# Mainstreaming the Rights-Based Approach in HIV/AIDS Prevention: Learning Experiences from the Philippines

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## I. The AIDS Epidemic in the Philippines

The HIV/AIDS problem continues to wreak havoc worldwide with the heaviest toll being shouldered by the developing world. For the past two decades, the AIDS epidemic, considered by most states and governments as one of the most pressing problems of the world today, has had devastating impact on the lives, structures and development of individuals, families, communities and nations. This can be gleaned from the loss of productivity, erosion of incomes, rising cost of medical, hospitalization and funeral expenses, premature deaths of productive workers and adults, decline in national investments and earnings, increased investments in HIV/AIDS prevention, care and support programs and life-prolonging antiretroviral drugs—all of which are experienced by individuals, families and governments. The HIV/AIDS problem has undermined whatever development gains have been achieved by governments and has further heightened impoverishment in already poor countries. As of December 2003, about 3 million people have died of AIDS and 5

million people have been recently infected with HIV, bringing to a total of 40 million the number of people globally living with the virus (http://www.unaids.org...). More than two-thirds of these cases are found in low and middle-income countries. Moreover, a total of 14 million children have been orphaned by AIDS as of the end of 2001 (UNAIDS July 2002, 8).

In the Asia-Pacific region, an estimated 7.4 million are now living with HIV. Over one million people have acquired the virus in 2003 while about half a million are estimated to have died of AIDS in 2003 (http://www.unaids.org...). About 2.1 million young people, aged 15-24 years, are living with HIV (UNAIDS & WHO 2002, 7).

No country has been spared by the AIDS epidemic. Countries rich and poor, developed and underdeveloped, continue to witness and experience the shocking economic, political and social consequences of HIV/AIDS and recognize the far worse destruction the epidemic is capable of producing if no decisive actions are taken by peoples and governments worldwide. Thus, the challenge posed at the beginning of the new millennium was developing an effective global response to arrest the further spread of the epidemic.

The severity of the problem and the determination of the world's governments to combat HIV/AIDS have been demonstrated in an unprecedented move last June 2001, when a Special Session on HIV/AIDS of the United Nations General Assembly was convened to discuss and map out targets and goals in its collective resolve to combat the epidemic worldwide. The Declaration of Commitment on HIV/AIDS signed by the various heads of states and governments was an important product of this meeting. It serves both as a basis for global action and a yardstick for political accountability (UNAIDS July 2002, 11).

Unlike in its Asian neighbors, specifically Thailand, Indonesia and Cambodia, the AIDS prevalence in the Philippines remains to be low and the increase slow. Since the identification of the first HIV/AIDS cases in 1984, it has been able to maintain the <0.1 percent prevalence rate among adults aged 15 to 49 years (UNAIDS 2002 Update, 2). As of June 2003, there were 1,892 HIV positive cases reported, 68 percent (1,280) of whom were asymptomatic while 32 percent (612)

were AIDS cases at the time of the report. Sexual intercourse continues to be the dominant mode of transmission (86%). (See Table 1 and Figure 1)]

**Table 1**
REPORTED MODE OF TRANSMISSION, HIV/AIDS REGISTRY
1984 TO JUNE 2003 (N=1,892)

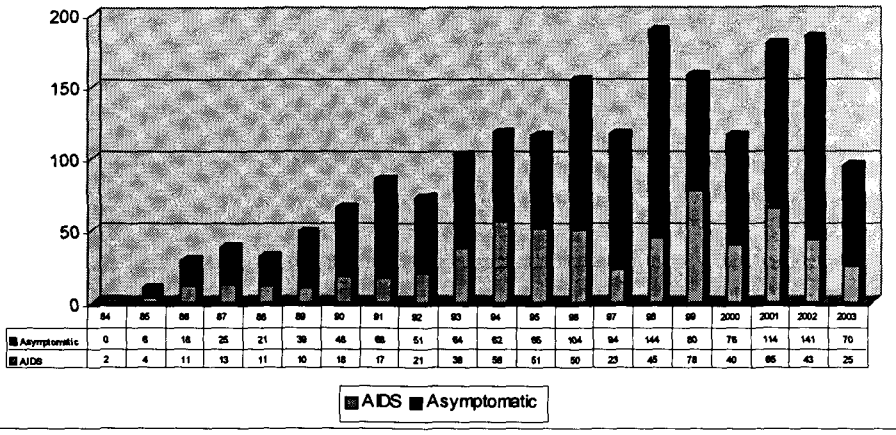
| Reported Modes of Transmission | Jan. 1984 – June 2003 **N = 1,892** | Jan-June 2003 **n = 96** |
|---|---|---|
| Sexual Transmission: | | |
| Heterosexual contact | 1,192 | 72 |
| Homosexual contact | 336 | 18 |
| Bisexual contact | 96 | 6 |
| Blood/blood product | 13 | 0 |
| Injecting Drug Use | 6 | 0 |
| Needle prick injuries | 3 | 0 |
| Perinatal | 27 | 0 |
| No exposure reported | 219 | 0 |

*Source: NEC-DOH. HIV/AIDS Registry (NHSSS), June 2003.*

Of the 1,892 HIV positive cases, 32 percent (600) were overseas Filipino workers (OFWs). Most of the cases were in the 20-39 age bracket. In terms of distribution by sex, more HIV/AIDS cases have been reported among females between 20-29 years old while most infections among the males have occurred in the 30-39 age group (NEC-DOH 2003). All regions in the country have reported HIV/AIDS cases.

The "low and slow" character of the AIDS epidemic in the Philippine has been attributed by the UNAIDS and experts to the early response of the country against HIV/AIDS, as well as other factors. These include the low partner exchange rate among prostituted women, low proportion of males patronizing commercial sex, the archipelagic character of the country and the low prevalence of injecting drug use (HAIN, NEDA & UNDP 2002, 18-22; Chin, et al. 1998, S88-89; UNAIDS 2002 Update, 2; UNAIDS, 2002; Dore et al. 1998, S5).

**Figure 1: HIV Ab Seropositive Cases by Year, 1984 to June 2003 (N=1,892)**




| | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Asymptomatic | 0 | 6 | 18 | 25 | 21 | 39 | 46 | 68 | 51 | 64 | 82 | 85 | 104 | 94 | 144 | 80 | 76 | 114 | 141 | 70 |
| AIDS | 2 | 4 | 11 | 13 | 11 | 10 | 18 | 17 | 21 | 38 | 38 | 51 | 50 | 23 | 45 | 78 | 40 | 65 | 43 | 25 |

*Source: NEC-DOH. HIV/AIDS Registry (NHSSS), June 2003.*

The early response of the Philippines toward the issues and concerns posed by HIV/AIDS builds the strong foundation of the country's HIV/AIDS program. The multisectoral participation in policy development, prevention and care programs of the various sectors in the country produced a high level of awareness and understanding among the general public on the disease (Simbulan & Balanon 2003, 6).

Various programs were undertaken by the government, non-government organizations (NGOs), private/business sectors and even the Church against the epidemic. Active surveillance and monitoring of the epidemic have been put in place. In 1992, the Philippine National AIDS Council (PNAC), the coordinating body in-charge of overseeing multisectoral efforts and activities geared towards awareness, prevention and care, was created. It was instrumental to the passage of the National AIDS Act, a comprehensive law that provides prevention and care directions towards HIV/AIDS in the country (DOH-National AIDS-STD Prevention & Control Program 1999, 1; HAIN, NEDA & UNDP 2002, 18-22).

Another factor contributory to the "low-slow" character is the geographical make-up of the Philippines. Its archipelagic character slows down population mobility within the country, therefore contributing to the slow spread of the disease.

Likewise, to some extent, since the country is detached from the mainland Southeast Asia, the spread of the epidemic in the continent does not have a significant effect on the country compared to those sharing land borders like Thailand, Cambodia and Vietnam. According to reports, the early outbreak of the epidemic crossed the borders of the African countries, America, Australia and parts of the Western Europe. However, the virus reached Asian countries mainly through sex tourism and injecting drug use. Compared to other Asian countries, the Philippines was not as exposed to tourism during the 80's although the existence of the US bases in the country may have contributed to the entry and spread of the virus. The Philippines receives relatively less visitors, about two million annually, compared to other Asian countries like Thailand, which receives six million visitors every year (HAIN, NEDA & UNDP 2002, 18).

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Sexual intercourse is the dominant mode of transmission of HIV, specifically facilitated by unprotected sex with multiple partners. However, in the Philippines, most studies concur that Filipinos are generally conservative when it comes to their sexual behaviors/practices manifested in their one-partner patronage and the low proportion of males patronizing commercial sex (HAIN, NEDA & UNDP 2002, 19; Chin, et al. 1998, S88-89; Dore, et al. 1998, S5). Moreover, the partner exchange rate of Filipino female sex workers have been reported to be lower compared to other Asian countries.

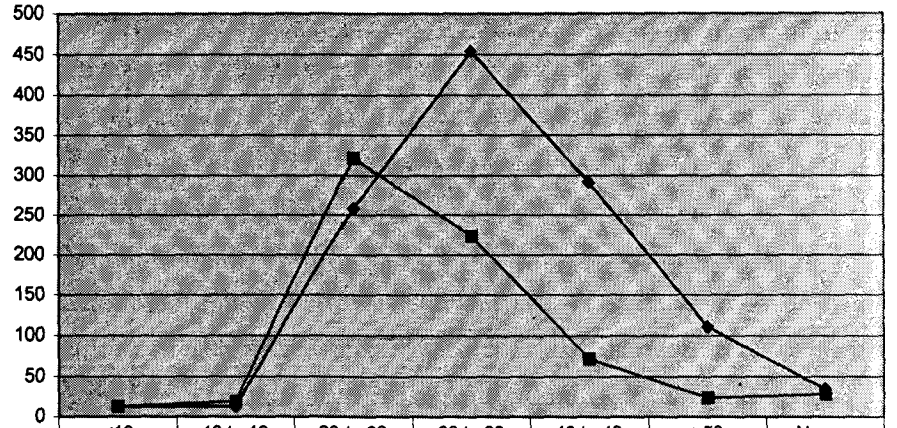
Furthermore, the Philippines has a low incidence of injecting drug use (IDU) and that the sharing of syringes and needles occurs among a small circle of drug dependents (HAIN, NEDA & UNDP 2002, 19). What is prevalent in the country constituting the serious drug problem, is the misuse of drugs like cough syrups, sniffing of chemical substances like Rugby and acetone, and smoking of marijuana and shabu or poor man's cocaine.

However, although the country has a low HIV/AIDS prevalence rate, the number of reported cases has slowly and consistently increased through the years. Experts believe there is no reason to expect that the "low and slow" character of the epidemic will remain to be so (PNAC 2000, 2). In fact, there are doubts if the available

estimates about prevalence are accurate and reliable because of the gaps or limitations in the current system of monitoring the disease in the country. It has been observed that before 1993 when the passive surveillance system was used to monitor HIV/AIDS cases, the number of reported cases was less than 100 per year. When the DOH established the National HIV Serologic Surveillance System (NHSS) in 1993, the number of reported cases increased to more than 100 a year. Yet the system in place covers only the so-called high-risk groups (HRG) namely, registered prostituted women, freelancers, men who have sexual intercourse with other men (MSM) and injecting drug users (IDU). Moreover, the surveillance is done only in a number of sentinel sites throughout the country and these are the cities of Quezon, Pasay, Angeles and Baguio in Luzon, cities of Iloilo and Cebu in the Visayas, and the cities of Davao, Gen. Santos and Zamboanga in Mindanao (DOH 2001, 6-8).

More importantly, all the known ways of transmitting the infection and factors that will lead to the further spread of the disease are present in the country. These

**Figure 2: HIV Ab Seropositive Cases by Gender & Age Groups, 1984 to June 2003 (N= 1,892)**




| | <10 | 10 to 19 | 20 to 29 | 30 to 39 | 40 to 49 | >50 | No age |
|---|---|---|---|---|---|---|---|
| Male | 13 | 12 | 258 | 454 | 291 | 110 | 35 |
| Female | 14 | 20 | 322 | 225 | 72 | 23 | 28 |

*Note: Before 1993, seven (7) cases had no reported age and sex.*
*Source: NEC-DOH. HIV/AIDS Registry (NHSSS), June 2003.*

include a flourishing commercial sex industry, a high proportion of prostituted women testing positive for ulcerative STIs like syphilis, a high percentage of mobile or migrant population, substantial level of casual sex between young men and women, blood transfusion under unsafe conditions, low and incorrect condom use and gender inequality (Balk et al. 1999, 82; HAIN, NEDA & UNDP 2002). As the experience of other countries in the Asia-Pacific region has shown, many of which have started also with a "low and slow" pattern of the epidemic, if no decisive and concerted national action is undertaken to arrest the spread of the infection, it is just a matter time before the country is confronted with an explosive epidemic.

## II. Evolution of the Country's Response to HIV/AIDS

Prevention has primarily been the emphasis of the country's response to the AIDS problem. The "low and slow" character of the epidemic has been the determining factor in the overall character of the various HIV/AIDS programs and activities undertaken since the first AIDS case was identified way back in 1984. Concomitantly, in countries with limited resources like the Philippines, prevention programs are considered to be the most appropriate and cost-effective means of addressing the epidemic, though this does not mean leaving out care and support and treatment programs for those already infected and affected by the disease.

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The country's response to the AIDS epidemic has followed the general course of the global response. When it was first detected in 1984, HIV/AIDS was viewed and treated more as a problem of individual behavior, particularly those engaged in high-risk behaviors. Using the traditional biomedical paradigm, the orientation of most intervention programs then was directed toward behavior change through increased knowledge about HIV/AIDS and safer sex practices. Other measures like the screening of blood and blood products for HIV, using sterile injection equipment among drug users, and avoiding pregnancies by HIV-infected women, for particular high-risk groups, were advocated (Tarantola 2000, 1). Emphasis was likewise placed in the development of programs

and projects which reduced the risks of acquiring the infection or eliminated the conditions which made people vulnerable to HIV/AIDS.

During this early stage in the country's response, efforts both by the government and civil society groups had focused on education and information programs side by side with risk-reduction intervention programs. With the so-called high-risk groups such as prostituted women and men who have sex with men (MSM) as principal targets, programs implemented were in the areas of education and information dissemination on HIV/AIDS, development of IEC materials, peer education and training, and condom distribution. Education and information materials centered on the dissemination of basic information about the nature of the disease, i.e. modes of transmission, differences between HIV and AIDS, ways of prevention and correct condom use. Other projects undertaken involved training of peer educators/counselors, raising the capability of prostituted women to negotiate with their male clients and teaching them creative ways of practicing safer sex like putting the condom through the mouth, and condom distribution.

The provision of clinic-based services such as the formulation of the National STD Case Management Guidelines (DOH-PNAC 2000, 34-35) and the conduct of serological surveys in particular sites in the country and with prostituted women as initial targets, were also manifestations of the dominance of the biomedical paradigm in the response to the HIV/AIDS problem. Efforts to strengthen the capability of the health care system like the education and training in AIDS education of DOH personnel and those in private STD clinics in Metro Manila, the skills enhancement activities in the early detection and treatment of sexually transmitted diseases of health personnel in the Social Hygiene Clinics (SHCs) were also undertaken. Moreover, medical protocols like the use of the Syndromic Approach in the detection of STDs among prostituted women were developed. Medical personnel assigned in SHCs have even undergone training in the use of the said protocol.

As the AIDS epidemic continued to infect and affect millions, the global response started to take a more comprehensive character. Governments and civil society groups started to realize and recognize HIV/AIDS not only as a public health problem, but also a development problem especially since it was becoming apparent

that those bearing the brunt of the epidemic were also the impoverished and marginalized sections of the Third World. Addressing the HIV/AIDS problem did not only entail convincing people to refrain from engaging in high-risk behaviors which increased their chances of acquiring the disease. More importantly, it required dealing with the conditions which made people vulnerable. As Peter Piot and Susan Timberlake asserted, HIV/AIDS extends beyond the physical health of the individual. It thrives in the economic, social and political environment in which individuals live (Piot & Timberlake 1998, 2). The health and well being of people are very much related and influenced by the economic, political and socio-cultural factors. Consequently, the economic, political and socio-cultural structures, policies and programs of a nation have an impact on the people's health. In the case of HIV/AIDS, this meant confronting the economic, social and political determinants of the disease.

Furthermore, as the problems of discrimination and stigmatization of people infected and affected by the disease heightened, the link between HIV/AIDS, development and human rights became evident. Human rights violations manifested in the form of poverty, powerlessness, lack of access to essential social services and gender inequality, were viewed both as the societal basis of people's vulnerability to HIV/AIDS and the condition which limited the choices of people with HIV/AIDS which further subjected them to human rights violations and discrimination in their communities. On the other hand, discrimination and marginalization have discouraged individuals at risk from seeking the necessary support like counseling and testing, consequently aggravating their marginalized status (Tarantola 2000, 2). Thus, the vicious cycle of poverty, discrimination and human rights violations has become deeply entrenched in the midst of the poor and marginalized people of the Third World.

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in health and human rights principles, the global response to HIV/AIDS has put emphasis on the role and obligations of governments, the multisectoral approach, people's participation and empowerment as exemplified in the principle of greater involvement of people with HIV/AIDS (GIPA), international solidarity and cooperation, and distributive justice.

In recent years, the recognition of the link between HIV/AIDS, development and human rights has been manifested in the formulation of a declaration endorsed by the United Nations member states on June 2001. The United Nations General Assembly Special Session on HIV/AIDS Declaration of Commitment (UNGASS DoC) is a historic document signifying the recognition of state leaders that HIV/AIDS is a serious development problem which can only be decisively addressed by scaling up both the national and international responses to the pandemic. The UNGASS DoC indicates the awareness of member states that the respect, protection and fulfillment of human rights is at the core of the fight against HIV/AIDS; that combating the epidemic is a major responsibility and obligation of the state. Thus, states should ensure that the necessary legal, procedural, budgetary, institutional and other mechanisms are in placed so that the human rights, particularly of persons living with HIV/AIDS (PLWHAs) and vulnerable groups, are not violated.

In the Philippines, these global developments both in the perception and approach to the AIDS epidemic had started to be seen in the various aspects of HIV/AIDS work sometime mid-1990s. Among the indications of the Philippine government's recognition of the importance of adopting a rights-based approach (RBA) to the HIV/AIDS problem were the following:

1. Creation of the Philippine National AIDS Council (PNAC), a multisectoral body which was initially tasked to act as an advisory body to the President on HIV/AIDS matters but later transformed into a policy-making body on HIV/AIDS with the passage of Republic Act 8504. The existence of the PNAC illustrates the recognition of mobilizing all sectors/groups in society and of the importance of GO-NGO partnership to effectively combat the epidemic (Department of Health-Philippine National AIDS Council. 2000. Seizing the Opportunity: The 2000-2004 Medium Term-Plan for Accelerating the Philippine Response to HIV/AIDS). As pointed by the World

Health Organization (WHO), civil society groups, including organizations of people living with HIV/AIDS, play a crucial role in the promotion of a rights-based approach HIV/AIDS agenda at all levels of interventions — global, national and even local (WHO 2003).

2. Formulation and endorsement by former Pres. Fidel V. Ramos of the Philippine National HIV/AIDS Strategy (1995). Contained in this document are important human rights principles in combating HIV/AIDS (DOH-PNAC 1995, 7-21)
   - **Respect and protection of the rights of PLWHAs** namely, the right to live and participate with dignity, self-respect and without discrimination in the community; to have access to health care, employment, education, travel, housing and social welfare as are available to others; to have access to timely, accurate, adequate, appropriate and relevant information about HIV infection/AIDS and its prevention; to privacy, including the right to decide about disclosure of his/her HIV status; to a full and satisfying sex life, without putting his/her partner at risk; to bear and raise children, if they choose; to legal representation; and to participate in the planning, formulation and implementation of programs.
   - **Empowerment of people as a means of preventing HIV transmission** through their having access to timely, accurate, adequate, appropriate and relevant information and resources.
   - **All HIV antibody testing should be voluntary with guaranteed confidentiality and adequate pre- and post-test counseling.** Since the start of the country's response to the AIDS epidemic, mandatory HIV-antibody testing had been rejected as a policy by the Philippine government (HAIN, NEDA & UNDP 2002). The "window period" which takes up to six months for the HIV antibodies to be detected in the test, makes mandatory testing ineffective and a waste of resources. What is instead emphasized is encouraging people to go for voluntary testing that is grounded on informed decision making with counseling as a means of protecting the rights of individuals. This also

entails making available and accessible testing facilities/services with competent and responsible health personnel.

- **The formulation of socio-economic development policies and programs should include consideration of the impact of HIV infection and AIDS.** Economic and social development improves people's ability to avoid HIV/AIDS by eliminating the conditions which make them vulnerable to the disease. Making jobs, schools, hospitals, housing, food, roads and bridges available and accessible increase people's choices and enhance their capability to combat HIV/AIDS. Likewise, creating an enabling environment where the people's economic and social rights like the rights to work, just and favorable remuneration, education, housing, social security, and freedom of thought, conscience and religion (UDHR 1948) are protected, respected and fulfilled will reduce people's vulnerability to HIV/AIDS.
- **Judicious allocation of resources in HIV/AIDS programs.** The allocation of resources to HIV/AIDS programs is one gauge of a government's political will to combat the epidemic. The uneven exposure of people to the infection entails that resources especially if these are limited should be rationally allocated giving priority to the vulnerable groups.

3. Formulation of the different Medium-Term Plans on AIDS Prevention and Control (1988-93, 1993-99 and 1999-2004). These documents reflect the government's recognition of the importance to come up with a national plan on HIV/AIDS to guide the country's response in combating the epidemic. The formulation of plans of action and policies is part of the obligation of the state to take the necessary measures including legislative, administrative, budgetary, to systematically address the HIV/AIDS problem in the country.
4. The promulgation of Republic Act 8504 or the Philippine AIDS Prevention and Control Act of 1998. The law, which is the first of its kind in the Asia-Pacific region, is another concrete step taken by the Philippine government

to safeguard the human rights particularly of PLWHAs. Among the important provisions of the law are the emphasis placed on HIV education in schools, workplaces, communities, for Filipinos going abroad and for tourists and transients; the prohibitions on mandatory testing; protection of PLWHAs from discrimination in the workplace, schools, health facilities; and the promotion of medical confidentiality.

5. The Philippine government's endorsement of the UNGASS Declaration of Commitment (UNGASS DoC). Being a signatory to the declaration is indicative of the recognition by the Philippine government of its obligations to protect, respect and fulfill the human rights primarily of PLWHAs by creating the conditions necessary to enable them to live a life of dignity in society. This includes ensuring they have access to care and support and treatment, as well as, their involvement in the formulation and implementation of policies, and the development of programs.

Furthermore, the current efforts of the national government through the Commission of Human Rights (CHR) to raise the level of knowledge and understanding of government officials and staff on human rights concepts and principles, international human rights instruments and mechanisms, indicate its commitment to mainstream the RBA in governance and development. Capability-building and skills enhancement programs in development planning, budgeting, monitoring and evaluation, are also being conducted in the various line agencies of government like the Departments of Health, Education, Justice, Interior and Local Government, Foreign Affairs, Budget and Management, and the National Economic Development Authority.

On the part of civil society groups, mainstreaming the RBA may be gleaned from the efforts taken by HIV/AIDS NGOs in education and information, advocacy, networking and organizing work. Many NGOs have been instrumental in the formation of Local AIDS Councils (LACs) and other HIV/AIDS formations at the municipal, city and provincial levels. They have taken concrete efforts to establish and strengthen relationship and coordination with local government units (LGUs) in the development and implementation of HIV/AIDS programs. They have also

been active in education and information, advocacy, networking and organizing work. Through their involvement in PNAC, NGOs, AIDS-service organizations and organizations of PLWHAs have been able to successfully work for the passage of an AIDS law in the country.

The adoption of the RBA in the response to HIV/AIDS requires more than knowing and understanding human rights concepts and principles. It entails a paradigm shift on how a problem is perceived and consequently, how it is treated. It requires a strong political will and commitment on the part of governments, and organizing and mobilizing of people, who, in the final analysis, will make all the difference in the fight against HIV/AIDS

### III. The Rights-Based Approach: An Empowering Strategy

HIV/AIDS and human rights are interrelated and interdependent. While the problem of HIV/AIDS is indicative of the existence of human rights violations, it is only through the respect, protection and fulfillment of human rights that the prevention and control of HIV/AIDS can be effected. It is also under this condition that those infected and affected by the disease can live a life of dignity and worth in society.

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Using the human rights framework in addressing the HIV/AIDS problem is a recognition of the multifaceted and multidimensional nature of the epidemic. It signifies that the HIV/AIDS problem is caused not only by the risky behaviors of individuals like unprotected sex with multiple partners, intravenous drug use, etc. It also means that structural and systemic factors have a role to play in making people vulnerable to and/or acquire the disease. It points out that the HIV/AIDS problem and related issues need to be approached beyond the levels of the individual and the family; that the human rights perspective in HIV/AIDS stresses that the epidemic cannot be treated separately or independently from existing socio-economic structures and

power relations. Thus, an effective and decisive means to respond to the HIV/AIDS epidemic is ensuring the full realization of the people's human rights.

It is the obligation of every State to protect, respect and fulfill the human rights of its people as a means of ensuring a positive and effective response to the HIV/AIDS problem. It is principally responsible in creating the conditions, instituting the mechanisms and providing the necessary resources and support services that will ensure the realization of the people's human rights. Meanwhile, civil society plays a crucial role in putting the government to task. The development and promotion of a human rights consciousness and culture among the people are, therefore, necessary in the protection of human rights and achieving HIV/AIDS-related public health goals.

The rights-based approach (RBA) in HIV/AIDS prevention is not simply a strategy or a framework. It is a process anchored on the principles of health and human rights which assert the following: (http://www.un.or.th...; UN-OHCHR 2002)

1. **All individuals regardless of who they are, what they are, where they are, have human rights because they are human beings.** Human rights are freedoms and entitlements every individual is born with and has a rightful claim. These form the foundation or basis of his/her dignified existence. This means that a person with HIV/AIDS have the same rights as a person without HIV/AIDS because they are both human beings. The presence of the virus does not make a person less human.

   A person with HIV/AIDS like everyone else has a moral claim to basic health care. As Chapman (1993) stated: *the universality of the right to health care requires that the definition of a specific entitlement be guaranteed to all members of our society without discrimination on the basis of financial means, employment status, disabilities, residence, gender, or racial or ethnic background.*

2. **The whole range of human rights—civil, political, economic, social and cultural rights—are indivisible, interdependent and interrelated.** Human rights have equal status and importance. They are inextricably intertwined with one another. Violation of one right means viola-

tion of other rights. For example, the advent of HIV/AIDS towards the end of the 20th century had provided an additional dimension to the stigma and discrimination being experienced by the impoverished and marginalized who are likewise those vulnerable to and infected by the disease. They are the very same people whose economic rights like the right to employment and decent wage have long been violated, consequently resulting in their social rights (e.g., the right to health, education and housing) being compromised.

3. **Human rights define and regulate the relationship between the people as claim holders and the State as duty-bearers.** Human rights are freedoms and entitlements which the people can legally claim and demand from the State. The State has the principal duty and obligation to protect, respect and fulfill these rights. Thus, the State including the various branches of government – executive, legislative and judiciary - can be made accountable for any breach or failure to perform its duties and obligations to the people.

The State's obligation to respect, protect and fulfill human rights has legal bases and is enshrined in the various laws, legal statutes, treaties, covenants and international human rights instruments signed and ratified by the government. In the case of the Philippines, the 1987 Philippine Constitution, the Universal Declaration of Human Rights (UDHR, 1948), the International Covenant on Civil and Political Rights (ICCPR, 1966), the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), Convention on the Rights of the Child (CRC, 1989), Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment (CAT, 1984), Convention Against Racial Discrimination (CERD, 1965), and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979), are among the major human rights documents which provide the legal bases for the government's accountability to its human rights obligations. At present, the Philippine government is a signatory to 23 international human rights instruments.

The above mentioned documents in addition to the UNGASS DoC to which the Philippine Government is also a signatory, means that in the context of HIV/

AIDS, the government is legally bound to respect, protect and fulfill the human rights of people with HIV/AIDS.

> The obligation to respect requires states to ensure that their laws, policies, and practices do not directly or indirectly discriminate based on HIV or AIDS status. Government should ensure that national laws, policies and their activities and programmes directly and indirectly affecting prevention, care and support take full account of human rights principles, and should review and reform that might that might hamper the ability of its population to take preventive action against infection or hinder access to services for care, treatment and support. The obligation to protect requires states to take measures that prevent HIV/AIDS-related discrimination by third parties, and the obligation to fulfill requiresstates to adopt appropriate legislative, budgetary, judicial, promotional, and other measures that address HIV/AIDS related discrimination and that compensate those who suffer such discrimination (Maluwa, Aggleton & Parker 2002, 9 & 17).

Moreover, in the case of HIV/AIDS, the State obligation to protect, respect and fulfill human rights means the state and its agencies are mandated to create the conditions, institute the mechanisms and provide the resources, necessary to ensure the prevention and control of the epidemic, and realization of the human rights of those infected and affected. This entails formulating the appropriate policies and laws that will facilitate the implementation of programs related and which have an impact on health and HIV/AIDS; putting-up the necessary infrastructures and systems and ensuring these are accessible to the people; and allocating sufficient funds and resources to answer the health needs and requirements of the population, especially the vulnerable groups and those already infected. Failure to fulfill these obligations indicates an abandonment of the state of its responsibility to the people and constitutes a violation of the people's right to health.

Related to State accountability is the justiciability of human rights. This means that claim holders or the citizens can take legal actions and redress if and when the State and its agents fail to comply with its human rights obligations or engage in actions that violate human rights.

4. **People's participation in all aspects of society that impact on their lives is upheld as a critical strategy.** In the various stages in the development of HIV/AIDS prevention programs, the formulation of strategic plans and policies, the identification of appropriate methodologies and activities, budgeting, monitoring and evaluation of programs, the active involvement of individuals, families, communities, sectors, and most especially the vulnerable groups and those infected and affected by the disease is ensured. Creating the conditions and providing the resources that will allow people to actively, freely and meaningfully participate in decision and policy-making processes is what the RBA is all about. This is contrasted to ceremonial consultation activities that are usually undertaken by the duty bearers or government officials with claim holders of human rights to give a semblance of people's involvement, as many of us in the past may have experienced in our interaction with government at various levels. In ensuring people's participation, attention and priority is given to persons with HIV/AIDS and vulnerable sectors. Trust in the people's capacities and power to transform themselves and their social environment is consistently recognized and upheld. Thus, the spirit behind the concept greater involvement of persons with HIV/AIDS (GIPA) promoted by the UNAIDS is in the light of the RBA.
5. **People's empowerment is at the core of the RBA.** Strategies that contribute to the enhancement and development of the people's capacities and potentials to enable them to become active participants and competent decision-makers in the attainment of human and social development are explored and maximized. High value is placed on education and consciousness-raising, organizing and mobilizing activities as effective ways of empowering peoples and communities. Through their organizations, people become aware and are exposed to the whys, whats and hows of daily existence and that of their society. They gain confidence in the process of confronting difficulties and solving problems, weighing their options and determining their priorities. They learn to become resourceful and creative. In other words, the people come to realize and appreciate their power as a

collective, what that power can do for them and how to use it towards the attainment of human and social development.

6. **The priority given to the impoverished, marginalized and vulnerable sections of the population is a principle advocated by the** RBA. Although human rights are universal and should be enjoyed by everyone, the RBA stresses that particular attention be given to groups or sectors who, for a long time, have been discriminated and marginalized because of their status and societal factors. These include women and children, overseas migrant workers, adolescents and young adults, prostituted women and prisoners. Programs, policies and initiatives are directed toward issues of equality, equity and discrimination since a goal is to decisively address and remedy power imbalances between groups in society.

## IV. The RBA as Applied in Work Among Prostituted Women

The work of a number of women NGOs with HIV/AIDS-related programs among prostituted women is replete with lessons on the use of RBA and its empowering effects on this marginalized group in Philippine society. Groups like Women's Education, Development and Productivity, Research and Advocacy Organization (WEDPRO), Bukluran ng Kababaihan sa Lansangan, Inc. (BUKAL), Buklod ng Kababaihan (BUKLOD) and Likhaan are examples of some of these groups.

Prostitution is illegal in the Philippines. This explains why prostituted women are viewed and treated more as offenders/criminals rather than victims, a condition which makes them highly vulnerable to discrimination and abuse especially in the hands of law enforcement personnel, including police women. The dominant perception of women in prostitution as immoral, low and dirty, home-wreckers, promiscuous and vectors of diseases is implicitly used as justification for treating them without dignity and respect, for applying violence and for the lack of basic services extended to them by government. When services are available, for instance, the requirement for women working in karaoke bars, beer gardens, massage parlors, clubs, etc. to submit themselves for mandatory medical screening/check-ups in Social

Hygiene Clinics (SHC), the law is intended more to ensure that the women are free from certain diseases like STIs. In exchange, they are issued "pink cards" or social hygiene cards which indicate they are clean and fit to work. The spirit of the law is not to safeguard the health and well-being of the women workers, but more to protect customers from acquiring infections when they patronize the products and services of these entertainment establishments (Interview with an AIDS NGO officer 2003).

The application of the RBA in the work among prostituted women is demonstrated in several important components of HIV/AIDS programs and activities of women's NGOs. These include the following:

1. **Education and consciousness-raising.** Regular topics discussed include basic human rights concepts and principles, women's rights, gender inequality, CEDAW and other human rights instruments, women's issues like VAW—prostitution, domestic violence, sex trafficking, etc., other national issues like the globalization, the war against terror, foreign debt, death penalty, etc.
2. **Capability-building and skills enhancement.** Training programs are integral parts of work among prostituted women which are intended to expand their capacities. They are usually exposed and provided skills and experiences in paralegal work, gender-sensitivity, counseling, advocacy and lobby work, livelihood, etc. where they get to learn new ideas and find themselves in new situations which are not commonly encountered in their daily routine.
3. **Organization and mobilization.** An important gauge of empowerment is recognition by individuals faced with similar interests, needs and problems of the need to organize themselves. One such group is that of prostituted women, which has been able to get organized through the help of women NGOs and use this formation to assert their rights through education and information, advocacy and networking with other sectors in society.
4. **Advocacy and networking.** These are part of the day-to-day activities of NGOs as a means of educating, getting the support and mobilizing the

public and civil society groups. Forums and dialogues with government officials, conferences, exhibits, political actions like pickets and rallies are examples of activities undertaken to get the attention and support of people to the issues and concerns of prostituted women.

5. **Provision of services.** Providing concrete services needed by the target clients is commonly used as an initial strategy to get their attention and interest. These include medical/health examination and treatment, STI referrals, distribution of condoms, counseling, legal assistance, livelihood, etc.
6. **Fund generation.** An organization will not be able to sustain itself, its activities and projects without funds. NGOs together with prostituted women conduct fund-raising activities such as selling goods/products, submitting project proposals, etc.

In a focus group discussion (FGD) conducted last December 2003 among a group of streetwalkers or prostituted women not attached to any entertainment establishment, the participants shared the changes which have taken place in their lives after their involvement in NGO work. According to the women, the education and training sessions on human rights which they received from the women's NGO helped in making them aware of their rights and the causes of their marginalized status in society. Knowing that they had the support of NGO workers made them confident and determined in fighting for the ideas they espoused. Whereas before they were timid and passive when face to face with police authorities, now they are able to assert their rights and negotiate. As shared by an interviewee in one of her encounters with police authorities:

> *.... Naniniwala silang masama kami at sinisigawang mga jokards lang naman kayo, a. Ano ba ang karapatan nyong magreklamo? Sir, sabi ko, kahit po kami na ang naabuso? Dahil po ba pulis yung nang-abuso sa amin, wala kaming karapatan? Ang sabi sa amin, customer is always right.*
>
> (.... they [policemen] believe we are bad and shouted that were just "jokards" [street label for prostitutes]. What right do you have to complain? Sir, I told him, even if we are the ones abused? Is it because a policeman is involved that we lose our rights? He told me, "Customer is always right".)

A milestone in the work of NGOs among prostituted women was the holding of the First National Conference of Women Victims-Survivor of Prostitution last October 21, 2003 in Olongapo City, and attended by about 100 women. In a statement issued by the conference participants, they have asserted that prostitution cannot be considered work; that prostitution cannot be labeled "sex work". Although women earn money from prostitution, they detest the sex and violence that go with the activity. Every minute, women in prostitution face the risks of getting infected with sexually transmitted diseases including HIV/AIDS, being beaten up and abused, even getting killed. Thus, they consider prostitution a gross violation of human rights, a glaring form of inhuman treatment.

As part of asserting their human rights, the conference participants have put forward the following calls to the Philippine government:

1. Repeal laws which treat women in prostitution as criminals and offenders; they should be treated as victims of the system of prostitution and should be accorded all forms of protection. Instead, a law should be passed to criminalize those who exploit and traffic women and children, pimps and clients of prostituted women, owners and/or operators of businesses, which sell sex, brothels and other establishments, used as fronts for prostitution.
2. Provide protection to all victims of prostitution and trafficking based on human rights principles, and
3. Provide comprehensive and sustained assistance and support to women victims-survivors of prostitution.

Furthermore, in mainstreaming the rights-based approach in addressing the concerns and problems of women in prostitution and in order to safeguard their rights against various forms of violations committed by the State and its agents, the following recommendations are being put forward:

- Raise the level of knowledge and understanding of the police forces and other law enforcement agencies on human rights concepts and principles in order for them to be conscious of their human rights obligations. These can be done by integrating human rights courses, including the various human rights instruments like the Convention Against the Elimination of all Forms

of Discrimination Against Women (CEDAW), Convention on the Rights of the Child (CRC) and Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment (CAT), into the formal education and training of policemen and officers, holding of seminars, forums and workshops on human rights issues and topics.

It is also important that gender orientation and gender-sensitivity training and workshops be included in the education and training of law enforcers. By making policemen and officers, including those assigned to the Women and Children's Desk in police stations nationwide, gender sensitive and aware of the rights of women and children, human rights violations committed in the course of police operations may be lessened, if not stopped, in the treatment and handling of prostituted women and children.

- Raise the level of awareness and understanding of health personnel/staff on human and patients' rights. Conduct human rights, gender-orientation and sensitivity seminars, forums and workshops among health personnel particularly those assigned in Social Hygiene Clinics (SHCs) nationwide. There is a need to raise the consciousness of health personnel especially those directly dealing with prostituted women, in ensuring that women's rights are respected, protected and fulfilled every time they undergo routine check-ups in SHCs as a requirement in the renewal of their work permits. A re-orientation of the purpose and manner by which the regular pap smear women working in restaurants, bars and entertainment establishments are made to undergo is necessary so that the interest and welfare of these women becomes the foremost concern. The rights of women as patients like the right to medical care and humane treatment, information, privacy and confidentiality, and informed consent, should be upheld and protected by public health personnel at all times.
- Improve the level of knowledge and understanding of patients, including prostituted women, about their rights as individuals and as patients. Incorporate topics on human and women's rights in the health education programs and services of patients in public health facilities and SHCs. Patients

should be made conscious of their rights and taught skills on how they can exercise and defend these rights in promoting their health and well-being.

## V. Conclusion

Governments and the international community now acknowledge that HIV and human rights are closely linked; that human rights violations are the very conditions contributing to the spread of HIV/AIDS and making people vulnerable to the disease. This perception of the HIV/AIDS epidemic, more than ever, stresses the urgency of mainstreaming the rights-based approach (RBA) in every country's response.

The RBA has provided a broader and clearer view of the determinants of the spread and impact of HIV/AIDS. From the original biomedical and traditional public health approach, a paradigm shift grounded on the principles of health and human rights has led the global response to address, not only health factors but moreso, issues of economic inequities, powerlessness, gender inequality, mobility and insecurity (Tarantola 2000, 2). A multisectoral and multipronged response involving the mobilization of civil society groups including people with HIV/AIDS has been recognized as critical to effectively deal with the AIDS problem. Non-government, people's and sectoral organizations have proven to be reliable partners of governments in the development and implementation of HIV/AIDS prevention, care and support programs in various parts of the globe. Composed of highly competent and dedicated workers, civil society organizations have consistently taken a leading role in the fight against HIV/AIDS. Experiences have shown that especially with government support at the local and national levels, NGOs, POs, CBOs, ASOs and organizations of PLWHAs, can accomplish much in undertaking sustained intervention efforts toward mitigating the impact of and reducing people's vulnerability to, the disease.

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