drug use in southern and Western China and unsafe practices among paid blood donors. The percentage of female sex workers who do not use condoms decreased from 67% in 1999 to 37% in 2001 ([www.avert.org/aidssouth\\_eastasia.htm](http://www.avert.org/aidssouth_eastasia.htm)). HIV in China has been established in IDU networks, just like in many other countries in Asia. Compounding matters is the fact that the female injectors who sold sex without condoms were the most likely to be using non-sterile needles (AIDS Epidemic Update, 2005).

27. In Vietnam, the transition to a market economy was accompanied by an increase in injecting drug use and commercial sex. There is evidence that many drug users share injecting equipment,



despite the fact that clean equipment has been made legally and cheaply available. Surveillance in 2002 found that 20% of IDUs in most provinces are HIV-positive. Prevalence rates have also increased among female sex workers to 11%, 15% in Hanoi, and 24% in Ho Chi Minh City ([www.avert.org/aidssoutheastasia.htm](http://www.avert.org/aidssoutheastasia.htm)).

28. In Lao People's Democratic Republic, injecting drug use is believed to be very limited or non-existent, but no studies have been conducted to confirm this impression. Overall, less than 1% of indirect sex workers tested in 2000 was found to be HIV-positive. One of the reasons identified for the low prevalence rates in this area might be the consistently high rate of condom use among female sex workers ([www.avert.org/aidssoutheastasia.htm](http://www.avert.org/aidssoutheastasia.htm)).

29. In Cambodia, where the national HIV prevalence rate is considered the highest in Asia, HIV is transmitted through sexual contact, and the highest HIV prevalence is observed among female sex workers ([www.avert.org/aidssoutheastasia.htm](http://www.avert.org/aidssoutheastasia.htm)).

## B. The Philippine Experience

30. Although HIV prevalence among most-at-risk populations (MARPs) in the Philippines remains at 0.08% (PNAC 2008), the country continues to face the possibility of a significant HIV epidemic, particularly among IDUs. Data show that the number of HIV and AIDS cases is increasing, and condom use among MARPs remains below the universal access target (UNGASS, 2008).

31. In 1999, there was a significant ( $p < .01$ ) decline (from 77% to 53%) in the proportion of IDUs who share injecting equipment. However, among those who shared injecting equipment, a decrease from 50% to 25% was found in the proportion of those who cleaned their equipment with bleach prior to use (Department of Health, Philippines, 2000).

32. Surveillance results and qualitative studies conducted in areas where a sizable number of IDUs exist (PRIMEX, 2007) pointed to significant injecting and sexual risk behaviors among and between this group. They continue to share injecting paraphernalia, employ ineffective methods of cleaning injecting equipment, have poor health-seeking behaviors, engage in unprotected sex with both women and men in their social and sexual networks, and use multiple drugs. Furthermore, existing prevention programs (HIV testing, condom, needle and syringe) have reached only 14% of IDUs (UNGASS, 2008).

33. Population size estimations done in the three sites reveal the following figures: Cebu: 963 (lower limit) –1458 (upper limit) (Social Hygiene Clinic - Cebu City Health Office, 2006); General Santos: 627 (PRIMEX-ADB 2008); and Zamboanga City: 1190 (PRIMEX, 2008). Data obtained from the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) and studies of rehabilitation inmates revealed that the number of Filipino women IDUs remains low, and various studies have estimated the proportion of female IDUs at between 10%-15% (PRIMEX, 2008). Yet, they are disproportionately at risk to HIV infection because many of the women IDU respondents (in both the IHBSS and FGDs) are also engaged in sex work. The 2007 IHBSS results in Zamboanga revealed that the mean age at first sex among FIDUs in 2006 was 18, and in 2007, was 17. In 2006, 14 women were found to have been engaged in sex in exchange for drugs/money (PRIMEX, 2007). Results from the FGD in Zamboanga City point to many gender differences, including women's perceptions regarding men using drugs to boost sexual desire. In addition, female IDUs have less access to rehabilitation facilities.

## IV. SCOPE AND METHODOLOGY OF THE STUDY

34. The study population comprised of women who inject drugs (including sex workers) of varying ages in Metro Cebu and Zamboanga City, who have injected illegal drugs in the six months preceding the study period. The study aimed at gathering data/information related to the following: (i) history and





evolution of drug use; (ii) behavioral, social, and family-related factors that influenced their decisions and actions; (iii) knowledge and practices of risks (injecting, needle-sharing, sexual); (iv) prevention practices and other measures to cope with drug use and minimize drug-related harm; (v) access to HIV and other relevant health information, treatment, and rehabilitation services; (vi) experiences related to stigma and discrimination; and (vii) sexual behavior and practices.

35. The study employed qualitative methods consisting of (i) in-depth one-on-one interviews (Cebu and Zamboanga) and (ii) focus group discussions (FGDs) with women IDUs (Zamboanga) to allow for cross-checking of data sources and provide depth towards identifying the range of important factors needed to fulfill the study objectives. At the early stage, data obtained from observations were used to highlight areas for research, identify means of access, build rapport with key informants, and gain an understanding of local behaviors.

36. Recognizing the illegal and clandestine nature of injecting drug use and the difficulty in getting them together, two FGD sessions, with 10 participants per session, were held with female IDUs in Zamboanga City, and two case studies/in-depth interviews with a different set of participants. In Cebu, no FGD was conducted given the more complex situation in the province, and the time needed to convene the group, but case studies were done with 15 women, bringing the total number to 17 cases.

37. For representation purposes and to capture similarities and differences in experiences and opinions, utmost effort was exerted to ensure that case study participants came from various locations and categories, e.g., sex workers, professionals, students, housewives, out-of-school youth (OSY). Given these parameters, the study team spent weeks with key informants to find women IDUs who matched the inclusion criteria and were willing to participate in the study. It should be noted that the study team found women nurses, teachers, and dentists who inject drugs, but no amount of convincing made them agree to one-on-one interviews.

38. Participants from both sites were purposively chosen, that is, on the basis of the abovementioned categories. Key informants who were identified in the course of the fieldwork were used to locate the study participants. Having penetrated their circle, the snowball technique was employed: information extracted from key informants/participants led the study team to other locations where a potential FIDU could be found.

39. Participation in the study was voluntary, but food, beverages, tokens, bother fees, and transportation allowances were provided. The women were interviewed in private, after obtaining their consent to participate in the study and to record the conversation. They were also provided with an overview of the project and the study objectives and how their participation in the study can contribute to the HIV/AIDS program of government and other organizations.

40. In Cebu, the study relied on the assistance of IDU key informants who accompanied and introduced the study team to places where other women IDUs can be found. In Zamboanga, assistance was sought from HDES, a local NGO working on HIV and AIDS. They identified and invited the women to participate either in the FGD or one-on-one interviews, and activities were successfully carried out as scheduled, despite the alarming peace and order situation in the City at the time of the study.

41. A guide was developed and pre-tested to ensure that expected results are obtained. Field notes and recorded conversations were entered into a computer using a word processing program. Prior to data analysis and report writing, the following steps were undertaken: 1<sup>st</sup> level: word-for-word transcription of conversations in the local language; 2<sup>nd</sup> level: color-coding of significant findings related to identified themes; 3<sup>rd</sup> level: English translations of color-coded data in bullet form. Assistance was sought from transcribers to ensure completion of deliverables on time. All names used in the report are pseudonyms to protect the participants' privacy.



42. In Zamboanga City, there were no problems encountered, given HDES' preparedness for the activity. A problem encountered in the course of fieldwork in Metro Cebu was the difficulty in getting female, non-sex worker IDUs to participate in the study. Considerable amount of time was spent in convincing non-sex workers, particularly students and professionals, because they were afraid that participating in the study might jeopardize their work, relationship with family and others, and reputation as a professional or student. In short, they did not want their identity exposed. Interview appointments were postponed in several instances, and some were eventually cancelled, thereby necessitating the identification of replacements.

43. Qualitative data were analyzed according to identified themes. To ensure clarity in the presentation of findings, tables, matrices, and graphs were developed to show simple frequency distribution of significant variables and/or similarities and differences among the various participants. As necessary, results were presented separately for Metro Cebu and Zamboanga City. Given the small number of women interviewed, generalizations were avoided. Instead, this study offers insights that may be useful for determining or rethinking target- and gender-specific approaches for further intervention.

## V. FINDINGS OF THE STUDY

44. This section presents the results of case studies of 17 female injecting drug users (FIDUs): 15 in Metro Cebu and 2 in Zamboanga City. These women were interviewed separately and in private, between June and September 2008, and asked about why they use drugs, how they became IDUs, their drug use practices, knowledge of risks, exposure to HIV information and intervention, experiences related to stigma and discrimination, and sexual behavior and practices. **Pseudonyms are used in this report** to protect the participants' privacy, and other identifiers such as specific locations of dwelling units and injection sites are not provided. The individual cases are presented below. The qualitative analysis of the data obtained through these in-depth interviews and the findings from two FGDs conducted in Zamboanga City, each FGD with 10 women participants are presented in the main report of the Draft Final Report.

### A. Cebu Case No. 1: Jaja

45. Jaja, 22 years old and a Roman Catholic, resides in a lowland barangay in the southern section (Labangon), approximately eight kilometers (km) from Cebu City. She dropped out of College because she passed in only one subject in the previous semester. For two years now, Jaja has been separated from her live-in partner, himself a regular drug injector, with whom she has three male children aged 3 years, 2 years old, and 5 months. She lived in with him when she got pregnant at age 17. Her parents and other siblings in the family do not like him but were left with no choice. They gave him a chance by allowing him to help in the family business where he was paid PhP50 per day. He was, however, accused by Jaja's parents of stealing money, and they threatened to send him to jail if he did not leave and stay away from Jaja and her children. During the first few months of the separation, the man would quietly sneak in their house at night to have sex with Jaja, until he found a new live-in partner, a guest relations officer.

46. Box 1 presents Jaja's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices. Below, Jaja relates her experiences on stigma and discrimination:

- *"Di ko ganahan tawgon ko'g adik. Di man ko adik, user ra ko. Bati kaayo ng tawgon mig adik ba, ang uban man gud ubos ra kaayo ilang pagtan-aw."* [I do not like to be called an addict. I am not an addict, I am only a user. It is not good to call us addicts, the others look down on us.]
- *"Gamay ra babaye nga shooter, kasagaran namo kauban puros baya lalaki, mao na ilang tan-aw usahay bugal-bugalan lang gain ka. Naglagot na man ko anang wala na sa limit gani, dili lang bugal-bugal sa istorya, agbayan ka pa og kalit kay tungod ingon ana ka, ug usahay mokalit lang og kiss nimo. Ikaw*



*babaye baya ka, dapat respect baya ang kinahanglan sa tawo.* [Women IDUs are few, most IDUs are males, that is why they make fun of us. I get really mad if they not only make fun of you, they place their arm on your shoulder and kiss you. But a woman needs respect].

- *“Ilang pagtan-aw okey ra kung lalaki, pero tungod kay babaye man ka, ang baya dili dapat, ang baya dapat sa balay lang, Maria Clara ba.”* [They think that it is okay for men to inject, but women are not supposed to become injectors. They are supposed to stay at home, like Maria Clara.]
- *“Dili ko gusto nganong ingon ani man sila oi, nga ako man silang pamilya, pero nganong akong pamilya mismo maoy nagduot nako. Kung kasab-an ko sa akong parents, akong kaugalingon akong pasakitan.”* [...they are supposed to be my family, but why is it that my own family puts me down. When my parents scold me, the more I hurt myself.]
- *“In our home, my family has a separate plate, glass, and other utensils for me, and every time I go out, my family would accuse me of doing bad things. I feel that I am looked down upon by my own family, who think I am hopeless. My family never saw me using drugs.”*
- *“I experienced being physically hurt by my brother when I was pregnant.”*
- *“My former live-in partner was my only refuge (“mao ray akong kadampan”). I always shared my problems with him because my family does not understand me.”*

#### Box 1: Cebu Case No. 1 - Jaja

**Age:** 22 **Religion:** Roman Catholic **Education:** 1<sup>st</sup> year Commerce – dropped out of school

**Profile:** Jaja is the second child in the family, and has one brother and two sisters. While her father earns approximately PhP5,000 per day in a “*lechon*” (roast pig) business, her mother owns a small eatery which earns an average of PhP1,800 a day. Jaja receives a daily allowance (PhP50) from her mother for assisting the latter in the eatery business, hence in a month, she earns PhP1,400. Both of her parents are in-migrants from Mindanao. At the time of the study, Jaja and her children lived with her parents, while her former live-in partner was in prison for drugs and physical injury cases – he was caught with one ampoule of Nubain and a syringe in his pocket and got involved in a fight. Despite his having another partner, Jaja continues to visit him in prison where they have sex.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Jaja learned to use injectable drugs at age 17, with Nubain as the preferred drug. During difficult times she would buy the generic drug (Nalbuphine Hydrochloride) because it is cheaper (they call this ‘Nalvo’). The cost for one ampoule of Nubain is PhP130 while the generic drug costs PhP65, and “we have regular suppliers for these,” she says. Jaja and her male and female friends call themselves “the punks.” She has resorted to combining drugs: “Drop-Shoot,” or cough syrup before any injecting episode, and “Drop Shoot-Blow,” or cough syrup followed by injecting and capped with smoking marijuana.

Jaja has been injecting for five years now, usually 8-10 times a day. She injects drugs everyday (0.5ml), usually in the afternoon (starting at 1:00 or 2:00 PM) when most of her friends started a drinking session. Jaja says that she, her friends, and live in partner (when they were still living together) find the need to drink alcoholic beverages everyday because if not, they experienced dry throat (“*mag-uga ang tutunlan*”). They pool their resources or chip in to buy drugs. She usually goes home at dawn bringing some Nubain (or Nalvo) with her so she could inject again before she sleeps. Jaja describes the effects of Nubain on her: “I feel like a robot, I have droopy eyes, light mind and I feel calm, and I do not like to hear any noise or argument because I am easily irked.”

In the past, she usually injected drugs with her live-in partner or he accompanied her to the “center” or “Mt. Kamagayan” to inject with “the punks.” After the separation, Jaja continues to inject with “the punks.” She prefers to inject by herself, saying that “other members are selfish and would fight over who gets more” (“*mag-ilog ug mag-away*”). The actual practice, however, is injecting in a group using only one needle.

There are times when she would buy her own syringe from a drugstore and use it three times before discarding it. She used the word “*ukay-ukay*” (the term used for used clothing for sale) to refer to the many used syringes in the converging point that IDUs would use whenever a new needle is not available. Jaja admits to sometimes sharing needles with others, particularly when she is drunk and eager to inject.

Whenever a needle is shared, they sprayed it with alcohol until the syringe is emptied of blood droplets and looks clean (“*mura’g limpiyo na tan-awon*”). Jaja says that “being able to see another person’s blood in the syringe does not make her comfortable” (“*luod tan-awon*”). Sometimes, only water is used to flush the syringe.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** She has heard of HIV from an NGO, and has had an HIV test when she participated in the 2005 IHBSS conducted in Metro Cebu (the result of which was negative). She was found positive for hepatitis. She has also attended a seminar on HIV/AIDS at the City Health Office (CHO) with some members of “the punks.” She has availed of a syringe which was distributed free to IDUs in the community where she hangs out, but later on learned from friends that these are no longer given free. However, the syringe she received was defective and had no rubber (referring to the green cap). Her former live-in partner also received a condom, which they never used. Jaja avers that she wants to undergo rehabilitation, but does not want her parents to decide for her.

She perceives herself to be at-risk because she forgets to use her own syringe when she is drunk. She drinks alcoholic beverages regularly. For one month, she tried to stop injecting (rather than be brought to a rehabilitation center by her parents) and did not experience any withdrawal symptoms, but the longing for the excitement that comes with using drugs made her to resume injecting drugs.

To the question on HIV and AIDS programs for women IDUs, Jaja said that needle distribution is good (“*maayo*”) because IDUs can save money and will no longer have to buy a syringe. Further, she says that “such program would be a great help in ensuring the safety of injectors and that they care for us even if we are addicts – we still have value to them” (“*dako kaayo og tabang namo kay para ma safety pod mi, kay nag care sila sa amo bisan mga adik-adik mi, naa pa diay mi bili nila*”).

**Experiences Related to Stigma and Discrimination.** When at home, Jaja does not go out of the house because she does not like being talked about (*tsismis*) by neighbors who are aware of her vice. She hangs out only with friends and claims that injecting drugs is their only happiness (“*mao ra na ang among kalipay*”).

**Sexual Behavior and Practices.** Jaja’s first sex was with her boyfriend when she was 15 years old. She never used a condom. She had multiple sex partners, particularly when she separated from her live-in partner, but these “fling-fling relationships are just for fun,” she says. Even when her live-in partner had moved out of her parents’ house, they continued to secretly meet and have sex—just for the sake of it or “*trip-trip lang*,” and they never used condom, saying “*walay lami*” (not pleasurable) and “there is no need because we have lived-in together already.” When he was sent to prison, and even now that he has found a new partner, Jaja still visits him, and they have sex in a “*kubol*” (an improvised room where inmates can bring their partners and have sex).



**Box No. 2 Cebu Case No. 2: Tessa**

**Age:** 30 **Religion:** Protestant **Education:** 3rd year College, major in Political Science

**Profile:** Tessa is the eldest child. She has one sister and two brothers and comes from a well-off family. Her father is a lawyer, and her mother is a housewife. At age 18, in one injecting session, Tessa was introduced by a female friend to a pimp. That was when she started running away from home and accepting clients for sex services to support herself and sustain her drug habits. The pimp would just give her a call if he has a customer for her. Tessa charged PhP5,000 per customer per day. She does not have a regular income. Engaged in the buying and selling of ladies' items, she earns P200 a month on the average. When she has no money for drugs, she would sleep in a friend's (usually male) house, but if she has money, she checks-in at a lodging house.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** At age 16, Tessa learned to use drugs when her friends at school taught her. Curiosity drove her to try shabu (they call it "tattoo"), injectables, and marijuana, but stopped using the latter after experiencing undesirable effects (e.g., numbness of body). Tessa wanted to belong to the group and have a sense of belonging, so she agreed to chip in money to buy drugs. She never expected that she would be addicted to both shabu and injecting drugs. Depending on the availability of money and on what her friends would recommend, they would use shabu or injectables or both. Sometimes, she sniffed shabu first and followed it up with an injection of Nubain (0.5ml). If she had limited funds, she would only go for an injection, once or twice a day. All her live-in partners also used drugs everyday, particularly shabu. It was only when her current partner decided to take his CGFNS review seriously that he reduced his frequency of drug use.

Tessa has been injecting Nubain for 14 years, usually twice a day. When she experienced some discomfort (nausea), she started to reduce her usual dosage from 0.5 ml to 0.1ml, although she continues to use shabu. She asks a friend at the "center" to inject for her because she does not know how to do it herself, or pays a "male shooter" PhP10 to do it for her. She feels good and wants to walk around after she has injected. Drugs and needles can be bought from suppliers at the "center," at PhP150 per package (including service fee for the injector) and an additional of PhP10 per person for "house rental." Sometimes, she bought her own pack of syringe for PhP30 at a nearby pharmacy, and at other times, she used a service needle. Tessa does not share needles anymore but admitted to having shared needles with others. She was always given the privilege to use it first because she contributed a bigger amount of money than the others in the group. When asked why that was so, Tessa said that she feared the possibility of infection because a friend reportedly died of rabies after using a used needle in injecting drugs. Tessa admits that they sometimes use the same needle in the second round. When asked whether they cleaned the needle in between users, Tessa said, "I have not experienced cleaning a needle, I would only accept a needle passed on to me by my friends" ("*modawat ra man ko'g limpiyo*"). This is an expression referring to a situation when everything has been taken care of, and one does not have to exert any effort to do something.

Tessa still injects with friends at the shooting place, but uses only her own needle. When unable to inject drugs, she experiences chills (and wraps herself in a blanket), which is relieved by drinking cold water, soda, or by eating ice cream. Because her current live-in partner has stopped using drugs to concentrate on his CGFNS review, Tessa no longer tells him about her drug practices, both shabu and injecting. She secretly goes to the shooting place and does not inform him anymore about her going out with friends.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** When asked whether she knows of some injecting risks, she mentioned that one can have HIV/AIDS, blood infection, fever, and skin disorders. She has read about HIV in the newspapers and has heard about it from neighbors and from teachers' lectures when she was 18 or 19 years old. She believes that she is not at risk of acquiring HIV or hepatitis because: (i) in the past, she would use the needle/syringe first and now, she uses her own needle; (ii) when she was engaged in sex work, she always used a condom with customers; (iii) she never experienced an overdose; and (iv) she does not eat or drink water anywhere.

Tessa has not been tested for HIV, nor has she attended meetings or discussions about it. However, she knows that HIV and AIDS information can be obtained from doctors and health centers. Her knowledge of HIV is limited because she has not availed of any service from government or NGOs, but hopes to participate in one, if available. She thinks that offering a program for IDUs is an indication that IDUs are accepted by society and that the provision of information on HIV/AIDS and drugs information is important to increase their knowledge of HIV and the effects of using drugs. She has been wanting to quit injecting drugs to go back to school, finish her college education, and make her parents happy, but her several attempts have all failed.

**Experiences Related to Stigma and Discrimination.** Because she is a drug user, Tessa has been abandoned ("*gipasagdan*") by her family, particularly by her father who is furious ("*nasuko*") and ashamed ("*naulaw*") of what she has become. She has experienced discrimination not only from family members but from relatives as well. Relatives think that when she visits them she will be asking for money. Even if she is not on drugs they would say that she is. Tessa hopes that, one day, she would have the courage to ask for forgiveness. She has realized that she needs her family.

**Sexual Behavior and Practices.** She had her first taste of sex at 18 years old. "I did not use a condom with him, that is why I got pregnant." However, Tessa always used condoms with her customers (when she was still a sex worker), but not with friends and live-in partners because she knew them ("*kay kaila man ko nila*").

- "Despite all these, I kept my silence ("*hilom lang ko*"). I look at life with hope. I know that I am an industrious person and I know how to look for money. I help my mother in the eatery business."

**B. Cebu Case No. 2: Tessa**

47. Tessa, was born in Lapu-Lapu City (east of Cebu City) but resided in Cebu City (Day-as) at the time of the study. She has had three live-in partners. She met the first one, who came from Mindanao, when she was 18 years old. They had a son who, at the time of study, was graduating from elementary school. That relationship failed and she parted ways with him. The second was when she was between 20 and 21 years old. She left her son with her mother, but again, the relationship was a failure. Her third (and current) live-in partner is a male nurse, who obtains support from an aunt who works abroad, and who was reviewing for the CGFNS exam at the time of the study. They have a son. Tessa stopped doing commercial sex work when she got pregnant with her second child. Box 2 presents Tessa's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

48. Tessa used to have a good life ("*maayo nga kinabuhi*"), and her family would only wake her up to eat ("*pukawon ra man ko sa amo kung mokaon*"). When she was still a student, she had a substantial daily allowance from her family and took a taxi to and from school – she has never tried taking a public utility jeepney. Box 2 presents Tessa's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.



49. She has experienced discrimination from family members and relatives. "It is as if I have leprosy, they are afraid to come near me, and if I go home to visit them, they would say I am asking for money again. Even if I am not on drugs they would say that I am. My relatives think I am crazy or mentally disturbed. My cousins are not allowed to go out with me because they might learn to use drugs from me."

### C. Cebu Case No. 3: Kelly

50. Kelly, a resident of Mandaue City, started using drugs (injectables, particularly Nubain; cough syrup; and shabu) when she was 14 years old as a result of peer influence and curiosity, and not because of a personal or family problem. Box 3 presents Kelly's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

51. On her own volition, Kelly underwent hepatitis and HIV tests, which gave negative results. On stigma and discrimination, she says:

52. *"Kaming babaye nga naay bisyo kasagaran gyud sa mga lalaki ubos ang ilang pagtan-aw. Ang ubang baye kahibalo sila nga gibastos na sila sa ubang lalaki, mura lang gani og wala. Di gyud malikayan, kay bisan moanha lang ka diha magtuo sila nga ana ka. Ako bisyo ra gyud ng akong anhaon diha."* [Men have low regard for women with vices. Some women know they are being disrespected, but do not mind it. It cannot be prevented, because once you go there (referring to the injecting site) men would think that you are like that (referring to a woman who would agree to have sex). I just go there for my vice.]

### D. Cebu Case No. 4: Vanet

53. Vanet, 20 years old, Roman Catholic, with one year in college, was born in a municipality located approximately 70 km from Cebu City. In the last three years now, she has been residing in a lowland barangay (Labangon) 8 km south of Cebu City. Vanet has two sisters (26 and 25 years

#### Box 3: Cebu Case No. 3 - Kelly

**Age:** 28 **Religion:** Roman Catholic **Education:** 1<sup>st</sup> year Dentistry

**Profile.** Kelly, a 1<sup>st</sup> year Dentistry student, who also works as a call center agent, earns a monthly income of PhP15,000. She has a brother and a sister, and her family is engaged in an electronic business that earns approximately PhP3,500 - 5,000 per day. She got married at age 27 and, at the time of the study, had a nine-month old baby. Her husband, himself a regular injector, works as a company collector and earns an average of PhP1,500 a week.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Kelly started using drugs (injectables, particularly Nubain; cough syrup; and shabu) when she was 14 years old as a result of peer influence and curiosity, and not because of a personal or family problem. She has used all three drugs in one sitting (first, they injected Nubain, then sniffed shabu, and took cough syrup). "It was just for fun" until she became a regular injector and a shabu user.

Kelly claims to have a supportive family who provided her with all her needs when she was still living with them. When her parents found out about her drug behavior, Kelly was sent to a rehabilitation center at age 15. She stayed there for six months. When she got out, Kelly went back to using drugs saying that all of her friends are users, and she could not avoid joining them. At age 19, she was again sent to a rehabilitation center where she stayed for two months. Kelly never stopped using drugs, until she got married to one of her friends, an IDU who is also an occasional user of shabu. She has been injecting for 14 years now, usually four times in one day.

Even at the workplace, Kelly finds time to inject. She buys one ampoule before going to work and injects 0.3 ml in the toilet during her break or any time she wants to. Because Nubain could not be bought at any pharmacy without a doctor's prescription, she goes to the "center" to obtain drugs from a regular supplier. In 2007, when supply for Nubain became scarce, Kelly started to use the generic brand they call "Nalvo," which she finds to have a stronger effect on her. Kelly reduced her frequency of sniffing shabu since the time a drug test was conducted among agents at her workplace. She injects everyday, but sniffs shabu only twice a week.

Kelly also admits that because of curiosity, she has tried injecting Nubain with shabu (milkshake), but she had an overdose when she consumed eight ampoules of Nubain and "milkshake" in just one day. She experienced difficulty in breathing, was hospitalized, and had fever on and off for a month. Kelly was also found to have a heart ailment. At the hospital, she was advised by the doctor to stop using drugs, but Kelly found it difficult to stop. A week after the hospitalization incident, she went back to injecting drugs. If she is unable to inject, she experiences fever and headache, and feels cold all the time. Even when she was pregnant (1st to 7th months), Kelly continued to inject drugs either with friends or with her husband.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Kelly believes that there is no risk in drug injecting (that is why she does it often), and it all depends on the person doing it. In the 1990s, when she was in high school, she has joined discussions on STI, HIV, and hepatitis as part of a class requirement. She learned that one can get malaria, hepatitis, and AIDS from injecting drugs. When asked where she would go, should she need information on HIV, Kelly cites the CHO and the local barangay health facility.

When asked whether she has availed of any HIV programs/services, Kelly says she has heard of a needle exchange program and she finds this "acceptable because an unused needle is safer." However, "syringes, which are supposedly given free to IDUs at the "center," are now for sale and not given free." Kelly also cites condom distribution as "equally important, particularly for women, because they need to protect themselves from HIV/AIDS; seminars and discussions on HIV/AIDS are helpful for both women and men."

**Experiences Related to Stigma and Discrimination.** Although Kelly does not recall any experience related to stigma and discrimination, she believes that most men think that women injectors also provide sex services, saying that men have low regard for women with vices, and that some women know they are being disrespected, but do not mind it. She said that this could not be prevented, because once you go there (referring to the injecting site) men would think that you are like that (referring to a woman who would agree to have sex). "I tell them that I only came here for my vice."

**Sexual Behavior and Practices.** She first had sex at age 13, and condoms were never used at that time. However, she uses a condom with her husband – to prevent another pregnancy and because they are both injectors. This is a decision which both of them have made.



**Box 4: Cebu Case No. 4 - Vanet**

**Age:** 20      **Religion:** Roman Catholic      **Education:** 1<sup>st</sup> year College

**Profile.** Vanet got pregnant got married at age 19. She has a one-year old son with her husband (26). He works as assistant to Vanet's father and earns PhP250 a day. When she got pregnant, her parents advised her to stop going to school. Vanet was not engaged in any economic activity at the time of the study, and stays at home to take care of her child.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Vanet has been injecting (Nubain, and lately Nalvo) for two years now (she started at 18), usually three times a day. She started using shabu when she was 16 years old as a result of peer influence and not because of a problem in the family. Her boyfriend (now her husband) is also an injector, who taught her to inject. It started when she was drunk one night and he told Vanet that she "will get over the dizzy feeling" if she injects. After the first injection episode, Vanet felt good and light-headed, and started to appreciate it. She prefers to inject (than sniffing shabu) saying, "*mas maayo ang tama*" (the effect is better).

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** In August 2007, for more than a month, Vanet tried to stop injecting, but her body craved for it ("*nangita ang akong lawas*"). She experienced withdrawal symptoms such as body malaise, headache, chills, hot and cold feeling, sleepiness, and skin disorder. Vanet usually injects, with her husband, three times in a day, with 0.3ml per injection, although there are times when she injects alone or by herself. She starts at 6:00 AM, then between 12:00 noon and 1:00 P.M., and gets her last dose between 7:00 to 8:00 PM. Although she prefers Nubain, she uses the generic "Nalvo" when the supplier does not have supply of the former. One ampoule of Nubain costs PhP140, while Nalvo costs PhP70. A syringe with an orange cap costs PhP20, while the one with a non-orange cap costs only PhP12. They inject at home, but they usually inject at their usual congregation site, saying that is the only place they know of ("*mao ra ni lugar among nahibaluan*"). Sometimes, Vanet shares a needle with her husband when they only have one, and they clean the syringe with alcohol ("*pasiritan lang og alcohol, after nako, gamiton sa akong bana dili niya limpyohan*"). She is always the first one to use it, and has not tried sharing a needle with others. She prefers to inject alone or with her husband, and although they inject in a group, they have their own needle. During the first two months, Vanet's husband did the injecting on her, but she later learned to do it by herself, as her husband had to go to work.

Vanet is aware that she can get hepatitis if she uses a used needle, and thinks that it can be prevented by using a new needle, or by not using a needle used by others. She heard of HIV from an IDU in the congregation site, but thinks that she does not have the possibility of being infected because she is careful with the syringe that she and her husband is using, and they do not share needles with others, except with themselves. Vanet has not experienced overdose or hepatitis. When asked about HIV preventive measures, she mentioned "cleaning the syringe" and "buying new needles."

Even during her first month of pregnancy, Vanet continued to inject. She could not say if she could stop the habit because her "body craves for it." If she does not inject, she becomes irritable or easily gets angry, the reason why she ends up quarreling her husband. Both of them have tried quitting, but the feeling of discomfort makes them go back. Vanet has not tried "milkshake" because she says, "it is dangerous and can cause death" ("*dilikado ug makamatay*").

Vanet is aware that information on HIV/AIDS can be acquired from the CHO, but she has not tried any test for HIV nor attended meetings and discussions on STI, HIV, or hepatitis. Vanet is also not aware of any program of government for IDUs, but says that should there be programs for them so they would understand the risks and prevent themselves from acquiring the disease. She says that nobody has approached her to talk about rehabilitation.

**Experiences Related to Stigma and Discrimination.** Vanet claims that other people in the community where she lives do not know that she is a drug user. Hence, she has not experienced discrimination from others or from her family. However, she says that when the time comes when people start talking about her, she will feel bad, saying that "other people do not have the right to mangle in her affairs."

**Sexual Behavior and Practices.** Vanet first had sex at age 16. She claims that she uses a condom two to three times a week when having sex with her husband to prevent another pregnancy. Even her mother-in-law advised them to always use the condom, but sometimes her husband would insist on not using it. Vanet does not mind a condom, but could not do anything at times when her husband does not want to.

old) and two brothers (23 and 17 years old). Her father manages a transportation business which earns an average of PhP2,400 a day, and her mother manages a store situated about 68 km south of Cebu City, earning an average of PhP2,000 per day. Vanet got married at age 19 and has a one-year old son. Box 4 presents Vanet's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

54. Vanet has been injecting (Nubain, and lately Nalvo) for two years now (she started at 18), usually with her husband, three times in a day, or alone by herself. She says that nobody has approached her to talk about rehabilitation.

- "*Nindot na siya para makahibalo ka unsa gyud ang meaning ana o angay ipasabot anang mga programaha o services. Makaayo na sa among health.*" [That is good so that one will understand the program and the services offered. That would be good for our health.]
- "*Ang needle distribution para makalikay sa sakit gikan sa hugaw nga*

*dagum. Ang HIV/ AIDS information para makalikay sa sakit nga HIV ug sexually transmitted disease.*" [Needle distribution will help us avoid diseases that may be transmitted from dirty needles. HIV and AIDS information is needed to prevent HIV and sexually transmitted diseases.]

**E. Cebu Case No. 5: Cetrin**

55. Cetrin was born in Talisay City but was a resident of Cebu City at the time of the study. She has four brothers (ages 29, 27, 25 and 15 years old). Her father is unemployed for health reasons and her



mother works intermittently as an assistant to a real estate agent. Box 5 presents Cetrin's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

56. Cetrin has been injecting for two years now. She prefers to inject by herself or with her boyfriend in her room. Her usual practice is injecting in a group (boyfriend, a male friend, a female friend) at the "center" using only one needle. They share needles and clean this only with water between users. She has never tried cleaning a needle with a bleaching solution.

57. Cetrin feels that people have low regard for IDUs ("*ubos ang ilang pagtan-aw namo*"), particularly when she hears them say "*mo-shoot diay ka? nganong mo-shoot man ka oi nga babaye man ka?*" (Do you inject drugs? Why do you inject drugs when you are a woman?) But she does not mind these talks ("*dili ra nako tagdon, dili ra ko magtagad ana, balewala ra na sa akoa*").

#### F. Cebu Case No. 6: Jenalyn

58. Jenalyn, 17 years old, single, was born in Cebu City (Guadalupe), has two sisters and one brother, and is the second child in the family. Her mother is a self-employed housewife, and her father, a construction worker earning an estimated monthly income of PhP1,500. Jenalyn's education is supported by her aunt, a former OFW, who has an OFW husband. Her family and her boyfriend do not know anything about her injecting behavior. She injects because her friends are doing it. Box 6 presents Jenalyn's

#### Box 5: Cebu Case No. 5: Cetrin

Age: 31 Religion: Roman Catholic Education: 2<sup>nd</sup> year Commerce

**Profile.** Cetrin, 31 years old and Roman Catholic, had two years in college as a Commerce student. While in College, Cetrin worked as a TV soap opera talent in Cebu. She stopped schooling when she met and 'married' a 46-year old businessman who was also married to another woman. They have had seven children, but three of them died (4 months old, 2 months old, and a stillbirth), reportedly of unknown causes. They lived together in Luzon with her husband's parents, until one day, they caught her using shabu. Cetrin and her children were asked to leave ("*guipalayas*") the house.

While her husband went back to live with his first family in Cebu bringing with him his only son with Cetrin, the latter returned home to her parents' house. Because of a misunderstanding with her family, she decided to leave her three other female children with her parents, and ended up living in a community where IDUs abound. Her husband, she says, continues to provide financial support (PhP400-500/day) for her daily needs. Either she goes to his workplace to get the money or he brings the money to her house where they also have sex sometimes. In this community, she works as a sex worker, earning PhP12,000 a month.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Cetrin started using shabu when she was 19 years old while working as a TV talent. She narrated that her male co-workers, including the director, taught her how to use it to keep her awake during rehearsals or tapings, until she became a habitual user of shabu. The situation became worse when she resigned from work because of some interpersonal problems with other workers at the workplace ("*lagot man ko kay daghang samokan sa trabahoan*"). She and her friends would sniff shabu between 11-12 AM, 6-8 PM, 10-11PM, and 3 AM.

She learned to use injectable drugs at age 29 when she had an IDU boyfriend, after her husband decided to go back to his first family. This made her very upset, hating her husband's wife. This was her problem, and she thought of this all the time that she could hardly sleep at night. Her boyfriend advised her to inject so she can sleep, and so she did. Both of them also used shabu (but not injected), depending on the availability of money. One day, she experienced nausea and felt weak, so she stopped using shabu but continued injecting drugs.

Cetrin has been injecting for two years now. At the time of the study, Cetrin would Nubain (PhP40 for every 0.3 ml) and a syringe (at PhP20) everyday from the supplier in the same community where she lives. A syringe, she says, is used four times before this is discarded. Her usual dosage per injection is 0.3 ml, and she injects usually six times in one day, usually between 10 AM to 12, 1-4PM, and 6 PM to 12 midnight. For fear of police arrest, Cetrin prefers to inject alone or by herself (or with her boyfriend) in her room. But her usual practice is that she injects in a group (boyfriend, a male friend, a female friend) at the "center" using only one needle. They share needles and clean this only with water between users ("*para lang mawala ang dugo*"). She has never tried cleaning a needle with a bleaching solution. They have tried "milkshake" (Nubain mixed with shabu), and injected "just for fun" ("*kabuang lang gud*"). She stopped after the first try because of a negative experience (cold feeling and vomiting).

When she injects only with a boyfriend or a female friend, Cetrin claims that a small amount of Nubain is used to clean and flush the syringe once just to eliminate blood droplets. Whoever pays or buys a new syringe is always the first one to use it. She says "I am not afraid to use her or his syringe because it's just the two of us using it" She has not experienced overdose, but there were times when she had unusual feelings such as headache, nausea, or a feeling of discomfort. Cetrin thinks she has hepatitis.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Cetrin has not tried any test for HIV and has not attended any meetings, seminars, or group discussions on this. She does not know where to get information about these, and claims that she has not availed of any services offered by government. However, she knows that a faith-based NGO is helping sex workers and IDUs in the community where she resides, and they distribute condoms to prevent HIV infection. This group, she says, is helping ensure the safety of sex workers, and she asks them for condoms once a month. She suggests that free syringes be distributed also.

She heard of HIV at the "shooting place" ("*shootanan*"), and said that in order to keep away from HIV, she learned that one should stop injecting. There have been times when she thought of quitting (referring to drug use, both shabu and injecting), but as she thinks of problems and heartaches all the time, she was tempted to go back.

**Experiences Related to Stigma and Discrimination.** Cetrin feels that people have low regard for IDUs, but she does not mind their talks

**Sexual Behavior and Practices.** She first had sex at age 17. After her separation from her 'husband,' Cetrin became a club dancer and started to accept customers for sex services at PhP1,500 per client (without her husband's knowledge). On average, she has two clients per week. She uses the condom during sexual intercourse with customers, but not with her husband (or IDU boyfriend), for fear of what he might do to her. When asked about her boyfriend, she says, "*dili man ni siya mangabang, wala ni AIDS*" (he does not buy sex, he does not have AIDS). On average, Cetrin has two clients per week, and she charges PhP1,500 per customer. She also admits that, although she and her 'husband' have separated, they have sex whenever he comes to visit her to give her money.



**Box 6: Cebu Case No. 6: Jenalyn**

**Age:** 17      **Religion:** Roman Catholic      **Education:** 2<sup>nd</sup> year Nursing

**Profile.** Jenalyn, is the second child of four siblings. At the time of the study, Jenalyn had a boyfriend – a college student who smokes, but does not inject, and does not know anything about her injecting behavior.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Jenalyn started injecting drugs at age 17 because of curiosity and peer influence. It started when she was told by a female friend, an injector herself, to try it so she would not be ignorant (*"suwayan aron dili ma ignorante"*), and said that it will make her feel sleepy (*"katulogon ka"*). They first did it in school, and she liked it (*"giganahan ko"*). Jenalyn says, *"na feel nako nga ingon ato diay ng mag-inject... hangtud nakat-on ko... hangtud naanad nalang ko."* (I felt what it means to inject, until I learned to do it by myself and got used to it). She claims that she does not have any personal or family problem, and she just wants to inject because her friends are doing it. Jenalyn has kept this a secret from her parents and her boyfriend, and does not bring her classmates or female groupmates to their house for fear that her mother might suspect. Her family knows that she smokes cigarettes, but they do not mind her doing so.

Jenalyn uses only Nubain, and her usual dosage is 0.2ml (costing PhP20) per episode. She injects drugs with male and female friends (but mostly with males) twice a week, between 8-9 AM or between 4-7 PM, or between 12 midnight and 3 AM. She has a male friend (somebody who is close to her but has no romantic feelings for) at the IDU congregation site, and they inject at the "seller's house" (*"balay sa namaligya"*). She says that it is safe there because they know the owner, and sometimes he agrees that we pay later if we do not have enough money (*"puwede ra utang, unya ra mobayad"*). She has been injecting for two months now.

At school, Jenalyn's friends are mostly females who are also injectors, but at the injecting site, her friends are mostly males (a high school student, parking aides, bystanders). Her friends would steal or snatch other people's things just to have money for drugs. *"We have a give-and-take relationship, we share resources."* (*"iya-iya man mi og hatagay gani, kon wala siyay ayo karon, naay mo-free niya."*)

Jenalyn, or her male friend, buys the drug and syringe from the congregation site. She injects in a group, but has not tried using a needle used by others or by her friends because she fears acquiring HIV or hepatitis. She learned from someone that sharing needles can cause hepatitis, and she says that this is also the reason why she injects only twice a week. Jenalyn uses her own needle twice before discarding it, and does not clean it with anything, saying *"ako ra bitaw ang mogami"* (I am the only one who uses it anyway). She throws the used syringe in a garbage bin because of a notice at the seller's house that says "do not throw the syringe anywhere, a child might pick it up" (*"dili pataka'g labay og syringe, naa unyay makapunit nga bata"*).

She has observed that when sharing needles, her friends would clean the syringe using alcohol. Jenalyn prefers that someone else does the injecting for her, although she knows how to do it when she injects by herself. She prefers to 'shoot' with friends for "jamming" purposes.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Jenalyn heard of HIV when she was in high school and in college as part of a class lecture. She has not tried a test for HIV, but has been interviewed by an NGO about it in 2008. She says, *"nakatabang gyud sila, tudluan mi unsaon paglikay ana, kon unsaon nga dili ka matakdan anang sakita."* (They have been a great help, they taught us how to avoid and prevent an infection). She has also attended a lecture on HIV and was told that that she can get information about HIV from the NGO. She has heard about needles and condoms, which are distributed free, but has not availed of the service. On services needed for women users, Jenalyn suggests, "provide HIV and AIDS information to women users so they can be prevented from acquiring a disease, including hepatitis, because others say that it can cause death".

**Experiences Related to Stigma and Discrimination.** She has heard of talks (in the community where she injects) such as *"sayanga anang babayhana oy, gaskuwela pa baya... sayanga niya og barog... enter-enter ra diay og shoot-shoot"* (This woman is such a waste. She is still in school, she is beautiful, but she is involved in injecting drugs). Upon hearing these, Jenalyn thought of quitting.

**Sexual Behavior and Practices.** Jenalyn has not had sex with another man, except her boyfriend (a college student) since she was 14 years old, with whom she has an on and off relationship. They have sex once a week, usually after Sunday mass. They never use a condom because Jenalyn does not like it and finds it bothersome, besides, her boyfriend knows how to practice withdrawal.

drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

59. When asked whether she is aware of injecting risks, she mentions that "one can have hepatitis." An IDU, she says, experiences fever (*"hilanat"*) and tremors (*"magkorug"*) when he/she is unable to inject. She does not think that she has any chance of acquiring hepatitis or HIV because she is an "occasional user" (twice a week) and uses her own needle or a service needle, even when she is with friends.

60. Jenalyn says that programs of government for IDUs can help raise their awareness on how to prevent diseases, such as HIV and hepatitis, and how to manage the consequences of injecting drugs. If invited again, she is willing to attend discussions and avail of government services. She has thoughts of quitting drugs especially when she heard some people talking about her.

61. Jenalyn never uses a condom with her boyfriend because she does not like it. She says, *"dili lang ko ganahan kay lain man kuno na, kay samok, ingon man sila nga mas nindot man kuno kung wala na."* (I just do not like it, they say it's not good. It's bothersome. They say it is better without it.) Besides, "he knows how to control" (*"kabibalo siya mo control"*), referring to their practice of withdrawal.

**G. Cebu Case No. 7: Janjan**

62. Janjan was born in Carcar, Cebu. Her mother is engaged in a shoe business, earning an average of PhP1,200 a week, and her father is a government employee. At the time of the study, Janjan had a boyfriend, a college student and a native of Carcar. Box 7 presents Janjan's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

63. At age 14, Janjan was introduced to



**Box 7: Cebu Case No. 7: Janjan****Age:** 18    **Religion:** Roman Catholic    **Education:** 2<sup>nd</sup> year College

**Profile.** Janjan, 18 years old, single, Roman Catholic, with two years of college education, is a member of a known fraternity in Cebu. Janjan says that she is an illegitimate child and saw her father only when she was 5, 14, and 17 years old. Her parents had been separated since she was two years old. Her mother left for Manila to work. Janjan lived with her grandparents in a rural area south of Cebu. At age 16, her uncle brought her to Manila to stay with her mother. She stayed there for only two months and came back to live with her grandparents. Eventually, she ran away from home and lived with a female friend who brought her to a club to work as a dancer in cheap bars where she earned only PhP150-300 a night. She stopped dancing to work for a pimp who would send her text messages (SMS) whenever a customer was willing to pay her between PhP1,500 - 2,500 per night. In a week, she earns PhP5,000. At the time of the study, Janjan had a boyfriend, a college student. .

**History and Evolution of Drug Use, Drug Combinations, and Practices.** At age 14, Janjan had a boyfriend, reportedly a "drug lord," who taught her how to use shabu. Because shabu is expensive, and there were times when she and her friends would "feel bored" but do not have money, they would use "weeds" (her term for marijuana).

Out of curiosity, Janjan learned to inject drugs at age 18, "to go with the fad" and because she heard from her friends who are drug injectors, that "it will make her feel tired and sleepy." With shabu, Janjan could not rest and sleep properly ("*dili makatulog og tarong*"), and felt like she was always drunk ("*mura ko'g perming hubog*"). With injectable drugs, she feels "relaxed."

Janjan injects three times a day (0.3ml Nubain per injection episode), between 8-9 AM and 1-3 PM. For every 0.3 ml, she pays PhP60 and PhP20 for a new syringe. Although she uses Nubain most often, she says that the generic brand, which they call "Nalvo," has a stronger effect. She prefers Nubain saying, "*kay makaya ra ang epekto*." (The effects are manageable.)

When she injects at her friend's house, she buys her own syringe, uses it only once, and leaves it there (or does not mind if others use it). The live-in partner of Janjan's female friend is a drug dealer, and a "brod" in the fraternity. Janjan has used his syringe three times already, but he would clean this with water between uses (by simply flushing until blood is completely flushed out). A small amount of water is used to clean/flush the syringe, after which the water is discharged through a series of whipping motions. Sometimes, no water is used at all, and the syringe is emptied of blood droplets by sharp taps with one's finger. The group sometimes uses/sniffs shabu first prior to injecting Nubain, saying "the effect is better." They pool their resources (about PhP300) to buy shabu and injectable drugs. She injects with her "brod," her "brod's" girlfriend, another female friend, and her current boyfriend whom she taught to inject. Sometimes, there are others (whom they do not know) who inject with them. Janjan prefers to be in a group or with friends when injecting. Besides, she does not know how to do it herself and has never tried. It is usually done by her "brod," and they use only one syringe.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** While in school, Janjan learned in Biology and Psychology classes that HIV can be acquired through sexual intercourse. She thought of quitting drugs when a non-injector friend got mad at her, and because she was told that it can cause death ("*naa ko'y plano nga moundang kay nasuko akong friend, nahadlok pod ko kay makamatay kuno na*"), but until the time of this study, she continued to inject. Janjan undergoes a hygiene check every week, but she has not tried an HIV test.

She has attended meetings and discussions on STI, HIV, and hepatitis but could not remember the name of the organization that initiated it. Except for free condoms and free medicine provided by a faith-based NGO in the community, Janjan has not availed of the syringes which are given for free. She was once invited by a faith-based NGO to attend a seminar on HIV prevention, but failed to attend. She knows that she can get information on HIV from the health center, public and private hospitals, and schools. Her uncle told her that she should be sent to a rehabilitation center because she is a member of a fraternity, she is always out of the house, and he suspects that Janjan is on drugs.

**Experiences Related to Stigma and Discrimination.** Janjan has experienced discrimination, particularly from people who would say "yaks!" Some say "she's dirty" because she is a woman and she injects drugs. Janjan thinks that maybe they find IDUs dirty because their skin has warts "as a result of using Nubain." Some people have told her that IDUs die early because they can easily contract disease, and advised to stop injecting because some people have already died. Janjan fears that this would happen to her, and says that "in time, I know that I will need to stop this."

**Sexual Behavior and Practices.** Janjan first had sex at age 14. She uses the condom with customers, but not with her boyfriend because he will not allow it. She has also never used the condom with a former boyfriend. If she uses a condom with a boyfriend, "he would say that she does not trust him." However, with a customer, Janjan would leave if he insists on not using the condom. Her clients are mostly policemen and Koreans, and some are students. Some of her student customers are also IDUs.

shabu and marijuana. At age 18, she started injecting drugs (Nubain). She feels more relaxed with the effect of injecting Nubain than sniffing shabu. She has not tried injecting shabu with Nubain (or Nalvo) and does not have any plans of trying ("*wala'y plano*"). She says that needle sharing is a way to acquire HIV, and the use of one's own syringe is a way to prevent it. She thought of quitting drugs when a non-injector friend of hers got mad at her, and because she was told that it can cause death ("*naa ko'y plano nga moundang kay nasuko akong friend, nahadlok pod ko kay makamatay kuno na*"), but until the time of this study, she continued to inject.

64. She desires that other women will be aware of the effects of needle sharing and suggests the following: (i) distribute new syringes, (ii) distribute pamphlets on HIV and its preventive measures, and (iii) conduct seminars on how to inject properly. Janjan undergoes a hygiene check every week, but she has not tried an HIV test.

65. Although she is aware of the mode of transmission of HIV is thru sexual intercourse, she uses a condom with her customers but not with her boyfriends. If her customer will not agree to using a condom, she leaves them.

**H. Cebu Case No. 8: Marian**

66. Marian, 21 years old, single, and Roman Catholic, is a fourth year Nursing student. She has two brothers and four sisters. Her family is from Davao City. It was their parents' decision that

Marian and her sister study and work in Cebu, where they have relatives. Her father manages a family



land business, and her mother is a barangay health worker. While Marian's mother earns approximately PhP10,000 a month, her father does not have regular income. Box 8 presents Marian's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

67. At age 16, while Marian was in high school, she had her first experiences in drugs and sex. Her friends in high school introduced her to first to marijuana, cough syrup, then shabu. At age 19, a male friend introduced her to inject drugs. She injects drugs four times a day, usually 0.3ml (at PhP45.00) every injecting episode, starting at 4 PM and between 8-12:00 PM.

68. Marian says that a needle is also shared among users. Sometimes she gets to inject first, sometimes she injects last, and they clean this between users by just flushing blood droplets, by pumping the syringe and making sharp taps on the syringe with one's finger.

69. Marian heard about HIV from other IDUs. She has heard of announcements that there are activities on HIV awareness raising but Marian considers these "a waste of time" ("*saya-sayang lang na sa oras oi*") and has not attended any. She believes that such information on HIV and AIDS can be obtained from other sources such as the internet, books, barangay health center, health workers.

70. Marian is experiencing "memory gaps" ("*kalimtanon*") and trembles whether she has injected or not. For a week, she was able to stop, but the withdrawal symptoms made her resume injecting.

#### I. Cebu Case No. 9: Mingay

71. Mingay, 45 years old, has three sisters and five brothers. Her mother

#### Box 8: Cebu Case No. 8 - Marian

**Age:** 21      **Religion:** Roman Catholic      **Education:** 4<sup>th</sup> year Nursing

**Profile.** She has two brothers and four sisters. Her family is from Davao City, but for many years, Marian and her sister (who works in a pharmacy) have shared a room at a boarding house in Cebu (Guadalupe). It was their parents' decision that they study and work in Cebu.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** In high school, Marian (16) started using marijuana with friends. They then tried cough syrup and shabu at different times. Because shabu is expensive, Marian oftentimes resorts to using marijuana and cough syrup. At age 19, her male friend taught her to inject drugs. He brought Marian to one of their injecting sessions. At first, she watched them "shoot." Later, he injected her until she became a regular user of Nubain, and sometimes Nalvo, the generic drug. Marian injects drugs almost everyday. She says that everything started out of curiosity and not because of a family problem "*Lingaw ang mag shoot, pang pastime man lang,*" she says. She has been injecting for two years now, usually four times in a day.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Marian injects drugs four times a day, usually 0.3ml (at PhP45.00) every injecting episode, starting at 4 PM and between 8-12:00 PM. Sometimes she injects alone at her boarding house (when her sister is not around, after she learned how to do it by herself), sometimes in the comfort room at school, but most of the time, at the congregation site where she and her friends buy drugs and syringes (at PhP20) from a regular supplier. When at the congregation site, Marian injects usually with her *barkada* composed of one female and three males. They would buy and share expenses for one ampoule (PhP130) and divide the drug among three to five persons. They inject in a group three times a week. She says she enjoys injecting with friends because she finds it "boring when she is high on drugs and they are not around". During the first few times, a male friend would do the injecting for her. Later, she learned to do it by herself.

Marian says that a needle is also shared among users. Sometimes she gets to inject first, sometimes she injects last, and they clean this between users by just flushing blood droplets, by pumping the syringe and making sharp taps on the syringe with one's finger.

Marian heard about HIV from other IDUs. She has not had an HIV test, nor has she attended meetings or group discussions on AIDS. She says she heard of announcements that there are activities on HIV but Marian considers these "a waste of time" ("*saya-sayang lang na sa oras oi*"). "Information on HIV and AIDS can be obtained from the internet, books, barangay health center, health workers," she says

She has not experienced overdose or hepatitis, but says she has "memory gaps" ("*kalimtanon*"). As a side effect of using drugs, she trembles all the time, whether she has injected or not. She has thought of quitting, saying it is a waste of money ("*usik sa kuwarta*"), and she pities her parents who give her money that she only uses to buy drugs. For a week, she was able to stop ("*kay usik sa kuwarta*"), but the withdrawal symptoms she experienced (cough, a feeling of malaise, and cold feeling), made her resume injecting.

She could not say if she has a chance of acquiring infection. Instead, she replies "*ambot lang kay dili man kita ang nagkupto sa atong kinabuhi*" (I do not know because we have no control of destiny). When asked about HIV prevention services, Marian avers that she has received free condoms in the congregation site as well as referral for rehabilitation, although she would not want to go to a rehabilitation center. Her suggestion for female IDUs is "to be always aware that they are using a clean needle to prevent HIV."

**Experiences Related to Stigma and Discrimination.** Although none of her relatives know that she is a drug user, Marian says that this is what people say to drug users, particularly if one is a woman: "*babaye baya ka, sayang kaayo ka, adik ra diay ka, unsaon pagrespeto nimo nga dili manka mo respeto sa imong kaugalingong tungod kay adik ka.*" (you are a woman, you are a waste, you are an addict, how will other people respect you if you do not respect yourself by being an addict). Further, she says: "*dili gyud na malikayan labi na kay babaye ko, kanang barkada nako se eskuwelahan, at first nagbadlong sila sa akua nga babaye baya ka, di iba ka maluo sa imong sarili, adik ra ka.*" (You could not prevent it most especially if you are a woman. My other friends at school reprimanded me at first. They said that I am a woman, and asked if I don't pity myself, being an addict.)

**Sexual Behavior and Practices.** Marian had sex for the first time when she was 16 years old. Her previous sexual partner was an injector himself. He lived in Davao City but would sometimes come to Cebu to visit her. When they had sex, they did not use condoms, mainly because they had sex when they were drunk and high on drugs. Further, she says "nobody has ever told me that a condom must be used, I only knew about it from friends when they shared their experiences."



**Box 9: Cebu Case No. 9 - Mingay****Age:** 45      **Religion:** Roman Catholic      **Education:** 2<sup>nd</sup> year High School

**Profile.** Mingay, 45 years old, Roman Catholic, and with two years in high school, was born in Cebu City (San Antonio). At age 16, Mingay, her sister, and a female classmate got drunk and found themselves in a boat going to Manila the next day. The man whom they had not met before brought them there and assured them that he would bring them back to Cebu. There was nothing they could do. They landed as sex workers in a casa (brothel), locked in a room, and allowed to go out only when they had customers. Mingay's first sexual experience (at age 16) was with a Japanese client. To avoid embarrassment, she did not inform her family of her experience in Manila. For many months, they were not paid for providing sex services, until Mingay found a way to get out, leaving her sister behind. She went to a park in Manila, and there she met another pimp who offered to bring her to another brothel where she would be paid for doing sex work. Eventually, she found a Chinese boyfriend, stopped working as a sex worker, and they lived together for three years. But the man was the jealous type and constantly battered her. Mingay decided to run away and went back to Cebu, even when she knew she was pregnant. In Cebu, she gave birth to a son, became a pimp herself, and continued to provide sex services. She met another man, himself an injector, and they got married. At the time of the study, Mingay's husband was a garbage collector, earning PhP2,000 a month. They have eight children (four females and four males), bringing her total number of children to nine. For health reasons and because he experienced lung problems, Mingay's husband stopped using or injecting drugs.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** In high school, Mingay started using cough syrup at age 13, out of curiosity. In Manila, as an unpaid sex worker in a brothel, she used rugby, marijuana, and shabu which later on became a diversion to forget her personal problems. At age 42, and as a result of peer influence, Mingay tried using injectable drugs when a female friend, also an injector, convinced her that nothing will happen to her, except feel sleepy. A regular injector for three years now, she injects six times a day, i.e., between 8-11 AM, 3- 4 PM, and 7 PM - 12 midnight. She had an IDU boyfriend. She tried "milkshake" with friends (shabu melted, mixed with Nubain, and injected), but stopped when she experienced its negative effects - initially active/energetic, then experiencing sweating, fast/strong heartbeat. "I was always afraid as if I would fall down."

Mingay feels alive whenever she injects. In most cases, she shares needles with others, either with the female friend who first taught her to inject, or with other male injectors at the shooting place (since her husband no longer injects). Mingay admits that she has never tried cleaning a needle, but she has observed that at the "shooting place" ("*shootananan*"), the seller cleans the "service needle" only with water between users. A small amount of water is used to clean/flush the syringe three times, after which the water is discharged through a series of whipping motions until the syringe is emptied of blood droplets. There are around six service needles available in case a user does not have his/own own, and cleaning the needle is part of the seller's service. Sometimes, Mingay (or her friend) would buy a new syringe (at PhP20) before they would go to the seller's house. The seller would ask them to just leave the used needle/syringe because they can still let others use it as a service needle. Mingay (and her friend) have stopped buying or bringing their own syringe since service syringes are available.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Mingay's husband no longer injects drugs for health reasons, and he wants her to do the same, particularly when she got sick with lung problems. Mingay finds it difficult to stop. If her husband refuses to give money, then she goes into tantrums and would not stay at home. Her husband is forced to give her PhP20 (to buy 0.2ml of Nubain).

Mingay admits she has limited knowledge on HIV and AIDS, but has heard of hepatitis from another drug injector. She knows that "*tulo*" or "*sira*" (referring to syphilis or gonorrhea) can be acquired through sexual intercourse. When she was a sex worker, she availed of the weekly hygiene check conducted by the CHO. Mingay is appreciative of the services provided by a faith-based group to sex workers and drug injectors. A priest goes to the community where their shooting place is located to distribute condoms to sex workers and even medicine when she had lung problems. She also availed of the free syringes distributed by a group of outreach workers. On HIV prevention services for women IDUs: "A needle distribution program is good, I can prevent myself from acquiring a disease, I can save on the cost of the needle." Mingay does not know of any risks from injecting drugs, although she has heard of someone dying of tetanus from using a used syringe. She admits, however, that she is starting to reduce her dosage to 0.1ml per episode, the frequency of drug use from six times a day to two or three times a day because of some uncomfortable feeling, and her intake of alcohol for fear that her lung problem might get worse.

**Experiences Related to Stigma and Discrimination.** Members of her community discourage others to be her friend because she is an addict and judged as bad. Some take pity on her and understand her. Mingay has started to reduce her daily dosage and frequency of drug use and alcohol intake.

**Sexual Behavior and Practices.** Mingay has never used condoms during sex with customers. Mingay has never used the condom with her former live-in partner and her husband because both she and her partner/s do not like it.

died a long time ago, and her father, 85 years old, is largely dependent on the monthly support (PhP10,000) given by a son who works at a hospital in Canada. Sometimes, or during special occasions like Christmas, Mingay also receives financial support (PhP500) from her brother.

72. At the time of the study, Mingay was engaged in many economic activities. She sold ladies' items and earned a minimal weekly income. As a community worker she was paid PhP1,000 monthly for cleaning the surroundings of the barangay (PhP50 per day, 5 days a week). As a 'shabu runner,' Mingay receives PhP50 per 'run' from clients. Except for one sister, Mingay said that all of her other brothers and sisters were also using drugs. Box 9 presents Mingay's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

73. When she injects at her friend's house, they buy (at Ph20) and use only one syringe, cleaning (referring to flushing) it only with tap water. They take turns on who injects first. They would share the cost for one ampoule of Nubain (PhP150), and divide the drug between the two of them (0.2 ml per person per episode).

74. Unhappy about all the talk in the community about her, Mingay has started to reduce her daily dosage and frequency of drug use and alcohol intake.



## J. Cebu Case No. 10: Mamay

75. Mamay, born in Cebu City (Cogon, Ramos), has three sisters and four brothers. Her mother is a local masseuse and her father, a taxi driver. Both of parents do not have regular income. At the time of the study, Mamay worked as a taxi cleaner/washer and earned approximately Php350 a month. Her IDU friends (one female and one male) provide her with emotional (and sometimes financial) support. They would sometimes give her money for food and also pay for her drugs. In return, she offered them services like house cleaning or anything they would ask her to do, e.g., running an errand. Sometimes, Mamay would also ask food from the owner of an eatery located near the city market and, in return, Mamay would do services for the owner. Box 10 presents Mamay's drug use history and practices, knowledge of HIV, experience related to stigma, and sexual practices.

76. Mamay began injecting drugs at age 39. for one year now, usually four times in a day. Her first injecting experience was an "enjoyable one." At the time of the study, she admitted that, despite her lack of resources, she craves for the drug and is happy to have a friend who provides her the opportunity to continue with it. Sometimes she would run errands for her friend as a way of showing her gratitude.

77. She has heard of HIV-related services (needle and condom distribution) offered by the CHO and other groups in the community where she regularly hangs out to inject, but has not

### Box 10: Cebu Case No. 10 - Mamay

**Age:** 40    **Religion:** Roman Catholic    **Education:** 2<sup>nd</sup> year Midwifery

**Profile.** At age 15, Mamay got pregnant by a Chinese boyfriend who left her six months after she delivered a female child. At 20, she went to Japan to work as a cultural dancer-entertainer, leaving her daughter with her parents. Her promoter abandoned her in Japan and took her passport. She eventually met a Filipino who offered her work as a storekeeper and food attendant. For five years, Mamay worked for this Filipino friend, until she met a Japanese boyfriend who asked her to live with him. The man taught her how to use drugs, until she became a regular user herself. She got pregnant three times, but all ended in miscarriages. Mamay was not happy with the relationship. She left her live-in partner and went back to work as a storekeeper and food attendant. She stopped using drugs because of a severe weight problem. She lived with another Japanese boyfriend for six years and had a son by him. Since she started working in Japan, she had no contact with her parents or her daughter, and she also did not send them any financial assistance.

In 2001, Mamay came home to Cebu with her son and Japanese boyfriend. They bought a PhP7.8M house and lived a luxurious life. Mamay's sister, a regular drug user, encouraged her to use drugs again. Since then, Mamay was rarely seen at home. Her boyfriend eventually knew about it, sold the house, left her, returned to Japan, and said that he would come back for her only if she stopped using drugs. Mamay befriended drug users, ran out of resources, and lived miserably. An IDU boyfriend was put behind bars (caught with shabu, Nubain, and a syringe in his pocket). Mamay has not visited him for fear that the authorities might suspect that she is also a drug user. At the time of the study, Mamay worked as a taxi cleaner/washer and earned approximately PhP350 a month but she and her son would sleep anywhere - in the street, under a tree, or at the marketplace. Ashamed that she is not able to send money, she does not seek help from her parents or other members of the family.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** In Japan, Mamay first learned to use LSD, cocaine, shabu, and other tablets from her first live-in partner, a Japanese businessman. Her addiction or regular use of these has led her to experience severe weight loss, which led her to stop using drugs. In 2001, upon her return to Cebu, she was convinced by her sister to use drugs again (shabu and ecstasy), and became a regular user once more. Mamay has been injecting for one year now, usually four times in a day. She met a friend, an injector, whom she considers a good friend because she shares her resources with Mamay even if she has nothing to contribute. During Mamay's first injecting experience, they bought a syringe at PhP30 and shared this, but her friend injected first. They cleaned/flushed the syringe/needle with hot water three times and tapped the syringe with one finger. She injects drugs four times a day, starting at 8 AM, then between 10-11 AM, 1-3 PM, and 8-9 PM. She injects with male and female friends at the place where they purchase the drug (center/shooting gallery), saying that she feels secure in the area. Mamay prefers to inject in a group because she does not know how to inject herself. Usually a male friend does it for her. At the injecting site, approximately one km from where she lives, Mamay shares needles with other male injectors when she joins them in a group session. They do not buy a new syringe because service syringes/needles are available. As part of the service, the seller cleans this with hot water by flushing the syringe three times and making sure that it is clean, then he would wipe the needle with cotton and alcohol before he gives it to a user.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Mamay first heard of HIV/AIDS when she went to Manila for a medical examination when she applied to work as a cultural dancer in Japan. She also had her first HIV test there. In Japan, she underwent her two HIV tests as required for cultural dancers. She knows that information on HIV can be acquired from the CHO and barangay health center. She knows one can have hepatitis, HIV, and other diseases by sharing needles. To prevent hepatitis, she eats nutritious food, takes Vitamin C, drinks milk and lots of water, and eats sweet food. She thinks she has a chance of acquiring the disease because she regularly shares needles with other injectors (males or females), and she is not certain if the needle she used has been used by someone who is already infected with a disease. Asked why she continues to inject, "I enjoy it." She has heard of HIV-related services offered by the CHO and other groups (needle and condom distribution) in the community where she regularly hangs out to inject, but has not availed of any of these. In previous years, she attended in a Mother's Class where the lecturer talked about safe water, dengue, and ailments such as hepatitis. Mamay has plans of quitting, but for now, she is still enjoying the euphoric feeling of injecting drugs. "Come April 2009, I plan to quit. That is what I promised my Japanese boyfriend, who said he would come back for me once I stop using drugs."

**Experiences Related to Stigma and Discrimination.** She has heard of talks, received all sorts of negative reactions and insults, but she does not mind these. "I do not care what they say. It's not their body that will be affected, it is mine."

**Sexual Behavior and Practices.** Mamay has had several men in her lives, starting at age 15 when she had a Chinese boyfriend. When she went to Japan, she had two Japanese boyfriends, excluding her customers. Back in the Philippines, she met another man after her Japanese boyfriend left her. She also had another boyfriend who has been in jail for drugs and robbery. In all her previous sexual encounters, Mamay never used a condom. At the time of the study, she claimed that she has not had sex for a long time, because what is more important to her is that she is able to inject drugs.



**Box 11: Cebu Case No. 11 - Emmalyn**

**Age:** 33      **Religion:** Roman Catholic      **Education:** High School graduate

**Profile.** Emmalyn, originally from Laguna, migrated to Cebu with her mother. At age 14, she got pregnant by an OFW boyfriend who left her. She had to stop schooling and helped out in her mother's small eatery in Cebu. At age 22, Emmalyn worked as a guest relation officer (GRO) in a first class club. Without Emmalyn's knowledge, her mother decided to go back to Laguna to live with the relatives of her father, bringing along Emmalyn's son. At 32, she had a boyfriend, and they decided to live together in a low-income barangay (Lorega) situated approximately one km from the community where she met her drug injector friends. Her boyfriend advised her to resign from the GRO job. At the time of the study, her live-in partner, a butcher, earned an average of PhP300 per day, five days a week. Emmalyn worked as a shabu runner earning PhP500 per day (four transactions) or about PhP14,000 a month.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** At age 13, she and her high school classmates tried using cough syrup just for fun. They then tried marijuana. She continued to use both cough syrup and marijuana, but only when in a group. At age 22, Emmalyn joined a shabu session with some GRO friends. Since then, she has been into regular sniffing of shabu, before and after work. When shabu was not available, Emmalyn and a female friend smoked marijuana. Emmalyn has been injecting drugs for two years now, usually three times a day. She started in 2006 when she was 31 years old and before she had a live in partner. "*Tungod sa barkada nako, unya adtoon man ko nila sa akong gipuy-an.*" She said she became an IDU because of her friends who would go to her place. Emmalyn said she became curious of the effects of injectable drugs, particularly when a female friend tried injecting at her place and she was asked to try it. They sniffed shabu first and injected drugs after. During the first few sessions, they used Nubain (brought by her friend to her house). Eventually, her friend brought her to a community and introduced her to other IDUs. They became comfortable injecting in that place because Nubain, or the generic Nalvo, is accessible to users.

When she first used injectable drugs, she "almost fainted and vomited, could hardly walk and felt sleepy." Eventually her body craves for it everyday that she became a regular and daily user. Only after six months of injecting did she have the courage to inject herself. In the past, her female friend would do it for her, who advised Emmalyn to try doing it on herself. She eventually had a boyfriend who was also an injector. They started living together and met many of his IDU friends. Emmalyn also had the chance to use Dormicum when a friend of her live-in partner brought some of these to their place. However, she found this drug very strong and did not use it anymore. They bought Nalvo instead of Nubain because it is cheaper and the effect is the same. Emmalyn is satisfied with a dosage of 0.1ml, but usually injects 0.3ml.

She never stopped using shabu. When she uses drugs, she would sniff shabu first, then inject Nubain. As shabu is not always available, she would only inject most of the time. Sometimes she injects herself (after learning how to do it); sometimes, her live-in partner or her female friend injects her. When Emmalyn injects alone or with her live-in partner at their house, they use only one syringe for both of them. Her partner injects first then she cleans the needle and syringe by flushing it thrice with ordinary water until the bubbles disappear. She then wipes her arm with cotton and alcohol before she starts injecting. She discards a syringe after using it for two days. On average, she injects thrice daily (usually 0.3ml of Nalvo at PhP30), between 8-9 AM, before or after lunch, and between 4-6 PM. If she uses Nubain, she pays PhP50 per 0.3ml. She prefers injecting at the shooting place and considers it a safer place because the drug can be bought there, and she is afraid to bring drugs home. Emmalyn prefers to inject alone (or with her live-in partner or friend at home) because she is a woman and does not want to be seen by people ("*morag mauwaw sad ko makit-an kay gamay rang mga babaye nga shooter*"). In actual practice, however, she injects in a group using only one needle.

When in a group (usually with four members, including her live-in partner, males and females, but mostly males) and at the "shooting place" (referring to the house of the drug seller), they pool resources and buy one ampoule of Nalvo at PhP130. They converge in the community because drugs are accessible there. Although sometimes they buy a syringe at PhP20 and share this among users in the group, Emmalyn admits that when they do not have enough money, they would just borrow a syringe from the drug seller. She claimed that "service needles are clean." The group would take turns on who gets to inject first. Sometimes, the person who has contributed a bigger amount of money injects first. Only four people are allowed to inject at the seller's house. Once they are done, they are immediately asked to leave, and another group would come in. In their group, Emmalyn is the only female member, although there are times when another female friend of hers would take over the place of a male friend. Emmalyn says she has not tried injecting shabu. At the shooting place, the seller, as part of the service, takes care of cleaning the syringe/needle between users. Emmalyn observed that he used tap water and flushed the syringe several times (usually three times) until the water became clear.

When asked about the type of injectors in this area (referring to the shooting place), Emmalyn said that they are mostly males, students, workers, garbage collectors, older people (including those about 60 years of age), dirty looking males, snatchers, male and female students from a Catholic and known university, some male dentists, and some male office workers.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** When asked whether she is aware of some risks, particularly in injecting drugs, she enumerated the following: "one can have HIV/AIDS, will become pale and may suffer from illnesses, become untidy, have skin rashes, and hepatitis." She says that these could be prevented by stopping the use of drugs and by not sharing needles with others. Emmalyn intends to adopt the following to prevent herself from acquiring HIV and hepatitis: (i) avoid using used/service needles, (ii) buy her own needle and not allow others to use it, (iii) take a bath everyday, (iv) not have sex with other men (other than her boyfriend), and (v) avoid injecting in a group so she does not have to share needles with them.

availed of any of these. She believes that "needle and condom distribution" are services needed for female IDUs. In all her previous sexual encounters, Mamay never used a condom.

**K. Cebu Case No. 11: Emmalyn**

78. Emmalyn was born and raised in Laguna until she graduated from elementary when she migrated to Cebu with her mother. Her parents decided to separate and sold their house in Laguna. Emmalyn graduated from high school in Cebu, but did not get any college education. Aside from curiosity, Emmalyn admitted taking drugs because she wanted to please herself so she will not think of the marital conflict between her father and mother. Further, she says that "this vice is cheap" ("*barato ra ning bisyoha*"). Being away from family, she says, is difficult and makes one feel very lonely and hopeless. She is sad that her family left her in Cebu and did not inform her of their going back to Laguna. On the average, she injects thrice daily (usually 0.3ml of Nalvo at PhP30), between 8-9 AM, before or after lunch, and between 4-6 PM. If she uses Nubain, she pays PhP50 per 0.3ml. Box 11 presents Emmalyn's drug use history and practices and knowledge of HIV.



79. Many times, she has thought of quitting but has not put this into action, saying, "...*Wa gihapoy kapaingnan, murag kada adlaw gabalik-balik...*" (There are times when she is able to inject drugs only once a day, but that is because of a lack of money to buy drugs and not because she is serious about quitting ("*...giagwanta lang nako, lami gyud unta kaayo iadto ba, i-shoot ba, pero wamay kuwarta...*"). If she is unable to inject, she feels very irritable and warm. Emmalyn believes that her only chance of quitting drugs is if she transfers to another place, away from her friends, away from the shooting place.

80. Emmalyn has heard of HIV from the radio and television, posters, and other information materials at the CHO. She knows that HIV can be transmitted through sex and needles. She has not had a test for HIV even when she was working as a GRO, but she had regular hygiene check at the CHO as part of the club's requirement. She sometimes used condoms with club customers (because there were customers who did not want it). When asked why she has not had an HIV test, she says "*wala man nako na huna-hunaa*" (I did not think of that).

81. Emmalyn has attended a CHO-initiated seminar on STI and HIV. The insights she learned from the seminar include: HIV/STI can be prevented if one uses condom when having sex, and if a female does not have multiple male partners. At the same seminar, the consequences of taking drugs were also discussed. At the club where she used to work, condoms were distributed free by the CHO. Emmalyn found the lecture very helpful because she learned about diseases which can be acquired through sexual intercourse, particularly when a condom is not used.

82. At the "shooting place," she has heard of a needle distribution program from other IDUs, but she has not availed of it. She reports that there are needles which are supposedly distributed free by "leaders" (referring to outreach workers), but these are instead sold by them to IDUs/suppliers at a cheaper price.

83. When asked whether there are services which female IDUs need, she enumerated the following: distribution of free needles and leaflets as well as lectures on preventive measures and on how to stop taking drugs. She suggested that the CHO and NGO should go to communities where there are many injectors and drug users and provide them with lectures and counseling services.

84. She added, "*Maayo man ng taga CHO kay motabang man sila sa pagpasabot sa mga mo-shoot, mo-lecture man sila nga dili ka magkasakit. Motabang gyud sila kay bisan nagbisyo ka tabangan ka nila pagpasabot. Bisan kadtong sa club pa ko, taga CHO moadto man mag lecture o patambungan pod mi og lecture sa CHO.*" (People from the CHO are good because they help IDUs understand the risks of disease, and they give lectures on how to prevent the disease. They will help you even if you are engaged in a vice, they will help you understand. Even when I was working at the club, people from the CHO would give us lectures or request us to go to the CHO to attend a lecture.)

85. **Experiences Related to Stigma and Discrimination.** Emmalyn is aware that people talk about her being a drug user. She has heard of impressions like "*laina ana'ng babaye'ng kuan noh...daghan na kaayog tinuslukan*" (that woman is not desirable, she has many injection marks). She has heard those remarks many times, and has reached a point where she is disappointed at herself and thinks that her using drugs is not doing her any good. She feels that people have a low regard for drug users, particularly the women.

86. **Sexual Behavior and Practices.** Emmalyn's age at first sex was 14 years old. When she was working at the club, she sometimes used condoms with club customers, but there were those who would not agree to condom use. She has never used a condom with her previous boyfriend and current live-in partner, a decision made by her and her previous boyfriend and current partner.

**Box 12: Cebu Case No. 12 - Dayday**

**Age:** 46 **Religion:** Roman Catholic **Education:** 4<sup>th</sup> year Industrial Engineering

**Profile.** Dayday migrated to Cebu in 2005 together with some of her children. Dayday has had several men in her life, starting at age 18 when she worked as a billiard table assistant in an establishment owned by a foreigner in Ermita. This is where she met many foreigners who, after several billiard sessions, would invite her for a "night out." She has been to many places, traveled to other countries, and had several boyfriends of different nationalities.

- At age 21, she got pregnant and got married to a Filipino (but found out later that the marriage was a fake). They have two children who, at the time of the study, were both employed and well-paid in known establishments, and who provided financial assistance to their grandparents. They do not give Dayday money because they know that she has been addicted to drugs.
- She then lived with her 46-year old Australian boyfriend, whom she met when they (she, her son, and mother) went to Australia for a short vacation. They have a son (her third child) and he comes to the Philippines once in a while to visit them. He provides them with monthly financial support.
- When she separated from her Australian boyfriend, Dayday lived with another boyfriend, a British national, who was engaged in buying and selling cars. However, the business went bankrupt, forcing him to go back to his country.
- Then, she met the father of her fourth child, an Irish national, and they stayed in Boracay for eight months to attend to her boyfriend's beach resort business. They separated, and a retired General (and his wife) offered to raise and take care of her son.
- In Cebu, she had another boyfriend, a 26-year old Filipino from Cebu City who made a living as a "habal-habal" (tricycle) driver. They also had a son but he died at age seven. They lived together for more than two years.

At the time of the study, Dayday lived alone in a small rented room near the "center" ("shooting" area). Her room is equipped with an internet connection and a webcam, and this is what she uses for her cybersex business. She also brings young women to her place for male clients (particularly foreigners) who are willing to pay PhP2,000-3,000 every week to have cybersex. From this business, she earns PhP8,000 a month.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Dayday learned to use drugs at age 18 as a result of peer influence and because of curiosity. "Curiosity for one drug leads to curiosity in other drugs," she says. She claims that she does not have any family problem, but she enjoys taking drugs with friends, and later, with sexual partners. Her parents and children know of this behavior and they "are not happy about it" – the reason why she no longer lives with them. During the first experience, she and her friends used cough syrup and marijuana. Dayday says "the two always go together, *if mag-cough syrup ka, mag-marijuana ka rin para mas masarap.*" For six months, she used these everyday, at least once in a day, until she tried shabu. She has also tried heroin and opium in Thailand, when an Irish boyfriend brought her there and she was "forced" by members of what she calls 'Red Triangle' to try these. When they came back to the Philippines and stayed in Boracay for a vacation, Dayday also tried paper acid (bought by her Irish boyfriend from India) with other foreigner friends and their girlfriends. "The effect of paper acid is like marijuana... a downer...after it hits you, split *ka na.*" She and her boyfriend also use shabu. To enable her to get some rest (because she could hardly sleep), he gave her tablets which Dayday also became addicted to. When she went to Melbourne, Australia for two weeks as a tourist, another boyfriend taught her to use cocaine.

Dayday has been an IDU for two years now, injecting four times in a day. A female IDU friend told her that injectable drugs are better because even with a 0.1ml, one can get "high." Other than her female friend, Dayday's friends are mostly males. She does not want to inject with other women, saying "*ayaw ko sa ibang babae, hasol!*" (I do not like other women, they are a bother). After many years of being addicted to shabu, she has finally stopped using it when she found pleasure in injectable drugs ("*mas lami talaga ang injecting, mas lami ang tama para sa akin.*"). Dayday prefers to use the generic brand (Nalvo) compared to Nubain because of its "stronger effects." When she is "high" on drugs, she contacts clients on the internet. She starts injecting (usually 0.2ml) the moment she wakes up, followed by another dose between 10-11AM, 4-6 PM, and 8-10 PM). She prefers to inject on her leg. One of her children commented, "*Pangita nalang og lain kashootan kay pangit tingnan.*" (Just look for another spot to inject because it does not look good—referring to her leg.) She keeps her own syringe at home, she also has her own syringe at the seller's house, but she has also used service needles. An NGO informed them to use clean needles everytime they shoot and use it only once. In the past, the NGO would give them syringes every wednesday. Now, they sometimes use the service needles at the shooting place.

When Dayday tried using a service needle (the one used by other users), she had fever 20 minutes after she injected, her eyes and skin became yellowish, she experienced chills, and thought she was infected. That was the reason why she transferred and never went back to the same seller's house. In another house, new syringes are always available. This house opens at 4 AM and closes at 7 PM. Dayday buys and brings home some drugs and injecting paraphernalia for her remaining sessions in the evening. In the past, a male friend (or the seller) did the injecting for her. Now, she does it on herself saying that "it is less painful." She prefers to inject alone, but in actual practice, she injects at the seller's house because "if I inject alone in my room, I consume more."

She has also shared a needle with friends when they injected in a group at the seller's house using a service needle (but this is no longer her present practice). Dayday has not cleaned needles at the shooting place, but has observed how this is done. "Yes I have observed it. They do not use ordinary water, but mineral water. They would put a drop of Zonrox, a disinfectant solution, and flush the syringe three times to make sure the blood comes out. Then they wipe it with cotton, flush again with water, put drugs, then give it you." In a day, and at the house where she regularly goes to shoot, three new syringes are opened (at 4 AM, 10 AM, and 4 PM). "*Iyong ginagamit ko sa buntag tinatago nila, basta ang loyalty mo nasa kanila.*" (They keep the one used in the morning, for as long as your loyalty is with them.)

**L. Cebu Case No. 12: Dayday**

87. Dayday, 46 years old and Roman Catholic, reached 4<sup>th</sup> year Industrial Engineering but did not complete the course. For many years, she lived with her family in Manila. She has two brothers and a sister, all professionals (i.e., seafarer, hospital attendant, and resort caretaker). Her father is a retired seafarer, and her mother is a housewife who had a food business when Dayday was younger. In 2005, at age 43, she migrated to Cebu along with some of her children.

She had many boyfriends of different nationalities. At the time of the study, Dayday lived alone (in Cogon Ramos). Box 12 presents Dayday's history and evolution of drug use, drug combinations, and practices.

88. **Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** When asked if she could stop injecting, she replies in the affirmative, "*Di ko plano magdugay ani, kay daghan na kaayo ko og marka, yan ang one thing na ayaw ko, ang marka, di katulad ng shabu nga napangag ra ko, nanglarut ang buhok.*" (I do not have plans of injecting for a long time. I already have many marks. That is the one thing I do not like, the marks. It is not like when I used shabu and only lost a tooth and experienced hair loss.)



89. She heard of HIV from her employer (a foreigner) when she was working in Ermita, and she was told that HIV can be acquired through body contact or sex (“*sex iyan ang fastest way*”), and from using other people’s syringe. In 1986, Dayday attended a seminar on HIV and AIDS at San Lazaro, after which she decided to voluntarily subject herself to an HIV test. Her foreign customers in Ermita also asked if she is clean. At that seminar, she learned about AIDS, gonorrhea and its symptoms, how to use the condom, and that STI can be acquired from dirty toilet bowls. She mentions that difficult and painful urination are symptoms of STI.

90. Dayday has not experienced hepatitis or overdose, but she knows that one can get hepatitis and AIDS, which can be prevented by using a clean syringe. However, she said that “shooting cannot cause death,” but one will have dry skin. Unless the person engages in “milkshake” (shabu mixed with Nubain and injected), which she has tried but did not like, he/she can die.

91. To protect herself from HIV and Hepatitis, she does not have sex with her customers immediately, instead, she insists that her customers to have a blood test first. “Foreigners would agree, especially if they liked you very much, even they themselves would ask you to have a blood test. The foreigners she had relations with educated her about HIV.

92. When asked whether she is aware of some HIV prevention services provided to IDUs in the congregation site, she says that “in the past and every Wednesday, syringes were distributed free to IDUs in the community.” At the start, they gave out five syringes, but the number was reduced to three. She reported that “syringe distribution in the community is no longer done, it has been made a business by some people (particularly the one with an orange cap). Instead of giving these for free, they charged PhP5.00 per person. The syringe with an orange cap is being sold to Nalvo suppliers. Dayday prefers the one with an orange cap because it is better and easier to use. Together with the syringes are condoms, but she did not accept these because she does not want to use condoms during sex.

93. Dayday agrees with any HIV and AIDS program for drug users, and suggested that these should focus on barangays where there are many users and pushers. “Programs for women are necessarily for safety reasons, most especially in terms of sexual activities and sexual partners.”

94. She commented that men and women who are high on drugs have sex with anyone, including those they do not know. That is why it is important to have such programs, most especially for beginners (“*Ok ra man ko para ma aware ang mga users. Para sa akin mas ok kung gagawin in every barangay kay daghang pugad. Para sa safety namo, kahibalo na ka sa mga babae mawala na ang poise pag may tama na, torjak dito torjak doon, di na alam kung sino ka torjak nila, tapos magkasakit na. Mas okay kung may program na ganoon [referring to HIV and AIDS seminars], most especially sa mga papasok pa lang.*”) She says that distribution of needles in the community is a great help to IDUs, who then have clean needles to use. (“*Ok, kay nakatabang gyud kaayo sa amoa, mao gani nay akong sige ginagamit pag wa koy akong needle, para bag-o permi ang gamiton.*”)

95. She has heard of bleach and water distribution at the center and this is what personnel from the CHO had taught them. Dayday agrees saying, “*iyong bleach and water distribution kasi kahit na libre ang sy once na alam mo na limpiuhan at alam mo ang pinaglimpiyo mo, at least safe ka sa health mo. Kahit na sabihin mo na imo ra na ang sy pero dili ka kamao maglimpiyo, makakuha ka pa rin ng sakit ka yang dugo na naiwan doon, magkasakit ka pa rin.*” (I prefer bleach and water distribution because even if the syringe is free, once you know that you should clean it and you know how to clean it, at least, your health is safe. Even if you say that you have your own needle but you do not know how to clean it, you will still acquire the disease from the blood that has not been completely flushed out.)

96. When asked why she associates drugs with sex, she said, “*Kay tungod ang drugs may sex magkoyug gyud na ang duha, kay makadrugs ka kasagaran sa mga babae at lalaki sinasabi nila sex*





*trip, kaya pag may drugs may sex.*" (When a couple use drugs together, they usually end up having sex. Where there are drugs, there is sex.) That is why Daday suggested that HIV/AIDS and drugs information must be given to women.

97. To beginners, Daday would say, "*If I were you, undangan na nimo ang pag-shoot*" (If I were you, you better stop injecting), implying her concern for them. "*Naa gani ko nakit-an na 13 yrs old pa. Ako giingnan na bata pa nimo Dong oi. Dika maluoy sa imong kaugalingon. Dali ra mapatay ang tiil nimo kay at your age 13 for sure inig 17 mag milkshake naka. Pagdating mo 20 patay kana. Adto naka Careta di naka Junquera.*" (I met a 13-year old. I told him, 'you are still very young. Don't you pity yourself. Your feet will be weakened at your age and for sure at age 17 you will use milkshake. When you reach 20, you will be dead, and you will be buried at Careta (a cemetery in Cebu) and not in Junquera.") She said that seminars must be given to beginners.

98. She wants to undergo rehabilitation, "*kasi di naman ako katulad ng iba na pagtaas ang tama nakakatakot ng lapitan ba* (I am not like the others whom other people get afraid of when they are 'high'). She also dispensed an advice to drug users: "Don't let drugs control your brain, let your brain control the drugs."

99. Dayday has had a "blood test" at the CHO. They were asked to sign and were given a card/slip so they could get the results. "*Tinanong lang ako anong ngalan ko. Unsa nako ka dugayon nag shoot, may brief seminar, tatlo kami. Giingnan ra mi na ang mag pulipuli og sy maka cause og hepatitis, ug di lang daw hepa ang makuha may AIDS pa, malaria. Mura pud og gi-convince mi na moundang na sa bisyo.*" (We were asked about our names, how long we have been injecting. We had a brief seminar, where there were three of us. We were told that sharing needles can cause hepatitis, and it is not just hepatitis we can also have AIDS and malaria. It was as if they were also trying to convince us to stop the habit.)

100. **Experiences Related to Stigma and Discrimination.** On several occasions, Dayday's son insulted her, particularly when she gave him advice, saying: "*Pag inaaway niya ako, at ng makasab-an nako siya kay sayop iyang gibuhay, yan ang sinasabi niya ba nga badlungon ko nimo, 'ikaw gani wala kabadlong sa imong kaugalingon.*" (When we have an argument, and when I reprimand him for doing something wrong, this is what he tells me that I could not even behave properly.)

101. She has also heard of talks from neighbors, but Dayday proudly says that, "for as long as you are not a bother to them, even if you are a drug injector or a shabu user, people will respect you, that is the one thing I like even if I am a user," ("*Pero once na dika manghasol, kahit shooter ka pa, manuyopay, may respeto mga tao sa yo. Yan lang ang one thing na gusto ko kahit na user ako.*")

102. **Sexual Behavior and Practices.** Dayday's first sexual experience was when she was 18 years old. Dayday used a condom with her Swiss boyfriend because he insisted on using it, but when they became close, they no longer used a condom in any of their encounters. She also used a condom with some customers when she worked as a billiard table assistant in Ermita, Manila because there were foreigners who required her to use the condom. However, with most of her boyfriends, condoms were never used. At the time of the study, Dayday said that she has not had sex with any man, especially after she became an IDU.

#### M. Cebu Case No. 13: Yvonne

103. Yvonne, 34 years old, a Roman Catholic, and a resident of Talisay City, finished four years of college education but did not graduate with a degree. She was accelerated when she was in the elementary grades, an indication that her intellectual capacity was beyond the normal learning skills of a child. In college, she loved to read, study, and do library research. She also finished a vocational course



**Box 13: Cebu Case No. 13 - Yvonne****Age:** 34    **Religion:** Roman Catholic    **Education:** 4<sup>th</sup> year College

**Profile.** Yvonne has had two live-in partners before she got married at the age of 21. The first was when she was 14 years old; the second, when she was 17, got her pregnant. At the time of the study, her husband just started working as a member of the Armed Forces of the Philippines (AFP) and was assigned in Manila. Yvonne works in an establishment that offers life insurance. She has a regular salary of PhP1,800 a month and gets a commission of PhP1,000 for every walk-in client who buys a plan. She and her son lived with her parents at the time of the study. In 2003, she was imprisoned for "malicious mischief." High on drugs, Yvonne committed an act of violence and said many unpleasant words when a male bystander said something that she felt was a mockery of her person.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** At age 15, Yvonne learned to use shabu and cough syrup with friends due to a personal and family problem. At first, the use of drugs was just for fun and a pastime. A year after, she and her friends tried injectable drugs. Yvonne resorted to drugs at an early age due to her father who maltreated her starting when she was eight years old. On two occasions, her father attempted to have sex with her during her adolescent years. Yvonne struggled and refused to give in to her father's sexual desire, and the mother did not believe Yvonne.

At age 16, she went to Bohol and worked as a house helper. She met another man who, according to her, was "a thief and drug user." During the time they lived together (one year), they had a son, Yvonne became a regular drug user because her boyfriend had access to drugs and he eventually left her. After the separation, Yvonne was sent to Mindanao to live with her aunt and continue her studies. For many years, she stopped injecting, but continued to use shabu and cough syrup. When she came back to Cebu, Yvonne injected drugs to enjoy the company of friends and forget about everything that had happened to her. She has tried Nubain and Sosegon, and finds the latter better because "it has a cooling effect." She has also tried injecting Dormicum and Nalvo. In the absence of Nubain, and because Nalvo is cheaper (0.1ml of Nubain costs as much as 0.2ml of Nalvo at PhP20), Yvonne injects Nalvo regularly.

Sometimes (twice in a week), she buys drugs (at PhP20) and uses her own syringe, and cleans/flushes the syringe only with hot water. Her own syringe is used three times before she discards it. She does not allow other people to use it, not even her female friends. Sometimes she uses a service needle (three times in a week) when she goes to the "center" to inject and does not have extra money for a new needle. At the center, she saw that the seller cleaned the syringe using hot water mixed with alcohol, flushed the syringe three times, and made sure that no water was left inside the syringe before putting the drug and giving it to her (since she does not inject in a group). Yvonne prefers to inject drugs than use shabu. She injects 4-10 times in one day, depending on her mood, with a regular dosage of 0.2ml per episode. Yvonne usually injects at 10 AM, between 5-6 PM, and after 8 PM. She uses occasionally (or at least once a week) or when she has extra money because "it is expensive and PhP130 worth of shabu is good only for three sniffs." She does not like to inject in a group because they would fight over who gets to inject first, and if she would suggest to be first, it would not look good.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Yvonne has experienced overdose, when she took 20 pieces of Tuseran tablets just for fun. That incident caused her to be hospitalized for three days, and made her father very angry. Another incident was when she injected Nubain and sniffed shabu when she was very drunk. She has heard of HIV from a doctor who works at the CHO. She believes that unclean needles can cause illnesses, such as brain disorder, heart failure, and even death. When she planned to work as a masseuse, she had an HIV test as part of the requirements, and the result was negative. Yvonne has not attended any meetings or discussions on HIV/STI prevention but is aware that information on these can be obtained from the CHO. In the past, she has availed of syringes given free in the community where she regularly hanged out with friends. She has also received condoms and medicine (antibiotics and vitamins) from a priest who works with a faith-based organization. Slowly, Yvonne is trying to quit, feet, and went back to injecting Nalvo to relieve her from the discomfort brought about by withdrawal.

**Experiences Related to Stigma and Discrimination.** Yvonne narrated that "people do not trust a drug addict," and they look down on women and men known to have been using drugs. They presume that a female drug user engages in sex with any man. People call her a prostitute.

**Sexual Behavior and Practices.** Yvonne first had sex with her boyfriend at age 13, and lived in with her boyfriend at age 15. They used condoms during their sexual encounters (but only during her fertile period) to prevent a pregnancy. Yvonne does not use the condom with her husband because the latter claims that he is sterile and unable to have a child. With her second partner, she used a condom only after she gave birth to a son, she did not want to get pregnant anymore, and she found out that he was infected with a sexually transmitted disease. The decision to use condoms was hers, and was made to protect herself from being infected.

in cosmetology. She is the eldest in a family of five children. Her parents are engaged in buying and selling scrap/junk materials and earn an average income of PhP500 per day. They have a shop where they store these second-hand goods. Box 13 presents the history and evolution of Yvonne's drug use, drug combinations and practices, knowledge of risks, exposure to HIV information and preventive measures, experiences related to stigma and discrimination, and sexual behavior and practices.

104. Yvonne resorted to drugs at an early age as a result of her anger for her father who maltreated her at age 8 and attempted to have sex with her during her adolescence. Her own mother did not believe her when she related the two incidents when her father nearly raped her. At age 14 she started to run away from home either to live with a boyfriend, or live with other relatives, but always she was forced to return home upon the request of her mother.

105. Yvonne prefers to inject drugs than use shabu. She has been injecting for 18 years, usually four times a day. Yvonne injects alone.

106. Her aunt recommended that she undergo rehabilitation, but Yvonne refused because her former boyfriend who, after having been rehabilitated, "became mentally absent." She says that he became worst. She would not suggest that drug users/dependents be placed in rehabilitation. Instead, Yvonne believes that guidance from parents, brothers, and sisters is more effective.

107. When asked to comment on HIV and AIDS programs for IDUs, Yvonne says that it is good to join these programs to enhance your knowledge of drugs and sex-related matters. It is good because you will know what is harmful for you,

particularly if you use the syringe of others. Yvonne explained that she learned from friends that it is not good to use other IDUs' syringe; it is not good to have many sex partners because one can have AIDS; it is not good to have blood transfusion if you do not know the donor; and condoms must be used to prevent pregnancy, HIV and AIDS, and other infections. To prevent oneself from acquiring such illnesses, Yvonne said that "the only way is to stop taking drugs."

108. On the needle exchange program, she said "*para dili masakit og AIDS ug hepatitis, mas maayo nga may ipanghatag nga sy*" (in order not to acquire AIDS and hepatitis, it is better for syringes to be distributed), but reported that needles/syringes are sometimes sold at the "center," not given to the IDUs for free. On condom distribution, "*maayo ng gibuhay ni Father para di mi masakit og AIDS ug HIV ug STI*" (what Father [referring to a priest], is doing is good, so we will not acquire AIDS and HIV and STI).

109. For female beginners, Yvonne explained, "*Akong gisugyot nila dili sila mopadayon anang drugs kay walay mahatag nila nga maayong kaugmaon, mas maayo dili sila mopadayon kanang wala pa nagrabahan pagkadrug-dependent kay pareho namo mokorug na man mi kon dili makashoot.*" (I advised them not to continue using drugs because it will not give them a good future. It is better if they do not continue, particularly those who have not yet developed drug dependence so they would not become like us. We experience bodily tremors when we are unable to inject.)

110. Slowly, Yvonne is trying to quit, "*Kanang dili na gyud ko mokurog ba, mao gahinayhinay nako og undang og shoot, dili na gyud successive ba, ang usa ka drug dependent kung i-force nimo og undang kuyaw man gud mamatay.*" (When I no longer experience trembling, it is no longer as frequent as before, that is when I will stop. I am slowly trying to stop injecting, but there is a danger that a drug dependent, when forced to stop suddenly, might die). For three days, she tried to stop injecting in the hope that she would succeed. However, she experienced headache, chills, high fever, and cold feet, and went back to injecting Nalvo to relieve her from the discomfort brought about by withdrawal.

111. **Experiences Related to Stigma and Discrimination.** Some impressions Yvonne heard from her relatives, father, and neighbors about her: "*Si Yvonne adik man na, burikat man na.*" (Yvonne is an addict, she is a prostitute). "*Naa nasad ning panuway ay, demonyong dako. Naa nasad ning sungayan ay, burikat, ana bisag unsa nalay ilang itawag nimo*" (Here comes Satan. Here comes the one with horns, a prostitute. They call you with whatever names.) In response, she says: "*Ayaw ninyo siguradoha kay wa man mo kakita nagpaiyot ko og laki. Dili baya ko pampam, nganong mo ingon ana manka, naa baya koy trabaho.*" (Do not be sure because you have not seen me have sex with a man. I am not a prostitute. Why do you call me one when I have a job?).

112. When she was in prison, only her boyfriend visited her to give her advice and support. Not one from her family came to visit her or attended to her needs in prison because they were ashamed of her. All the more she was discriminated by relatives and neighbors when they knew that her boyfriend was a thief. On the whole, Yvonne said that people have negative impressions of drug users. They think of drug users as thieves. They think the females have sex with different men because they are addicts. They think drug users could not be trusted with money. Yvonne hopes to stop using drugs one day should she meet someone who understands her ("*Mao man gyud ni akong pangandoy nga mag-usab ko, moundang ko, basta naanay kanang kamao gyud mosabot sa akong pagkatawo.*") She opines that it is not good for females to engage in drugs because people look down on them. ("*Dili gyud maayo magbisyo aron dili i-look down sa mga tawo, labi na mga babaye, ubos gyud kaayo ang ilang pagtan-aw namong mga babaye kay adik man.*")

113. She suggested that drug users need not be scolded, like what her father used to do to her. Instead, they should be given advice, support, and prayer, and not be pushed further against the wall.



**Box 14: Cebu Case No. 14 - Jicjic**

**Age:** 29      **Religion:** Roman Catholic      **Education:** 3<sup>rd</sup> year High School

**Profile.** Jicjic has five children: a 13-year old male, the son of her high school boyfriend; an eight-year old female, the daughter of her Japanese boyfriend; a six-year old male, the son of another boyfriend who, according to Jicjic, is a “drug lord”; and a four-year old daughter. Despite her involvement with two other men, Jicjic says that her Japanese boyfriend loves her, even when she had other boyfriends and got pregnant again, he forgave her and continued to provide financial assistance. At the time of the study, they continued to see each other during his free time, and Jicjic had no relationship with other men.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Jicjic started taking shabu when she was 13 years old and a member of a drum corps in school, out of curiosity and “*pakikisama*” (smooth interpersonal relationship). The use of shabu among the group eventually became the norm everytime there was a special occasion and/or when they had money. A male member of the group had a friend who knew someone selling shabu. When she first used drugs, “she did not think of the risks,” and it was just “part of her being an adolescent”. When she worked as a guest relations officer, she and other co-workers also sniffed shabu before reporting for work. Somebody supplied them with the drug and they chipped in to pay for it. Jicjic, being young, beautiful, and attractive, never ran out of clients in one day, and her income from sex work was what she used to sustain her drug habits. Her younger sister also used shabu but she would always advise her to “take it slowly.”

She likes using drugs because it gave her a floating feeling, confidence, and she has gained many friends. She uses Nubain, and sometimes Nalvo, although she prefers to use the former. At the time of the study, Jicjic always had a syringe (or syringes) in her bag. She does not share or use other IDUs’ syringe/needle anymore. When she is at home, she makes sure that she has her own needle, or she would pay a female friend PhP50 to purchase three syringes at the nearest pharmacy (or at the “center”) and Nubain or Nalvo at the “center.” One ampoule of Nubain for Jicjic is good only for three episodes (0.4ml before breakfast between 8-9 AM, 0.3ml before lunch, and another 0.3ml in the afternoon before going to the “center” or to the house of a gay friend). She does the injecting herself, although a male friend used to do that for her when she was just starting out as an IDU.

Jicjic had an overdose when she tried “milkshake” (shabu mixed with Nubain) for the first time. Her male friends at the “center” told her to try it because it has a much better effect, so she did it at home. As a result, she was hospitalized and placed in the intensive care unit for three days and in a private room for another two days. All expenses were shouldered by her Japanese boyfriend. Only then did he know that she was using drugs. He advised her to stop, but Jicjic went back to sniffing shabu and injecting Nubain/Nalvo the moment she got out of the hospital.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Jicjic does not share needles anymore. She has observed her IDU friends experience tremors the morning after they inject using a shared needle. The needles/syringes at the “center” carry all sorts of diseases, such as malaria, meningitis, hepatitis. Jicjic has heard of HIV from a friend who does community outreach in the “shooting gallery.” In the past, this friend would usually give her 10 syringes with orange caps. Those are now being sold to IDUs at the “shooting gallery” by what Jicjic calls “leaders.” Jicjic thinks that she does not have any chance of acquiring HIV because she uses condoms with her Japanese boyfriend. Jicjic claims that she is even happier without sex. She claims that may look like a flirt but in reality, the men are the ones flirting with her, offering her shabu. “When I know that they would ask something in return, I would tell them, ‘No, I can also buy that. I can even buy you.’ That is why the men there respect me.”

Jicjic had an HIV test at the CHO when she was asked to go there together with other IDUs. She also participated in a meeting where doctors discussed how STI and HIV can be prevented. She claimed that at the meeting, “each IDU was given PhP200 as transportation allowance, while the ‘leaders’ were given PhP750 each.” Because she regularly hangs out in a community where there are many IDUs and because she has a friend who works with an NGO, she has availed of free syringes. She prefers needle distribution, not condom distribution.

**Experiences Related to Stigma and Discrimination.** Jicjic claims that she has had no experience of stigma or discrimination, because she has helped many people in times of need. She believes that “people who are discriminated are those who have been a bother to others,” but she has not bothered anyone. She said that people admire and idolize her because despite her being a drug user, she gives them money whenever they badly need it.

**Sexual Behavior and Practices.** Jicjic started having sex at age 13, and did not use condoms until after she delivered the child of her Japanese boyfriend. (There were times when she used pills to prevent pregnancy.) Her Japanese boyfriend always brings condoms in his bag and has not had sex with her without using one. Jicjic herself also prefers to use condoms with him because she does not want to get pregnant anymore. However, she did not use condoms with her other two boyfriends, even during the time of the study.

**N. Cebu Case No. 14: Jicjic**

114. Jicjic, 29 years old, a Roman Catholic, and resident of Cebu City (Cogon Ramos) had three years of high school education, She is the eldest in a family of three (she has one sister and one brother). Her parents separated when she was in high school. She became the family breadwinner, supporting her mother, sister, and the two children of her sister. Box 14 presents the history and evolution of Jicjic’s drug use, knowledge of risks, experiences related to stigma and discrimination, and sexual behavior and practices.

115. At age 17, she worked as a guest relations officer in a first class bar in Cebu, earning an average of PhP5,000 a day. At age 18, she worked in a first-class night club that offered a higher pay. There she met her Japanese boyfriend, a rich businessman working in an international firm in Lapu-Lapu City who gives her financial support amounting to PhP52,000 per month (PhP32,000 for their daughter and PhP20,000 for Jicjic’s personal needs).

116. At age 21, she had an IDU boyfriend. She injected drugs because she wanted to try it herself and made friends among IDUs (males, females, and homosexuals) in a community where injectable drugs were accessible. She and her IDU boyfriend injected separately because they had different groups of friends. By the time she and her boyfriend met to have sex, they were both high on injectable drugs, but sniffed shabu before having sex. That boyfriend committed suicide, which Jicjic attributed to his “insecurity with her Japanese boyfriend.” Jicjic first injected at the “center” (referring to the seller’s house). For eight years now, Jicjic has been injecting thrice a day and usually in the company of men.



117. Jicjic goes to the “center” twice a week to play computer games or bingo, inject, and drink liquor with friends. When the “center” is full, she would go to the house of a gay friend, bringing with her at least one ampoule of Nubain or Nalvo. This friend supplies her with shabu, and Jicjic considers his place “safe and private.” There they would sniff shabu, Jicjic would inject, and give him PhP50 as “house rental.”

118. In the past, she made sure that she was the first to inject at all instances by always contributing a bigger amount of money to the group. She did not care how they cleaned the syringe/needle after her. At times she paid for everything, including alcoholic beverages. At the time of the study, however, she injected using her own needle even when in a group, and paid for her own drug. “It is unfair if my share of the cost is bigger, but I get the same amount of the drug that the others get.” Her friends understand her and did not take that decision against her because she continues to contribute to their other costs.

119. She cleans the syringe/needle by flushing it four to five times until the blood is completely gone. She does not use a bleaching solution or water to clean the syringe because she “gets a headache if even a small amount of water is mixed with the drug”. Jicjic wipes the tip of the needle with cotton or cloth and keeps her needle inside her bag.

#### O. Cebu Case No. 15: Melba

120. Melba, born in Cebu City, 41 years old, and Roman Catholic, had three years of high school education. She has two sisters and two brothers. Her mother died a long time ago, and her father has since

#### Box 15: Cebu Case No. 15 - Melba

**Age:** 41      **Religion:** Roman Catholic      **Education:** 3<sup>rd</sup> year High School

**Profile.** At age 18, Melba worked as a club dancer in Manila. She stayed there only for a year, went back to Cebu, and worked in a third-class club. She stopped dancing and doing sex work when she was in her mid-30s. She used to have a live-in partner who worked as a welder, a carpenter, and sold frames, earning an average of PhP1,000 a week. He gave her an allowance of PhP350 per week. He did not know anything about her injecting behavior. They have a three-year old son, but they no longer live together.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** At age 30, Melba was invited by a friend to try shabu. Melba learned to like it and used shabu at least once a day at her friend’s house. Melba started injecting drugs in 2001 at the age of 34, before she had a live-in partner. A gay friend, also an injector, told her that if she injected, her asthma might be cured. Melba was curious to find out why her gay friend enjoyed injecting, so she went with him to the “shooting gallery.” Her gay friend introduced her to a female IDU who introduced her to a drug seller. She and her gay friend bought 0.1ml of Nubain for each of them, used a service needle and injected drugs, with the female IDU doing it for her. She could not recall how or whether the syringe was cleaned at that time, or who injected first. After the first experience with an injectable drug, which, according to her, is “cheaper and more affordable than shabu,” Melba became a regular IDU. Melba has been injecting for seven years, usually four times a day.

She observed how the drug seller cleans the syringe/needle: he uses hot water and makes sure that no water is left inside through a sharp tapping of the needle base with one finger and he wipes the tip of the needle with tissue or cloth. “It is 100% clean,” she says. Melba claims that nobody taught her how to clean syringes and needles properly, and her cleaning method, whenever she injects alone, is simply based on her observations on how the seller at the “center” cleans it.

She likes group sessions, because she gets to mingle with others, talk, get new ideas and learn from them. They chip in money to pay for the drug, and the seller divides this equally among them. Sometimes, Melba gets injected first, sometimes her other female friend, and sometimes another male IDU. At the time of the study, her usual dosage was 0.1ml per injecting episode for an average of four times a day, usually at 7 AM, 1 PM, 6 PM, and one before going home or before bedtime.

Although she likes the effect of Nubain better, the group buys Nalvo because it is cheaper (at PhP10 for every 0.1ml). Melba says that she injects on her right or left arm, making sure that it does not leave a visible mark.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** When asked about her knowledge and impressions of HIV programs, she says that it is good for them to learn something. The free syringes are also good for them because it will lower their expenses and increase their safety. The HIV/AIDS information will help them know if something is wrong. She added that the use of condoms protect females from getting pregnant and from acquiring a disease. Melba plans to stop injecting when the right time comes, but admits that it could not be stopped all of a sudden. Arthritis and hepatitis were first cited by Melba when asked about possible illnesses one can have by injecting drugs, and they could be prevented by “getting enough rest, taking vitamins, eating well and doing daily exercises.”

Melba had an HIV test (for free) when she was invited to participate in the testing in the community where she buys drugs, but she could not recall who or what organization initiated it. She has not attended a meeting or any discussion on STI and HIV, although she knows that one can get information on these infections from the CHO. Only once has she availed of a free syringe distributed to IDUs in the community. She has heard from other injectors that HIV can be transmitted through sex, and she could not say if she has a chance of acquiring the virus. When asked what particular service she would recommend for female IDUs, she mentioned “HIV/AIDS information, free needles, free condoms, and participation in meetings.” She added that “Women need to know the risks of injecting drugs. To keep them safe, free needles must be distributed. Condoms must also be distributed to prevent them from getting pregnant and acquiring a disease. It is good to attend meetings to expand our knowledge.” Somebody told her that if she could not stop injecting, she should buy and use her own needle, otherwise it could cause her death.

**Experiences Related to Stigma and Discrimination.** She is not aware of any discrimination as everybody knows about her injecting practices and she does not care about what they say about her. What is important to her is that they are able to inject. If ever she hears stories of discrimination, she won’t bother herself with it.

**Sexual Behavior and Practices.** Melba first had sex at age 18 when she went to Manila to work as a club dancer. A condom was not used in most of her sexual encounters with clients, but she had a few clients who would request for it. Her reason for not insisting on condom use is: “We need the money; if they do not agree [to the use of condoms], there is nothing we could do.” Before she started living with her boyfriend, they used condoms whenever they had sex because they kept the relationship secret from her family, and she did not want to get pregnant at that time. They stopped using condoms when they lived together.



**Box 16: Zamboanga Case No. 1 - Beverly**

**Age:** 37      **Religion:** Moslem      **Education:** High School Graduate

**Profile.** At age 15, Beverly got pregnant and married the man who taught her how to inject drugs. Beverly and her Moslem husband have 11 children (five males and six females), the eldest is 19 years old (a barangay auxiliary police) and the youngest, two years and six months old. After several years, her in-laws learned of her drug use. They accused her of being a bad influence to their son and asked her to leave with all her children. Unable to explain or defend herself, Beverly left with all her children, lived with her mother, with no financial support from her husband. Her husband took a second wife. A few months before the study period, Beverly and her husband reconciled, although they still do not live together. He left for Saudi to work to send financial support for his children. Despite the reconciliation, Beverly laments that she could not accept the accusations of her husband's parents. She worries about her husband having a second wife, blames him for making her an IDU, and for not defending her when she needed his support the most. Her husband had stopped injecting drugs so as not to jeopardize his employment in Saudi.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** Beverly started injecting drugs in her early 20s "for the sake of love," when her husband taught her. "Because I love my husband, I always agreed to whatever he wants," until she learned to do it habitually (twice a month) with her husband. During those times, she had not experienced using shabu, marijuana, or cough syrup. At age 26, when she attended a party with some male and female friends and became drunk, Beverly participated in a marijuana session after which they took cough syrup and injected Nubain. She said that she joined them as a way of establishing rapport with friends, and because she was emotionally upset and carried away by her problems. This was the first time Beverly appreciated the use of cough syrup prior to injecting. From friends, she also learned how to use shabu and said that if money is available, she prefers to use it because "injecting drugs is no longer the fad." She injects twice a month with male and female friends, but takes cough syrup first before injecting, usually using Nubain (0.2ml or 0.3ml per episode). Beverly has experienced sharing needles with them. A female friend injects for her because she is afraid to look for her vein.

Beverly started injecting almost everyday with a new relationship - a male IDU friend, usually before and after having sex. She injects on him, and he injects on her. The relationship lasted for six months because her husband found out about it and told her to end the affair pointing out that men can have other sex partners, but women should not. Beverly learned about the importance of cleaning used syringes with water and bleach in meetings with HDES. Now she continues to share needles with others but makes sure that it is flushed twice with water and twice with bleach until the blood is completely flushed out.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Beverly was diagnosed with STI by a doctor from the General Hospital whom she consulted when she experienced itchiness in her vagina, some yellow discharge with a bad smell, difficulty in urinating, and pain in the abdomen. She was prescribed an antibiotic and all the discomfort disappeared after a week. Suspecting that she contracted the infection from her husband, she confronted him about it but he denied, until one night, when he was deeply asleep, Beverly looked under his pants and saw that his penis was covered with cotton, and had some yellowish discharge. Beverly suspects that it is the reason why her husband avoided having sex with her at that time. Beverly heard of HIV and AIDS only in 2008 from HDES' lectures and meetings with IDUs. She learned that it can be acquired through sexual intercourse and through needle sharing, particularly if one does not clean a used needle. Given her sexual and injecting behaviors, she thinks she has a chance for infection, the reason why she now cleans the needle every injecting episode.

**Experiences Related to Stigma and Discrimination.** Beverly felt discriminated against when her in-laws accused her of being a bad influence to her husband because she was injecting drugs. She could not understand why she had been blamed when her husband was the regular injector at that time and she only learned to use it from him. Even her neighbors gave her negative looks and did not want their children to associate with her children. One of her children went home crying one day because he got himself into a fight with a classmate who said that "his mother is an addict." Even her children's teachers know about it.

**Sexual Behavior and Practices.** Beverly and her husband never used the condom whenever they had sex, before the separation and even after their reconciliation, because he does not want it. With her first boyfriend (during the separation with her husband), sometimes they used a condom (when she has been given by HDES), sometimes they didn't because he does not like it; and at other times, he was ashamed to buy condoms at the pharmacy. Their use of a condom, however, was intended to prevent a 12<sup>th</sup> pregnancy; thus, they practice withdrawal when condoms are readily available. At the time of the study, she had a new boyfriend who did not inject drugs but accepted her for what she is. They used the condom regularly, in all their sexual encounters, because she has reconciled with her husband and wants to prevent another pregnancy, a mutual decision.

For lack of money to buy food for her children, Beverly started accepting customers for sex. Her first experience was when she was introduced by her friend to a man, and she pretended to be a sex worker. She was brought to a motel, they had sex, and after two hours, she was paid PhP500. She says the feeling was terrible but she had to do it for her children and did it again because she was left with no choice. That happened after her husband left her and provided no support for the children. They did not use the condom because the customer did not want to, and she did not have one. Beverly worries about having many children to take care of, and none of them helped her earn a living. One day she told them that there is a possibility that she would not come back to their house anymore if she meets a man who would love me. "Even if he is not rich, I will leave you all here."

remarried. In the past, her father was engaged in a 'room for rent' business for those who would want to have short-time sex. That business came to an end when a big fire broke out in the community where these 'rooms' were located, and they were forced to move to a new location (Pardo). Box 15 presents Melba's history and evolution of drug use, knowledge of risks, experiences related to stigma and discrimination, and sexual behavior and practices.

121. At present, Melba goes to her father's house once in a while to wash clothes and do other household chores, and gets paid PhP50. Sometimes, she goes to her brother's cellphone repair shop to offer whatever assistance he needs, e.g., running errands, buying cellphone parts, and she is also given money for her son's basic needs. Melba also provides laundry services in the community where she injects, and she charges PhP250 per client. She also baby sits and is paid PhP30-50 per day. For these odd jobs, she makes an estimated monthly income of PhP2,500.

122. From elementary to high school, Melba used Ventolin, an asthma drug. However, she did not consider that an addiction, saying that her intake of Ventolin was for medical purposes only. She would take two tablespoons, six times a day, particularly when she was in high school at age 14.

123. Melba learned to inject by herself. Melba would go to

the “shooting gallery” with or without her friends, In the past, she went there only to buy drugs and syringes (placing these in her bra). She would bring those home, inject secretly in her room, and clean it herself by simply flushing the syringe with water. At the time of the study, and because she has made many IDU friends at the “shooting gallery,” she injected drugs with four to five people (males and females, but mostly males) using a service needle. When asked why she does not use her own needle anymore, she narrated, “*Siguraduhon nako nga makapalit ko og drugs, bahala na ng service needle.*” (I make sure that I can buy the drug, I do not care about the service needle). The cost for one syringe (PhP15-20) is expensive and is not included in her budget. A new needle is opened by the seller everyday, and she has been told that the seller discards it usually after it has been used by at least five clients. With this set-up,

124. Melba is not worried of any infection. She plans to stop injecting when the right time comes, but admits that it could not be stopped all of a sudden.

#### **P. Zamboanga Case No. 1: Beverly**

125. Beverly, 37 years old, Muslim, and a native of Zamboanga City, finished only high school. Beverly has four sisters, her father died a long time ago, and her mother, a self-employed woman, is also dependent on her late husband’s monthly pension. At age 15, she got pregnant and married a man who taught her how to inject drugs. She has 11 children with him.

126. At the time of the study, Beverly worked as a beautician (part-time in establishment and part-time home service), earning approximately PhP100-200 a day, including Saturday and Sunday. Her income is insufficient to meet her family’s daily needs. Box 16 presents the history and evolution of Beverly’s drug abuse, drug combinations and practices, knowledge of risks, exposure to HIV information and preventive measures, experiences related to stigma and discrimination, and sexual behavior and practices.

127. Beverly has never injected alone because she always wants to be in the company of friends. Her regular friends are composed of three males and two females, although Beverly admits that she prefers to be with males for the following reasons: “*mas accepted ko nila*” (I am more accepted by male friends), “*mas kampakanti ko nila*” (I am more comfortable to be with male friends), “*mas daghan sila og experience sa pag-inject, dili ka masakitan, mas kabalo sila mo-inject*” (they have more experience in injecting, you will not get hurt, they know how to inject compared to females), “*kung sa patak, kung kinsay naay kuwarta, mas dali pangayuan ang laki, ang baye kay perming wala*” (in terms of chipping in money to buy drugs, it is easier to ask money from the males, the women would always say they do not have money). Even with female friends, Beverly no longer tries sharing needles. She also says that one can get HIV if she/he is not faithful to his/her partner – that is why she thinks that one should know if his/her partner is faithful or not. (“*Kinahanglan gyud nato mahibaluan nga faithful siya sa ato.*”)

128. She had a test for HIV in Mariki when the NGO Human Development Empowerment Services (HDES) went to the area together with CHO staff. She has meetings and discussions with HDES, and she says that information on HIV can be obtained from HDES’ staff. She has been given free condoms and has tried talking with other IDU males and females in a meeting where they were asked to share their experiences. Beverly has not been to a rehabilitation center, and has not experienced overdose.

129. When asked about other services availed of, Beverly says she has been to the local health center several times in the past to avail of family planning-related and immunization services. “*Trabaho para sa mga baye*” (livelihood activities for women) is what she cited when asked what other services women IDUs need. Currently, she needs to have a stable income because she has many children to support.

130. Because she knows that she is being talked about by neighbors, Beverly does not mingle with them, and does not join in any community activity. Instead, she focuses on the needs of her family.



131. Her children, particularly the eldest son, would say. *“ngano man ka mi, ngano man nga ingon ana? Pur-iso nag-against sa imo tanan kay ikaw pod adik-adik man ka.”* (What’s happening to you? Why are you like that? That is why everybody is against you – you are a drug addict). She feels, however, that “her children still respect her, they pity her, they are wondering why she had been blamed by her in-laws when they know that it was their father who taught her how to inject.” (*“Kay taas man gihapon ang gihatag nga respeto nimo, maluoy sila kanako, kay ingon sila nga ngano man daw ako ang gi blame sa mga in laws nako nga bisag sila kabalo sila nga akong bana ang nagtudlo sa akoa.”*). Because she is a drug user, Beverly is prevented from giving advice to her children because “she is afraid” (*“kay di man ko ka-advise sa ilaha kay mahadlok man ko”*).

132. Beverly’s mother (since her father is dead) and other sisters blamed her for following what her husband wants (referring to the time when she was asked to inject drugs) and for agreeing to a reconciliation. This is what her mother said according to Beverly, *“Sunod-sunod ka sa unsay kagustuhan sa imong bana, unya karon di man mo depensa sa imoha, unya nabulag namo gusto ka pa mobalik sa iyaha, unsay imong nakuha sa imong bana? Unsa bulawan ba na*

#### Box 17: Zamboanga Case No. 2 - Ranny

**Age:** 39    **Religion:** Roman Catholic    **Education:** 2<sup>nd</sup> year High School

**Profile.** At age 15, Ranny left home and went to Davao with her friends to prove to herself that she can stand and live life on her own. In Davao, she worked as a club dancer and sex worker. She stayed there for 10 years and never had any contact with her family. Ranny had two clients in one night. Her rate then was PhP3,000, less PhP500 for the club manager and PhP500 as bar fine, she is left with PhP2,000 per client. One day, she decided to go home to Zamboanga and work as a club dancer. No member in her family, according to her, knows that she has been engaged in sex work. At the time of the study, Ranny no longer worked in a club. She is not married and does not have a child. She lives with her parents, performs daily household chores, and takes care of her niece when her brother is out to work. Ranny also provides laundry services to their neighbors, earning an average of PhP700-1,000 a month. What her family does not know is that, when she gets a chance to sneak out at night, she works as a freelance sex worker, earning an average of PhP1,500 per client. In one night, she gets to have sex with two to three customers. She goes home at around 2 AM, and when seen by her mother, she would just tell her that she was in the company of friends.

**History and Evolution of Drug Use, Drug Combinations, and Practices.** When she was 12 years old and in second year high school, she met a teenager who invited her to a disco and introduced her to two other males. When she got drunk, they brought her to a place, took turns in raping her, and left her. (Ranny presumes that a drug was mixed with the alcoholic beverage she had for that night, which was why she could not remember how she was brought to the place where she was raped.) Ranny went home and did not tell anyone about it because she was afraid about what her parents might do to her and she was ashamed of herself. She says that her parents were always quarrelling and she did not want to make the situation worst. Further, she did not want the neighbors to talk about her because “she is the one who had been raped yet people might say that it was her fault because, at an early age, she went out drinking liquor and taking drugs with men and that, had she not gone out with them, it would not have happened to her.” To forget about the incident and because she could no longer put up with the “noise” at home, she spent most of her time with female friends. One afternoon, they asked her to join them in a marijuana session and they also drank some alcoholic beverage. Such group gathering became a regular activity for 12 year old Ranny, and they smoked marijuana at least three times in one day.

At age 15, when she left her family and went to Davao, she was invited by female friends to inject Sosegon. At first, she wanted to prove to herself that she can stand alone. She went with her friends but did not know that they injected drugs. Eventually, injecting drugs became a habit, particularly when she worked as a club dancer because many of her friends (both males and females) in Davao were also injectors. She injected at least twice in one day with either Sosegon or Nubain, but Nubain was the preferred choice. They pooled resources to buy buy one ampoule per session from a regular supplier. They divided the ampoule among three injectors (all females and all club dancers) at 0.3 - 0.4ml for each of them, using only one syringe. There was no cleaning of needle involved except to wipe the tip of the needle with cloth, because at that time, they did not know how. In fact someone else would always do the injecting for her.

A customer in Davao introduced her to ecstasy tablets. Since then, she would take ecstasy before having sex with other customers because she needed to satisfy her clients, otherwise they might not come back. With friends, she injected drugs and drank liquor as pastime. With customers, she injected drugs prior to going out with them or before reporting for work, and she took ecstasy before having sex. She also used drugs so as not to feel embarrassed with her work.

After 10 years, at age 25, she went back to Zamboanga and worked as a club dancer. There, she and her other co-dancers also injected drugs and sniffed shabu (that was the first time she tried using shabu and liked its effects). Nubain has a warm effect on the body, she feels like taking off her clothes, not knowing if she will take a bath or not. With shabu, she craves for it. Since then, she has been injecting drugs twice a day, and when the cooling effect is gone, she sniffs shabu.

**Knowledge of Risks, Exposure to HIV Information, Preventive Measures.** Ranny admits that when she started using drugs, she did not think of the possible effects of drugs on her health. All she wanted was to forget about her problems and to enjoy life with friends. Even at the time of the study, at age 39, she had very limited knowledge of risks. She mentioned that hepatitis is a possible risk if one injects drugs. She has a lesbian friend, also an injector, with hepatitis. She describes her as having “yellowish eyes.” She says that if one has hepatitis, one should not share eating utensils with the infected person. Furthermore, she says that one should not have sex with a man who has hepatitis.

She has not tried cleaning a syringe, but observed the ‘leader’ in their group to have used water and bleach. She has heard of this cleaning method in a meeting with other IDUs in an HDES-sponsored activity. She heard of HIV and AIDS from HDES, and learned that it can be acquired through needle sharing, particularly if one does not clean a used needle, and through sexual intercourse. Despite her knowledge of the risks of needle sharing, particularly when one does not clean it with the right disinfectant solution, Ranny continues to share needles with friends.

**Experiences Related to Stigma and Discrimination.** Afraid of being discriminated, Ranny, until the time of the interview, has not mentioned anything about her past to anyone, not even to her closest friends. She does not want people to say that “she is bad”— the reason why she was raped. She has also not told her family about her engagement in sex work because she does not want them to dislike her.

**Sexual Behavior and Practices.** Ranny was 12 years old when she was raped. At age 15, she had another sexual experience when she worked as a club dancer and sex worker in Davao, where she stayed for 10 years. In all her sexual encounters, Ranny never used the condom with clients. At the time of the interview, Ranny admits that she does not use condoms.





siya?” (You followed everything that he had asked you to do, and now he would not even defend you. You already separated and now you agreed to reconcile with him, what did you get from him?, is he a gem/gold?). Beverly ended this section of the interview by saying “I am not proud of what I am now – an IDU. Of course, I am ashamed because I am an IDU, which is the reason why I have a broken family, and I have many children.” (“*Di man ko proud sa akua karon, IDU mura’g siyempre makauulaw kay IDU ko, mao na nagka broken family ko, ug daghan pa ko’g anak.*”).

133. Beverly recalled her happy childhood, saying that she never experienced problems with her family or orientation; they were supportive of her, and everyone in the family had a good relationship with each other. Beverly is happy that she has the support of her children because they themselves saw their father injecting regularly at home even before she started doing the same.

#### **Q. Zamboanga Case No. 2: Ranny**

134. Ranny, 39 years old and Roman Catholic, had two years of high school education. She is the eldest and the only female sibling in the family. She has three younger brothers. Her mother is a bakery storekeeper while her father is unemployed but used to work in a shipping company as a utility person. Since she was a child, Ranny claimed that her parents always fought over money, and being the only breadwinner in the family, her mother had to make both ends meet to support the family’s needs.

135. Ranny entered the world of drugs by first trying out marijuana, then progressing to injecting Sosegon or Nubain, taking ecstasy tablets, sniffing shabu, and their combinations. Ranny admits that using drugs will not solve one’s problem, but it is good because one momentarily forgets her/his problems. Hence, if she and her friends are together and have money, the norm is they pool their resources and buy drugs

136. At the time of the study, Ranny no longer worked in a club. She said that shabu has become scarce and very expensive (PhP300 for small cellophane), and the local authorities are watchful of shabu users. Hence, Ranny no longer uses shabu but continues to inject Nubain with friends. She says that a small container of Nubain (referring to a “merthiolate bottle”) is worth more than a hundred pesos, but if divided among three or four injectors, the cost for each individual is not that much. This time, she injects drugs at least once a day because she only gets to sneak out of the house at night, when her mother is asleep.

137. A male friend of hers has a friend who supplies them with Nubain whenever they want it. He is also able to produce a “doctor’s prescription,” but would not reveal his source. They inject drugs everyday. Her group is composed of three females (including herself) and two males. For all three females, the ‘leader’ in the group (the one who supplies the drug) prepares the injecting paraphernalia and takes care of dividing the drug among them (at 0.2ml each). The other male member takes care of cleaning the syringe by flushing it twice with water and twice with a bleaching solution. They take turns on who gets to be injected first. What is important for them is that they get an equal amount of the drug for contributing an equal amount of money. Ranny could not say, however, if the syringe is always cleaned with water and bleach, although she admits that needle sharing is the norm in the group.

138. When asked whether she prefers to be with male or female friends when injecting, this is what she had to say: “*Gusto pod ko naa kaubang babayi para paggawas ko didto dili ma isip sa tao nga usa ra ka babayi tapos upat sila kabuok lalaki tapos ikaw lang babayi dili sila mag-isip og lain.*” (I also like to be with females so when I get out of the house [referring to the place where they inject], people will not have negative thoughts.)

139. Another incident in her life that she wants to forget through injecting drugs is the unhappy experience she had with a former live-in partner who worked at the Villamor airbase. She met him when



she was a club dancer in Zamboanga. He brought her to Manila, and they lived with the man's parents. She stopped injecting not only because she loved the man, but because she was afraid considering that he is a law enforcer.

140. Although she experienced withdrawal symptoms, such as headache and stomach pain, and always "mentally absent," she did not inject drugs or use shabu during the time they lived together. The man wanted a child from Ranny, but when a doctor told them that she may not get pregnant due to some problem with her uterus, they always fought. The situation became worse because his mother did not like her and she presumed that it was because of the monthly financial support he gave her. One night they had a fight again, and Ranny almost shot him with his own gun. They parted ways and Ranny says, "*Mao ra gihapon nangita siyag anak tapos wala di man ko makahatag, basin adto siya makaanak sa lain, tapos nakaanak siya, syempre pakasalan niya ang babae, di kawawa ko.*" (It's just as well [that we separated] because he wants a child and since I could not give him one, he might look for someone who could, and marry her, and I will end up in a pitiful situation.)

141. When she experienced pain and swelling in her vagina, she requested help from a female friend who works with HDES. She was brought to the CHO for examination, was given some antibiotics, and after one week, she felt better. She was advised to maintain proper hygiene, to always use condoms during sex, and not to engage in needle sharing.

142. Ranny thinks she had an overdose in Davao when she took ecstasy tablet, had some beer, and injected drugs that she experienced hallucination.

143. When asked about her impressions on HIV and AIDS programs and what particular services are needed by women, she said: "*Tabangi ang babayi sa pag huna –huna og pagtrabaho, alamin nila kung paano yong kahirapan ng mga babayi para hindi kagaya namin nag dru-drugs, hanggang ngayon drugs pa rin.*" (Provide assistance to women in terms of livelihood, try to find out poor situations of women so they will not be like us, who continue using drugs.) She appreciates the HIV/AIDS information given them by HDES and the CHO, and she learned many things from the seminars she has attended with other IDUs and sex workers. She also appreciates the distribution of condoms by HDES and the CHO. She knows that use of condoms can prevent them from acquiring HIV/AIDS but should a client insist on not using the condom, Ranny says that she will also not use it.

**Appendix 10:**  
**PROGRAM AND POLICY IMPLICATIONS OF  
STUDY ON FEMALE INJECTING DRUG USERS**

**PROGRAM AND POLICY IMPLICATIONS OF STUDY ON FEMALE INJECTING DRUG USERS<sup>1</sup>****I. PROGRAM IMPLICATIONS OF FINDINGS**

1. The study yielded new information and validated existing ones. The information can be used in guiding harm reduction programs, especially for female injecting drug users. Below is a discussion of how such programs can be enhanced.

**A. Improving Harm Reduction Programs****1. Needle Distribution**

2. The case studies showed that, while the FIDUs have an expressed preference for injecting alone, it was not their actual practice, as none of them consistently injects alone. They either inject with their spouse or sexual partner and/or with a group of friends or fellow clients in the shooting gallery. They inject with a group for various reasons: to share the cost of an ampoule; to enjoy the camaraderie; to be injected on properly; and to avoid overdose. Just like any behavior or practice that generates the desired result, injecting with a group gets reinforced and, thus, becomes a social norm among IDUs. With this social norm comes a greater tendency to also share needles and injecting equipment, hence, a higher risk of infection owing to each other's exposure to various risk factors.

3. Most FIDUs have very limited financial capacity. Thus, their intention to use their own needles is constrained by cost and the fact that "service needles" are readily available in the shooting gallery. The commonly-cited cost of needles in local pharmacies was PhP20 per piece, or more than half the cost of a 0.2ml dose of Nubain.<sup>2</sup> As bluntly stated by an FIDU, "*I make sure that I can buy the drug, I do not care about the service needle. The price of one syringe is expensive (PhP15-20) and is not included in my budget.*" And, anyway, they are told that the seller discards the service needle after it has been used by at least five clients. A FIDU who wants to protect herself from infection has to pay a higher share ("*patak*") so that she gets to inject first during the session, without minding if she is a potential source of infection for the succeeding users of the needle. Because of such costs, there are times when an IDU, male or female, will forget about protecting himself/herself and inject as unsafely as the others in the group – just so he can get a "high."

4. Reducing the risky behavior of sharing needles is being addressed by needle and syringe distribution programs, accompanied by informational activities aimed at reducing the utilization of non-sterile injecting equipment. However, program implementors have limited resources, outreach capacity, and program coverage, especially vis-a-vis the increasing IDU population and the dispersal of new IDU hubs to other areas while the original hubs remain.<sup>3</sup> Moreover, harm reduction is not accepted by police and most local government authorities and, therefore, outreach workers face the risk of arrest, if not the suspicion of IDUs that they are undercover agents. In Cebu, where syringe and needle distribution has been implemented for many years now, there is reportedly a palpable lack of sterile needles that used to be distributed before for free. There are isolated reports in a program area saying that sterile needles for harm reduction are now being sold by enterprising peer outreach workers, a delicate implementation concern or issue that must be handled with utmost care and sensitivity as peer outreach workers (who are either current or former IDUs) play a vital role in the success or failure of outreach programs.

5. The FIDUs said that they used to avail of sterile needles when they were distributed for free. Now, free sterile needles are no longer being distributed. It is likely that whenever free sterile needles

<sup>1</sup> This paper was written by Pedrito dela Cruz, Policy Advisor, with inputs from Dr. Maria Theresa Ujano-Batangan, the Project's Behavior Change Communication Specialist.

<sup>2</sup> An ampoule costs around PhP130 and is usually divided among 3-5 users at 0.2 ml to 0.3 ml per user.

<sup>3</sup> In Cebu Province, for example, there are at least two 'new' IDU hubs distant from each other and from the original hub.



become scarce, the female IDUs, more than their male counterparts, will be the ones most deprived of the commodity. Such likelihood can be attributed to a confluence of factors like the FIDUs' limited resources and inadequate financial capacity as well as their dependence on the male IDUs when injecting.

6. The frequency of injecting episodes is also worth noting, as the more frequent the injecting episodes where needle sharing is practiced, the greater the risk of infection. Eight of ten of those who share needles in the shooting gallery inject for a minimum of three times, and a maximum of eight times, a day. One even said that she injects as often as eight to ten times a day.

7. Granted that resources are on hand, needle distribution or exchange should be sustained and scaled up. As learned from harm reduction programs in different countries, programs should be implemented on a large enough scale to be effective. **Other accompanying measures should include risk reduction education, referral to voluntary counseling and treatment (VCT) services and primary care services, and referral to drug dependence treatment.**<sup>4</sup>

8. Notably, the case studies and FGDs showed how the lack of knowledge or skills to properly inject the substance can cause the dependence of FIDUs on male injectors ("leaders") who may or may not use sterile needles or practice the proper way of disinfecting shared needles. Distributing syringes/needles alone may not suffice to foster safe injecting practices, especially among FIDUs, if they do not have the knowhow to properly inject the substance. Females who have only begun to try injectable drugs are good targets of information and education activities as unsafe injecting behaviors are not yet reinforced in them. Most of them are especially drawn to the shooting galleries where they are injected by the male "leader," and where the usual practice is to use service needles. One may ask then if, as part of harm reduction, the proper way of injecting the substance should also be taught in the hope of weaning FIDUs from needle-sharing and freeing them from the male-female relational archetype characterized by male dominion, where women are mere receivers of whatever men give them. While this may be considered as pushing harm reduction beyond its acceptable boundaries, based on legal, moral and reputational standpoints, this is something worth exploring in consideration of program efficiency. There may be creative ways to do this, especially with the help of peer outreach workers who are former or current IDUs themselves.

## 2. Adequate Cleaning of Syringes/Needles

9. If needle sharing cannot be avoided, given the limited resources for an intensive and expansive syringe and needle distribution program, then **behavior change communication (BCC) aimed at fostering and sustaining safe injecting practices (e.g., proper use of water and bleach to clean the syringe and needle) should be strengthened and allocated due resources.** In fact, whether or not there are enough needles for a thorough ongoing needle exchange program, BCC for adequate cleaning of the syringe and needle should be pursued.

10. Here again, female dependence or modeling based on what men do is brought to fore, both in a positive and negative light. In Zamboanga, an FIDU imbibed the practice of adequate cleaning of syringes/needles (flushing twice with water and twice with a bleaching solution until the blood droplets are completely flushed) just by observing the same process done by a male injector in the "center." In Cebu City, where cleaning of service needles is usually done by male "leaders" during group injecting sessions, it was reported that water is reportedly the most commonly used liquid to clean injecting equipment. This practice, no matter how inadequate, is passed on as a norm for cleaning syringes/needles.

<sup>4</sup> WHO, UNAIDS, UNODC. 2004. *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission.*



11. In view of their numbers, the influence they wield on FIDUs and the fact that their behavior threatens women, it is tempting to treat male IDUs alone as the primary audience for BCC interventions aimed at adequate cleaning of syringes/needles, and expect that male IDUs will take responsibility to protect FIDUs or, at least, their risk reduction behavior could serve as a good model for women to emulate. However, considering the fact that FIDUs are more vulnerable to infection than male IDUs, and in view of the traditional gender role of women as nurturers and caregivers, **the practical value of purposively targeting FIDUs for behavior change should be highlighted.**

12. Aside from male and female IDUs, **the operators of shooting galleries should also be targeted for BCC. As shown in the case studies**, shooting galleries can be effective conveyors of information about adequate cleaning of needles, as much as they can also peddle wrong information and reinforce unsafe practices. Those who supply or serve service needles must also be trained in proper cleansing procedures.

13. **A BCC campaign should also consider the spatial environment where group injecting sessions take place.** In an IDU hub in Cebu City, the shooting galleries are small makeshift shacks or dark corners in a crowded urban poor community where sterile water is not readily available and, in many instances, there is not even a chair to sit on or an object on which to place the containers or plastic bags with water and bleaching solution. Such physical set-up, as well as fear of police raids, encourages a shoot-and-run behavior that leaves not enough time for proper cleaning of needles. **A behavior change campaign should not stop with just the delivery of the motivational messages and the “how- tos,” but should include, as well, the delivery of the essentials necessary to behavior change** - the water and bleaching solution that will protect them from infection. These items should be made readily available in the centers or shooting galleries, so that demand generation (for adequate cleaning of needles and syringes) is logically followed by demand fulfillment (with the availability of water and bleaching solution to execute the desired behavior). **Hopefully, through repetition, the behavior is sustained either as a matter of ritual or as a matter of respect for one’s health.**

### 3. Condom Use

14. The study showed a predominance of unprotected sex involving FIDUs. Low and inconsistent condom use with the primary partner is the norm, even when the primary partner is also an IDU. Among those who are engaged in casual and commercial sex, condoms are not used consistently with clients or casual sex partners. Aside from the poor appreciation of the value of condoms in protecting them from infections like HIV/AIDS and hepatitis, this sexual risk-taking behavior can also be attributed to the lack of ability of FIDUs to negotiate with their spouses or sexual partners for the use of condoms. It is noteworthy that even among those whose husbands are IDUs, there is fear that negotiating the use of condom will breed mistrust.<sup>5</sup> Such learned helplessness is rooted in gender roles and, therefore, must be addressed using gender lenses and tools that foster gender awareness among FIDUs, challenge them to be aware and have greater control of their health and their body, and invite them to take a fresher look at themselves.

15. A hard-core drug user in her late 40s, with high educational attainment and with five children from her previous relationships with four men, expressed the need for this kind of activity as she observed how FIDUs lose control of their lives. There exist numerous gender orientation modules developed for reproduction health (RH) programs (e.g., UNFPA Country Program) that had been

<sup>5</sup> One FIDU in her late 30s, who was initiated into injecting drug use by her husband when she was in her early 20s, have 11 children. They never used a condom because her husband does not want it. Cases like this show how even routine public health programs like Family Planning can be far from the reach of women, especially FIDUs. Utilization of reproductive health services can also be discouraged by religious orientation and beliefs.



reviewed as effective in promoting this perspective. **These modules can be adapted or customized for FIDUs with the view to enlightening and empowering them to live healthier lives. The information on FIDUs, which has been generated by the FIDU study, can serve as inputs to the development of this module.** The module that will be developed/adapted/customized must cover not just condom use, but also other risk reduction behaviors, including safe injecting practices, HIV counseling and testing, hepatitis testing, and treatment of STIs.

16. The availability of condoms is something that was not probed by the FIDU study. However, given DOH's current position vis-à-vis reproductive health, which has resulted in unspent resources for commodities, condoms are not as readily available now in public primary health care facilities as they were before. In the case studies, the effort of a church worker to distribute condoms was well appreciated by FIDUs, indicating that the choice of people doing the outreach makes a difference in the acceptance and utilization of the services by the target community. In the absence of strong government support, condom promotion and distribution should be pursued by other development partners, with FIDUs as among the priority target segments. As much as possible, **distributing condoms to FIDUs must not be done in a mechanical fashion, but must exhibit nurturance and gender sensitivity and encourage responsibility taking.** The planning and implementation of condom promotion and distribution provides a good opportunity for the participation of FIDUs.

#### 4. Voluntary Counseling and Testing (VCT)

17. The case studies, while revealing the FIDUs' sense of vulnerability to infections including HIV and hepatitis, are also highly indicative of how FIDUs value their health and the steps they are willing to take to ascertain their health status through testing. Despite the seemingly high awareness about their risk behavior and the diseases that it could bring, more than half of the study participants have not undergone testing for HIV or hepatitis. That is quite alarming, considering that those who have not undergone HIV testing are engaged or had been engaged in commercial sex work, except for one, and almost all of them have or had a spouse or sexual partner who also injects drugs.

18. These findings could be indicative of two things: first, the helplessness, defeatism, or lack of control that FIDUs feel towards their health; and second, the lack of adequate and appropriate services that can encourage FIDUs to submit themselves to VCT. Either way, it shows that risk reduction programs have not effectively reached FIDUs.

19. There is a body of evidence from other countries, which point to the fact that most people who test positive immediately modify their behavior, thus reducing the risk of infection for others. Testing negative also tends to encourage people to adopt safer practices. Considering the traditional gender role of women as nurturers and providers of care, there is an excellent opportunity that is being missed here – the opportunity of influencing a segment that has a multiplier value for HIV prevention. **There is, therefore, a need to work towards making the value of VCT and testing for hepatitis known to FIDUs and to ensure that these services are available to them. Equally important, information about when to go for VCT<sup>6</sup> has to be disseminated to FIDUs.**

#### 5. Drug Abuse Prevention

20. In trying to tackle the IDU problem by making it manageable, one inevitably swings to the perspective of preventing drug abuse. Doing this through a well-targeted information, communication,

<sup>6</sup> When to go for HIV testing: If you are sexually active (or have been within the last 10 years) and (i) you have had unsafe sex with multiple partners; (ii) you are uncertain of the HIV status of your partner; (iii) you are uncertain if your partner is faithful; (iv) you have been the victim of sexual abuse; (v) you have contracted a sexually transmitted infection within the last 10 years; or (vi) you or your partner have used intravenous drugs and shared needles within the last 10 years.



and education (IEC) and peer counseling program requires taking a closer look at the factors that induce people to get into drugs, including injecting substance.

21. The case studies have shown that there are various factors that drive women into drug use. These include peer influence; the need to forget, even temporarily, about problems in the family; a traumatic life experience (e.g., having been raped or molested), or their miserable life situation; the influence of sexual partner, spouse, or sex client who is an IDU; and the influence of a family member/s (father, mother, brother) who is/are using drugs. Each of these predisposing factors is coupled with an element of curiosity. The influence of a sexual partner, spouse, or a commercial sex client who is an IDU may be considered as an immediate factor as there are cases where they are seen as directly responsible for the initiation of women into injecting drug use. So is drug use by several family members. These factors, which have influenced women to try drugs, including injecting drug use, also provide some insights into the essential components of an audience-focused IEC and counseling that could help reduce risky behavior related to injecting drug use among females and males.

22. **Peer influence should be factored into efforts towards demand reduction through the introduction or strengthening of peer facilitators' programs in schools, in the workplace (e.g., entertainment establishments), and in the community.** The early age of initiation (median age of 16) into drug use and the early age at first sex (17 years old in 2007, IHBSS, Zamboanga; 15 years old as per the cases in this study) imply that **programs on life skills and sexuality education in both the schools and communities within and near IDU hubs are worth exploring.** For schools (secondary and tertiary), the vital entry points are the existing peer facilitators' programs and health education classes. For the communities, this means parlaying of, or establishing, grassroots structures for women (e.g., primary health care committees, women's clubs, and mothers' clubs) and stimulating, educating, and mobilizing existing youth groups. In entertainment establishments, having a functional peer facilitators' program is something that can be added to the business licensing requirements of the local government unit (LGU). Messages should be developed in a way that they resonate with the language of the target segments and respond to the predisposing and immediate factors that drive drug use. Local social welfare and health workers should also be trained in providing care to families with several members who are into drug use.

23. To optimize resources and ensure consistency of messages, IEC initiatives on demand reduction in schools, in the communities and in the workplace should be piggybacked with messages aimed at reducing stigma and discrimination.

## 6. Referral to Drug Dependence Treatment

24. The case studies show how most FIDUs try to cope in a world where their dependence on drugs has made it difficult for them to live relatively normal lives. While drug dependence, uncertainty about the future, strained or severed family ties, and a traumatic past are common threads that connect the FIDUs, there is also that shared hope for a better future and for the day when they will muster the resolve to submit themselves to rehabilitation or treatment for their drug dependence.

25. Motivating FIDUs to submit themselves to treatment for drug dependence requires program workers with strong counseling skills. Compared to users of non-injective ATS substances like shabu, IDUs may be a more intractable segment to convince for drug dependence treatment. Former hard core shabu users speak figuratively of a threshold or a point in drug use when they had the feeling that they were inevitably falling deep into the gutter ("*ruma-rampa na ng malalim*") from which they may not be able to lift themselves. Grim hallucinations usually accompany this point. They say that it was at that point when they started to seriously consider getting treated or rehabilitated for drug dependency. In the case of injecting drug users, they enjoy other psychical incentives that shabu users do not (e.g., the camaraderie in sharing the same service needle and in drawing substance from the same ampoule; the





“eroticism” in the act of injecting as observed by a pioneer in harm reduction in the country). Also, the effect of the injecting substance on their psychological and mental health may not be as strongly corrosive as non-injective ATS, thus lulling them into complacency. Seen from this perspective, providing information and encouragement to IDUs to seek drug dependence treatment may be a tougher task, compared to encouraging treatment of non-injective ATS users.

26. **The training of IDU program workers who perform counseling functions should consider the distinct characteristics and situations of IDUs compared to other drug users and, among IDUs, the distinct characteristics brought about by gender.** With strong counseling skills, programs will be better able to influence IDUs, especially FIDUs, to seek treatment.

## **B. Towards a Client-friendly Provision of Services for FIDUs**

27. In view of the foregoing, the following are basic considerations that should be kept in mind when working with FIDUs:

### **1. Gender**

28. Risk reduction programs, including the provision of services in the referral system, should have a gender lens. Program workers must keep in mind that compared to male IDUs, FIDUs are more exposed to risks and are inhibited from utilizing health care services because of fear of stigma and discrimination.

29. **For risk reduction programs to effectively reach FIDUs, the quality of care should be enhanced.** This means ensuring the provision of gender-responsive services by (i) recruiting and training women as peer outreach workers and counselors; (ii) protecting the confidentiality of FIDUs accessing sexual and reproductive health services, including counseling and testing; and (iii) informing FIDUs that such services are available. While such requirements are best met by programs run by NGOs and faith-based organizations, program workers in public health facilities (e.g., rural health unit [RHU], city health office [CHO], social hygiene clinic [SHC], and city, district, and provincial hospitals), as well as social welfare facilities in areas where there is a significant and increasing IDU population, should also be trained to be more gender-sensitive and responsive. Moreover, the participation of FIDUs in planning and implementing risk reduction activities should be encouraged in order to give vent to their caring nature and to ensure gender responsiveness of interventions.

### **2. Civil Status and IDU Status of Spouse or Live-in Partner**

30. It is noteworthy that marriage counseling was identified as one of the services needed by married women who are into injecting drug use. Health programs, in general, tend to overlook the psychosocial needs of married women or those who are in a live-in relationship. The same holds for harm reduction programs that have only recently taken a closer look on the gender dimensions of drug use.

31. As shown clearly in the case studies, married women and women in a live-in relationship, who inject drugs, are more laden with emotional burden due to their multiple roles as wife or partner, mother, and worker, not to mention the stigma and discrimination that most of them live with. The burden could become even heavier if they have a spouse or a live-in partner who is also an IDU. Half of the FIDUs in the case studies have or have had a spouse or a live-in partner who is also an IDU, and except for one FIDU in this category, all inject as often as 3-10 times a day. Two of the three female IDUs who had an overdose are married or had a live-in partner who is an IDU, and most of the FIDUs who are into multiple drug use are either married or have or used to have a live-in partner. Civil status makes a profound difference on the psychological make-up and, subsequently, on the injecting patterns of



FIDUs. Women in these sub-groups need extra care and attention. In particular, they are the ones who are likely to benefit the most from gender-based interventions aimed at inculcating in them a new perspective as to their roles and empowering them to exercise control over their health and lives.

### 3. Age and Duration of Injecting Drug Use

32. Older FIDUs have different material, health care, and psychosocial needs compared to younger FIDUs. The years that FIDUs had been injecting also affect their world view and predisposition towards risk reduction practices and quitting. **Program workers who recognize these nuances are more able to take advantage of opportunities for encouraging health-seeking behavior among FIDUs.** Perhaps studies should also be done on the younger females or on those who are just starting out, as a way of identifying vulnerability factors.

### 4. Commercial Sex Work

33. Two-thirds of FIDUs in the case studies are currently engaged or had been engaged in the sex trade, thus exposing them, their spouses or sexual partners, and their peers or partners with whom they share needles to greater risks. **Harm reduction interventions, especially needle and condom distribution, should therefore be prioritized for this highly vulnerable subgroup.**

34. Most of the case studies showed that women who are forced to work in entertainment clubs (e.g., as guess relations officers or GROs) are prone to become drug users because of the influence of co-workers and clients, most of whom develop either a short- or long-term relationship with them. At RH services delivery points, especially the SHCs, female sex workers who avail of services can be asked if they are into injecting drug use and, if so, be given adequate information about risk reduction and the means to protect themselves and their partners and peers (e.g., condoms, needles, or referral to a needle distribution program). The dispensation of sterile needles to drop-in clients of SHCs may be considered as an extra means to reach this highly vulnerable subgroup.

### 5. Ethnicity and Religion

35. Ethnicity and religion can pose further obstacles to the utilization of preventive services by FIDUs. Program workers in a multi-ethnic community should be aware of culture-based inequities between men and women as well as religious orientations and beliefs that inhibit women from accessing health services. There are cultures that attach harsher punishments to erring women, more than men, which can further drive FIDUs underground and difficult to reach by risk reduction interventions. Program models that tap local and indigenous leaders, so that harm reduction programs can effectively reach IDUs, should be harnessed when aiming for a greater coverage of FIDUs.

### 6. Family

36. FIDUs who come from families that have a member or members (father or mother, brother, sister, spouse) who are also into drug use also require special attention. Skillful counseling, referral for treatment of drug dependence, and livelihood support are essential for giving them a reason to hope and nurture their self-esteem, and need to be made available. While FIDUs in this situation may prove to be difficult cases, program workers should see in this sub-segment an opportunity to generate a positive spillover effect to family members who are drug users, through the effective provision of services to FIDUs in this situation.



## 7. Other Factors

37. Understanding other factors like multiple drug use, education, occupation, and community characteristics in relation to drug use is also important in sharpening BCC interventions and in determining the most appropriate medium for the delivery of messages.

## II. RECOMMENDED POLICY ACTIONS

38. Women are vulnerable to HIV, while men are at risk. Most women are vulnerable because they have limited opportunity to protect themselves; many men are at risk because they refuse to do so – often deliberately, it seems. Not only will most women with the virus fall ill with AIDS, many will pass the virus to their newborn children, and most will also take on the burden of caring for other family members with the disease.<sup>7</sup>

39. One glaring lesson learned in HIV prevention in Asia is that resources have not followed the epidemic, driven primarily by injecting drug use and commercial sex. The importance of deliberately targeting FIDUs for risk reduction, its rate enhancing value in improving overall harm reduction efforts, and its contribution to the national response to HIV and AIDS cannot be emphasized enough. The foregoing discussions underscore the urgency for the following policy-related actions:

40. **Mainstreaming Gender into Harm Reduction Programs and Services in the Referral Chain.** Integrating gender into harm reduction programs and related services that contribute to risk reduction requires institutional capabilities that entail human resources and training. It also requires redefining or clarifying coordinative relationships between field agencies implementing vital support programs (e.g., reproductive health, livelihood, adult education) for IDUs and marginalized women. Monitoring how mainstreaming is being enforced and evaluating its results are also important.

41. **Review of the Dangerous Drugs Act of 2002.** Scaling up harm reduction so that it effectively reaches FIDUs will not be possible with a legal environment that criminalizes carrying of drug paraphernalia by outreach workers. The gender dimension of injecting drug use, the vulnerabilities of FIDUs, and the potential of injecting drug use in driving the epidemic in the country in the future can serve as sound bytes to convince decision makers and influential women in the legislature to take action now and amend the *Dangerous Drugs Act or Republic Act 9165*.

42. **Scaling Up Harm Reduction Initiatives.** Ongoing and pipeline projects or programs need to do more in order to cover program sites with greater consistency and tighter monitoring. Scaling up should translate into greater coverage of FIDUs. A challenge that harm reduction programs can bring unto themselves is to target a 100% coverage of FIDUs while their numbers are still low.

<sup>7</sup> Panos/ZED. 1998. AIDS and Men.

