Analyzing Philippine Legal and Policy Frameworks for the Protection of Women Migrant Workers from HIV/AIDS

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I. INTRODUCTION

Overseas employment has been more of a necessity rather than a choice, not only for Filipino migrant workers, but also for the Philippine government. Thus, despite the statement in the *Migrant Workers and Overseas Filipinos Act of 1995* (*Migrant Workers Act*),[1] that the State does not promote overseas employment as a means to sustain economic growth,[2] there is no indication of any easing up on the policy of labor exportation. As a matter of fact, in the latest survey published by the National Statistics Office in July 2004, Overseas Filipino Workers (OFWs) numbered 1.073 million and accounted for two percent of the total working age population and 2.9% of the total labor force.[3]

Against this backdrop, it is vital that the protection of migrant workers takes priority in the government's policies and programs. Overseas work, by its very nature, predisposes workers to discrimination and exploitation, and makes them vulnerable to human rights abuses, especially the so-called unskilled workers. For most women migrant workers, however, vulnerability is not only engendered by the skill they lack or possess, but also by the very fact that they are women, which preordains the kind of work they do or are expected to do.

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1. An Act to Institute the Polices of Overseas Employment and Establish a Higher Standard of Protection and Promotion of the Welfare of Migrant Workers, Their Families and Overseas Filipinos in Distress, and for Other Purposes [Migrant Workers Act], Republic Act No. 8042 (1995).

2. *Id.* § 2(c).

3. Bureau of Labor and Employment Statistics, *Monitoring Overseas Employment in the Labor Force Survey*, *at* http://www.bles.dole.gov.ph/labstat.htm (last accessed Aug. 31. 2004).

Statistics from the Philippine Overseas Employment Administration (POEA) show that from 1997 until 2001,[4] there has been a consistent increase in the deployment of women outnumbering the men by 3 to 1 in 2001. In the professional category, women dominate in numbers because this category includes entertainers who make up most of what are termed as Overseas Performing Artists (OPAs). There has been a steady increase of hired women – from 89% to 91% out of the total OPA workers deployed; while in the service sector, which includes domestic workers, there has been an increase in hired women from 72% to 85% of the total deployed.[5] The POEA does not publish statistics on the sub-categories for both the professional and service sectors; so there is no way to definitely determine how many are in the entertainment industry and in domestic work.

However, a look at the statistics on the deployment of OFWs by destination from 1998-2003[6] would show that the number one destination in the Middle East is Saudi Arabia, followed by the United Arab Emirates. In Asia, the consistent number one destination is Hong Kong, followed by Taiwan. Another frequent place for domestic workers is Singapore, which places fourth – overtaken only by Japan, which is the expected and accepted workplace for entertainers. Furthermore, in a study conducted by the Development Action for Women Network (DAWN), it cited POEA statistics showing that "out of the 73,246 OFW deployment to Japan, 69,896 women went as OPAs" and "[o]ut of 73,685 Filipino OPAs deployed in 2003, only 439 went to work in other countries; the rest went to work in Japan."[7]

There are well-documented cases and data on abuses and violations of migrant workers' rights in the workplace. Understandably, advocacy and protection have been focused largely on how they can be protected from these various forms of abuses. It is also a fact that migrant workers become vulnerable if they are not equipped with the proper and correct information on matters that might affect them when they go abroad. Hence, one of

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4. POEA.gov.ph, *Overseas Employment Statistics*, *at* http://www.poea.gov.ph/html/statistics.html (last accessed Jul. 30, 2005) [Overseas Statistics].

5. *Id.*

6. *Id.*

7. Development Action for Women Network (DAWN), *The Overseas Performing Artists (OPAs) in Japan from Pre-departure to Reintegration*. (Paper presented to the Asian Consultation on Vienna Plus 10, Bangkok, Thailand, December 15-16, 2003), *available at* http://www.forumasia.org/downloads/Viennaplus10/Bangkokconference.doc (last accessed Jul. 30, 2005).

POEA's main functions has been to conduct a Pre-departure Orientation Seminar (pre-departure seminar) in order to inform migrant workers with important matters prior to departure.[8]

The pre-departure seminar has generally been country-specific, not job-specific. However, with the growing numbers of migrant workers, the POEA has partnered with a number of non-governmental organizations (NGOs) and accredited them as entities, which may conduct the pre-departure seminar. Recruitment agencies have also been accredited to give pre-departure seminars to their new-hires. This is in keeping with the deregulation policy adopted by the government and mandated by law.[9] Furthermore, in 2003, the Comprehensive Orientation Program for Performing Artists, which covers the testing, certification and deployment of OPAs was integrated into the pre-departure seminar.[10] The accreditation of OPAs is part of the government's policy to arm migrant workers with the necessary skills and expertise on the job applied for, as it views this as the best way to protect them from vulnerability and abuses.[11]

As of late, a new threat has plagued migrant workers. Whether it is the result of a violation or abuse inflicted upon their persons or a product of their own decisions, there has been a slow but steady increase of migrant workers infected with HIV/AIDS.[12] Statistics show that from 22% in January 2000, the percentage of infected OFWs rose to 32% in April 2004.[13] It should be noted that OFWs are generally subjected to mandatory HIV/AIDS testing before they leave for abroad so it is understandable that they would figure prominently in statistics as a group than others.[14]

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8. This task has been transferred to the Overseas Workers Welfare Administration (Welfare Administration) under the POEA-WELFARE ADMINISTRATION Joint Circular No. 04, Series of 2002, but there has been delay in the actual turnover.

9. MIGRANT WORKERS ACT, §§ 29-30.

10. Comprehensive Orientation Program for Performing Artists (COPPA), DOLE Department Order. No. 48-03 (2003) (This also provided for the transfer of the orientation for OPAs to the Welfare Administration but there has likewise been a delay in the actual turnover.).

11. *See* POEA Rules and Regulations Governing the Recruitment and Employment of Land-based Overseas Workers, *at* http://www.sgshumanresources.com/rules.html (last accessed Jul. 30, 2005).

12. Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome.

13. MERCEDES B. APILADO, POSITIVE RESPONSE: A GUIDEBOOK ON HANDLING MIGRATION AND HIV/AIDS ISSUES FOR FOREIGN SERVICE PERSONNEL 7 (2004) (citing NATIONAL HIV/AIDS REGISTRY, DEPARTMENT OF HEALTH).

14. *Id.*

However, the fact remains that there is a steady increase in the number of migrant workers being infected, so that it becomes vital that this concern be addressed with measures before they leave, on-site, and upon their return.

In the latest country report submitted by the Philippines to the Committee on the Elimination of Discrimination Against Women (CEDAW Report), it stated that among women, the prevalence of HIV/AIDS was highest among the 19-29 age groups. Most of these women are engaged in prostitution, but there are also cases being detected from overseas domestic workers.[15] The 2004 Philippine Country Report made by the Commission on Population (Population Commission), which highlights the country's accomplishments in implementing the International Conference on Population and Development (ICPD) Program of Action from 1994-2004, and citing the National Epidemiology Center of the Department of Health, states that from January 1984 to June 2004 "[o]ut of the 2,107 cases, 676 (32%) were OFWs, of which 249 (37%) were seafarers, 119 (18%) were domestic helpers, 66 (10%) were employees, 40 (6%) were entertainers, and 34 (5%) were nurses."[16]

This Article will examine the pre-departure measures that the Philippine government has instituted to protect migrant workers from vulnerability to abuse and violation of their rights. The pre-departure seminar is also the mechanism by which the government, through the POEA, has sought to educate migrant workers on HIV/AIDS. As this seminar is the focus of the Article, discussions would also be inherently limited to documented women migrant workers and to the pre-departure phase of the migration process, and the legal and policy frameworks within which it operates.

This Article is intended to be a research aid in formulating a more gender-sensitive pre-departure program for women migrant workers that would reduce their vulnerability to HIV/AIDS. It also aims to assist in law and policy reform to make them more responsive to the needs of women migrant workers especially the domestic workers and OPAs, with the end in view of empowering them through effective delivery of information on HIV/AIDS.

There are various pre-departure and on-site protection mechanisms for migrant workers, which are mostly concentrated on prevention of illegal recruitment. This Article will discuss them only in so far as they might bear

15. Philippines, *Combined Fifth and Sixth Philippine Progress Report on the Implementation of the UN Convention on the Elimination of all Forms of Discrimination Against Women,* ¶ 447 (June 2004) [hereinafter Progress Report].

16. Commission on Population, *The Philippine Country Report* 2004 *ICPD at*10*: Putting People First*, 18 (2004) [hereinafter Country Report 2004].

relevance to the topic of this Article. Furthermore, the study will focus only on domestic workers and entertainers. The entertainers are most vulnerable to HIV/AIDS infections while the domestic workers are most vulnerable to abuses, including sexual abuse. These two categories of work are also the areas predominantly applied for by Filipino women.

II. THE PHILIPPINE LEGAL AND POLICY FRAMEWORK

A. The Philippine Constitution and International Treaties

The 1987 Philippine Constitution provides that "[t]he State values the dignity of every human person and guarantees full respect for human rights."[17] It shall also "afford full protection to labor, local or overseas"[18] and

> shall protect working women by providing safe and healthful working conditions, taking into account their maternal functions, and such facilities and opportunities that will enhance their welfare and enable them to realize their full potential in the service of the nation.[19]

The State is also mandated to "adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost."[20] The same provision prioritizes the needs of vulnerable groups, among which is women.[21]

It should be noted that when the Constitution was adopted in 1987, the Philippines had already ratified almost all the major human rights conventions that were in effect at that time.[22] Among these are the Convention on the Elimination of All Forms of Racial Discrimination (CERD),[23] the International Covenant on Civil and Political Rights

17. PHIL. CONST. art. II, § 11.

18. *Id.* art. XIII, § 3.

19. *Id.* § 14.

20. *Id.* § 11.

21. *Id.*

22. Philippines Ratification History, *at* http://www.bayefsky.com/./html/philippines_t1_ratifications.php (last accessed Sept. 01, 2004) [hereinafter Ratification History].

23. International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force Jan. 04, 1969 (The CERD was ratified on Sept. 15, 1967 and entered into force for the Philippines on Jan. 04, 1969.).

(ICCPR),[24] the International Covenant on Economic, Social, and Cultural Rights (ICESCR),[25] and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[26] The Philippines has also ratified the Convention on the Rights of the Child (CRC).[27] In addition to the above-mentioned treaties, the Philippines ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention).[28]

The ratification of these treaties is important because they provide the norms for human rights advocacy in law reform, policy formulation, and implementation and development of case law. For women migrant workers, these instruments can serve as the basis for articulating a law that would protect and promote their human dignity and well-being. For example, the Migrant Workers Convention is found in the preamble of the *Anti-Trafficking in Persons Act*[29] while the CEDAW is invoked in the *Violence*

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24. International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 03, 1976 (The ICCPR was ratified on Oct. 23, 1986 and entered into force for the Philippines on Jan. 23, 1987; the First Optional Protocol to the ICCPR was ratified two years after on Aug. 22, 1989 and entered into force on Nov. 22, 1989.).

25. International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976 (The ICESCR was ratified on June 07, 1974 and entered into force for the Philippines on Jan. 03, 1976.).

26. Convention on the Elimination of All Forms of Discrimination against Women, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force Sept. 3, 1981 (The CEDAW was ratified on Aug. 05, 1981 and entered into force for the Philippines on Sept. 04, 1981.).

27. Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept. 02 1990 (The CRC was ratified on Aug. 21, 1990 and entered into force for the Philippines on Sept. 20, 1990.).

28. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, G.A. res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), *entered into force* Jul. 01, 2003 (The Migrant Workers Convention was ratified on Jul. 05, 1995 and entered into force for the Philippines on Jul. 01, 2003.).

29. An Act to Institute Policies to Eliminate Trafficking in Persons Especially Women and Children, Establishing the Necessary Institutional Mechanisms for the Protection and Support of Trafficked Persons, Providing Penalties for its Violations, and for Other Purposes [Anti-Trafficking in Persons Act], Republic Act No. 9208 (2003).

Against Women and Children Act.[30] The Philippine Supreme Court, in the case of *PT&T v. National Labor Relations Commission*,[31] where a woman was terminated because she concealed the fact that she was married in lieu of the company's policy not to hire married women, ruled that the termination was illegal and the policy supporting this was discriminatory and contrary to the Labor Law and Constitution. The Court also stated:

> Corrective labor and social laws on gender inequality have emerged with more frequency in the years since the Labor Code was enacted on May 1, 1974 as Presidential Decree No. 442, largely due to our country's commitment as a signatory to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[32]

The ICESCR mandates States-Parties to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[33] General Comment No. 14 further proscribes "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement," on the ground of sex, "which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."[34] Additionally, it declares that the "realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[35]

Coming from the *People Power Revolution* which ousted then President Ferdinand E. Marcos from his 20-year rule, there was a strong public sentiment that respect for human rights be articulated in the Constitution. There was also the clamor that under the article on Social Justice and Human Rights,[36] the labor provisions include those who were working overseas. Thus, the framers of the Constitution drafted the provision,

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30. An Act Defining Violence Against Women and Their Children, Providing for Protective Measures for Victims, Prescribing Penalties Therefore, and for Other Purposes [Violence Against Women and Children Act], Republic Act No. 9262 (2004).

31. PT&T v. National Labor Relations Commission, 272 SCRA 596 (1997).

32. The Court has also mentioned the Universal Declaration of Human Rights (UDHR), ICCPR, and ICESCR as instruments which the Philippines adheres to as member of the international community.

33. ICESCR, *supra* note 25, art. 12.

34. ICESCR, General Comment No. 14, at ¶ 7.2, *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument (last accessed Jul. 30, 2005).

35. *Id.* ¶ 21.

36. *See* PHIL. CONST. art. XIII.

extending State protection of labor to all of the estimated twenty-one million workforce in the country, including half a million who were overseas.[37] This resulted in the change in government policy, directing the POEA[38] to take a more active role in protecting the rights and welfare of migrant workers.[39] The Welfare Fund for Overseas Workers[40] was also renamed the Overseas Workers and Welfare Administration (Welfare Administration) and its mandate extended "to include the protection and promotion of the interest and well being of overseas workers, including their families and dependents."[41] Various groups from the civil society advocated for the inclusion of other concerns under this article so that aside from human rights, said article covered land reform, housing, and health. Under the health provision, the State was mandated to

> adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the sick, elderly, disabled, women, and children.[42]

Having both the international and constitutional framework for law reform and policy formulation, it became imperative that the government

37. JOAQUIN G. BERNAS, S.J., THE INTENT OF THE 1986 CONSTITUTION WRITERS 917-18 (1995).

38. *See* AMPARITA STA. MARIA, ET AL., FILIPINO MIGRANT WORKERS IN SINGAPORE, MALAYSIA AND BRUNEI: WHAT THEY NEED TO KNOW... (... AND WHAT THEY HAVE TO TELL) 4-5 (1999) (The POEA is an agency of the DOLE, charged with regulating the overseas employment. It was established under Presidential Decree No. 797 in 1982. Among its functions are: process employment contracts; accredit, license and regulate employment agencies; approve job orders and adjudicate cases filed for revocation of license.) [hereinafter STA. MARIA, ET AL., FILIPINO MIGRANT WORKERS].

39. Kevin O'Neil, *Labor Export as a Government Policy: The Case of the Philippines*, Migration Information Source, *available at* http://www.migrationinformation.org/Feature/print.cfm?ID=191 (last accessed Jan. 21, 2005).

40. *See* STA. MARIA, ET AL., FILIPINO MIGRANT WORKERS *supra* note 38, at 6 (This agency was initially created under Presidential Decree No. 1694 in 1980 to provide social and welfare services to overseas workers, including insurance coverage, legal assistance, placement assistance and remittance service. In 1987, the overseas contract workers were required to contribute a membership fee of $25 to the Welfare Administration. The contributions are a source of funding for its projects and services.).

41. Jose S. Brillantes, *Overview of Philippine Migration Policies and Operational Framework* (Paper presented to the Second Roundtable Discussion on Philippine Migration, Asian Institute of Management-Policy Center, Nov. 24, 2003).

42. PHIL. CONST. art XIII, § 11.

adopt a plan or program to implement its treaty and constitutional obligations on women, including those who were working overseas.

B. Law on Migrant Workers

Preceding the country's ratification of the Migrant Workers Convention, domestic worker Flor Contemplacion was hanged in Singapore on March 17, 1995. Following public outrage at the perceived inability of the Philippine government to intervene in Contemplacion's behalf, the *Migrant Workers Act* was also passed in the same year.

Under this law, illegal recruitment was made a criminal offense that can be committed either by a registered or non-registered recruitment agency. The law set out the requirements for applying for overseas work. Moreover, it ensured the protection of migrant workers overseas through the adoption of the *country-team approach.* Under this approach, all government officers and personnel posted abroad, regardless from what Department they originated, are obliged to act as one country team under the mission and leadership of the Ambassador, with the end in view of providing services to overseas workers.[43]

C. Other International Commitments

1. Beijing and Other Programs for Women

Subsequent to the ratification of the CEDAW and its commitment to the Beijing Platform for Action (Beijing Platform), the government, through the National Commission on the Role of Filipino Women (NCRFW), adopted the Philippine Plan for Gender-Responsive Development (PPGD), 1995-2025.[44] This document translated the CEDAW and Beijing Platform into policies and programs for Filipino women, which had for its goals women's empowerment and gender equality.[45] Based on the PPGD, the Framework Plan for Women was drawn, which outlined three areas of intervention for women: women's economic empowerment, women's human rights, and gender-responsive governance.[46]

The main strategy adopted to implement the PPGD and the Framework Plan for Women is gender mainstreaming, which seeks the "integration of gender principles and concepts in the design, implementation, monitoring,

43. *Brillantes*, *supra* note 41.

44. This preceded the Philippine Development Plan for Women, 1989-1992.

45. Progress Report, *supra* note 15, at 25.

46. *Id.* at 1.

and evaluation of policies and programs."[47] In order to ensure that the strategy was carried out, the government introduced the Gender and Development Budget Policy in 1995, which required all government agencies to set aside 5% of their budget for programs, projects and activities designed to meet the goals of PPGD.[48]

Alongside these policies and programs was the 2001–2004 Medium Term Philippine Development Plan (Medium Term Plan), which focused on improving the reproductive health of women, men, and adolescents. It also addressed, among others, the goals set in the International Conference on Population and Development (ICPD) held in Cairo in 1994, which resulted in the ICPD Programme of Action. In the country report on the Medium Term Plan made by the Population Commission in 2002, it acknowledged that there was gender stereotyping of women migrant workers, with a ratio of 9 out of 10 in the service category and 3 out of 4 in the professional and technical categories.[49] It also reported that the women were largely in the 20–29 age group and that a little more than the majority (56%) were unmarried; while among the domestic workers, the unmarried were about 80% in 1995.[50] One of the recommendations the report made was to sustain the advocacy of mainstreaming "gender equality and reproductive rights in government agencies, industry, private corporations, and the grassroots."[51]

2. ICPD and Reproductive Health Programs

The Programme of Action of the International Conference on Population and Development devotes Chapter VII to Reproductive Rights and Reproductive Health. It provides:

> Reproductive health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.
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> Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and

47. *Id.* at 26.

48. *Id.*

49. Commission on Population, *Philippines Country Report, September* 2002, at 26 [hereinafter Country Report 2002].

50. *Id.* at 27.

51. *Id.* at 90.

> inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries.[52]

It should be noted that even prior to the Philippines' commitment to the ICPD, the family planning program adopted in 1987 by the Department of Health (DOH) had already accommodated the broader concept of family planning as a health issue rather than just a population issue.[53] After Cairo, the DOH also pursued a reproductive health program within the ICPD Program of Action, with a health care package that included the ten core service elements.[54] In 1999, the DOH further adopted the National Reproductive Health Policy, which set the guiding principles and strategies for program implementation. It identified women empowerment as the key to reproductive health and promoted a *life-span rights-based approach to reproductive services* as a strategy.[55]

In the 2004 report assessing the Philippines' achievements under the ICPD Program of Action from 1994-2004 (Cairo+10), the Population Commission stated the following as far as reproductive health and reproductive rights are concerned:

> The ICPD calls upon all countries to strive to make reproductive health services accessible, through the primary health care system, to all individuals of appropriate age as soon as possible and no later than 2015. In the MDG, the target is 100 percent access to reproductive health services by 2015.
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> Available data indicate, however, that the prospects for achieving the MDG target are low. Ten women die every day from pregnancy and childbirth-

52. UNFPA, *Programme of Action of the International Conference on Population and Development*, at chap. VII, §§ 7.2 & 7.3 (1994), *available at* http://www.unfpa.org/icpd/icpd_poa.htm#ch16 (last accessed Jul. 30, 2005).

53. Josefa Francisco, *Weighing Up Cairo Evidence from Women in the South: Philippines*, at 213 (2000) (compiled by Sonia Corrêa).

54. Country Report 2004, *supra* note 16, at 15. The ten core service elements are as follows: (1) family planning; (2) maternal and child health care; (3) prevention of abortion and management of its complications; (4) prevention and treatment of reproductive tract infections including STDs and HIV/AIDS; (5) prevention and appropriate treatment of infertility and sexual disorders; (6) prevention and treatment of breast cancer, cancer of the reproductive system, and other adverse gynecological conditions; (7) counseling and education on sexuality and sexual health; (8) adolescent reproductive health; (9) male reproductive health; and (10) prevention and management of violence against women.

55. *Francisco*, *supra* note 53, at 215.

> related causes and most maternal complications and deaths are due to limited access to reproductive health services.
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> Based on DOH records, 12 percent of all maternal deaths in 1994 were due to complications related to abortion, making it the fourth leading cause of maternal deaths in the country. The most vulnerable women, whether married or unmarried, are the poor. The top three reasons for terminating pregnancies are economic difficulty, too many pregnancies, and large number of children.
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> As for family planning services, data generally show patterns of increasing contraceptive use (46.5 percent in 1998 to 48.9 percent in 2003) and declining fertility (3.7 percent in 1998 and 3.5 percent in 2003).[56]

The Population Commission characterizes the failure to practice family planning, even though there is a desire to space and limit children, as an *unmet need*. Accordingly, "[u]nmet need reflects a woman's reproductive intentions. Women who prefer to space or limit births but are not practicing family planning are considered to have an 'unmet need'."[57] The major reason given for this is the high cost of family planning services including practicing contraception. Among the other reasons are: (1) fertility preferences; (2) perceived risk of conceiving; (3) perceived effects on health of contraception on husbands and wives; (4) husbands' fertility preferences; and (5) acceptance of family planning.[58] Similar findings can be read in the CEDAW report where it states that "promoting contraceptive practice among women remains a challenge" and that men objected to practicing family planning, with only few using condoms or taking responsibility for contraception and that they preferred more children, "unlike the vast majority of married women (81%) who wanted either to space their next birth or limit childbearing altogether."[59]

These facts are indicative of the pervasiveness of gender subordination in terms of sexual autonomy, which needs to be addressed if the government is truly committed to gender empowerment and equality. Unfortunately, programs pertaining to reproductive health have not achieved their full implementation not only because of lack of resources but also of lack of political will on the part of both the national and local governments. Despite the well-thought out long-term plans and programs by the implementing

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56. Country Report 2004, *supra* note 16, at 31-32. (*citations omitted*)

57. *Id.* at 15.

58. *Id.* at 16.

59. Progress Report, *supra* note 15, ¶ 446. (*citations omitted*)

departments and agencies, such programs are hampered by the lack of legal and institutional support. Since there is no law providing for a comprehensive reproductive health program, the implementation and strategies in pursuing the long-term goals for reproductive health are subordinated to the priorities of the existing political regime. Thus, in the ICPD+10 Report, the Population Commission – citing the research it conducted with the Philippine Institute for Development Studies in 2001 – said:

> A government policy is deemed good if the government actually mobilizes the resources needed to implement the policy effectively. In terms of population, one indicator is that the government actually appropriates money to purchase contraceptives for distribution to outlets. Data from 1994 and 1998 family planning expenditures by sources show that Congress did not appropriate a single centavo to purchase contraceptives during those years. The contraceptive supplies have all been financed from donor contributions, mainly from USAID and to some extent from UNFPA. A Contraceptive Interdependence Initiative (CII) by POPCOM and DOH during the Estrada administration was launched to increase reliance on government funding to compensate for the decline in donor funds.[60]

Furthermore, the report also states that the "[p]rospects for improving contraceptive prevalence might be uncertain…given the continued lukewarm support of government for the family planning program and the recent withdrawal of support for contraceptive procurement by traditionally active donor agencies…"[61] It also mentions that "changes in the strategies of the present national administration hinder the continuity of the program,"[62] which the CEDAW report identifies as the prioritization by the Health Department and the President of natural family planning.[63] The situation is mirrored at the local government level, where despite the strategies adopted by the program of actions to implement the ICPD commitments, a number of local governments, foremost in Manila, the country's capital, "are already banning the dissemination of information about the sale of emergency contraception as well as artificial contraception."[64]

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60. Country Report 2004, *supra* note 16, at 20.

61. *Id.* at 16.

62. *Id.* at 15.

63. Progress Report, *supra* note 15, ¶ 33.

64. *Id.* ¶ 481.

D. Other National Laws Bearing Importance to Women

Following the ratification of the CEDAW, the Family Code of the Philippines (Family Code)[65] was enacted in 1988 to amend the family law chapters of the former Civil Code.[66] The new law repealed a number of discriminatory provisions against women and replaced them with new provisions that reinforced their empowerment. Foremost was the provision that gave both husband and wife "joint administration and enjoyment of the community property,"[67] in contrast to the sole administratorship of the husband in the former law. However, in case of disagreement, the husband's decision prevails, with the law allowing the wife to contest such decision within a period of five years. In case there is no existing marriage although both parties are eligible to marry or if the marriage is void, the law fixes their property relation as that of co-ownership where everything acquired by the parties with their joint efforts are divided in equal shares. This provision further provides that the party "shall be deemed to have contributed jointly in the acquisition thereof if the former's efforts consisted in the care and maintenance of the family and of the household."[68] Also, under the Family Code, "either spouse may exercise any legitimate profession, occupation, business or activity without the consent of the other,"[69] unlike in the old law where the husband can object if his "income is sufficient for the family, according to its social standing."[70] Emancipation by marriage was also removed, setting the age of majority at 18 for both male and female.[71]

All these provisions were aimed at placing the women in equal position with men within marriage, and in terms of their property relations as husband and wife. For women migrant workers, these changes meant that they can freely decide to work abroad and can equally decide with their husbands what to do with the income derived from overseas work, which formed part of their joint property.

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65. The Family Code of the Philippines [FAMILY CODE], Executive Order No. 209 (1987). The Family Code took effect on Aug. 03, 1988.

66. An Act to Ordain and Institute the Civil Code of the Philippines [NEW CIVIL CODE], Republic Act No. 386 (1950).

67. FAMILY CODE, arts. 96 & 124.

68. *Id.* art. 147.

69. *Id.* art. 73.

70. NEW CIVIL CODE, art. 117.

71. An Act Lowering the Age of Majority from Twenty-one to Eighteen Years Amending for the Purpose Executive Order No. 209, and for Other Purposes, Republic Act No. 6809, § 1 (1989).

In 1997, the law on rape was amended, as far as criminal laws are concerned, reclassifying the offense from a crime against chastity to a crime against persons.[72] It also provided for marital rape, which held the husband criminally liable unless his wife forgave him.[73] Significant changes in jurisprudence followed the amendment of the rape law. Before its passage, the credibility of the offended party – the woman or girl-child – had been associated with her character and reputation. Court decisions have assumed that there was an inevitable link between the woman's good or bad reputation and her credibility, although the woman's reputation whose credibility is put into scrutiny would refer not to her penchant for telling untruths but to her lifestyle – on whether she has led a licentious or chaste life. Often there was also the stereotyping the kind of woman who would likely tell the truth; and more alarmingly, who would likely be unable to cope with the trauma caused by rape so that these types of women were expected to react differently than those who were more empowered such that the former were given wide latitude for unexpected reactions like the delay in filing rape charges.

To illustrate this point, in *People v. Blazo*,[74] a 10-year old girl took two years before she was able to tell her mother that she was raped. It was only then that the present criminal case was filed. The Supreme Court reiterated earlier cases stating that "[a] young girl, such as the victim in this case, cannot be expected to have the courage and intelligence of a mature woman to immediately report her defilement, especially when accompanied by a death threat."[75] Similarly, in *People v. Lor*,[76] a 13-year old girl was raped by her uncle. Upon conviction, the accused raised the defense that the victim did not offer any resistance or vocal protestations. The victim also did not report the alleged rape immediately. In affirming the conviction, the Court held that the victim, who was "a thirteen-year old sexually inexperienced provincial lass…cannot be expected to act like an adult or a mature experienced woman who would have the courage and intelligence to

72. An Act Expanding the Definition of the Crime of Rape, Reclassifying the Same as a Crime Against Persons, Amending for the Purpose Act No. 3815, as Amended, Otherwise Known as the Revised Penal Code, and for Other Purposes, Republic Act No. 8353, § 2 (1997).

73. *Id.*

74. People v. Blazo, 352 SCRA 94 (2001).

75. *Id.* (citing People v. Manggasin, 308 SCRA 228, 244 (1999); People v. Soan, 243 SCRA 627 (1995)).

76. People v. Lor, 361 SCRA 402 (2001).

disregard the threat to her life and complain immediately that she had been sexually assaulted."[77]

Fortunately, in more recent decisions of the Supreme Court, it has begun to exhibit sensitivity to women's situation and has brought in the importance of social context in its rulings. Thus, in *People v. Padrigone*,[78] the victim, who was 16 years old, was raped in the presence of her 14-year old sister. The accused questioned the credibility of the latter as witness, claiming that her behavior was "unnatural, unexpected and mind-boggling," for having slept after the incident and even worked the next day. The Court ruled that "there is no standard form of behavioral response when one is confronted with a strange or startling experience…different people react differently to a given situation or type of situation."[79] Similar rulings were given in *People v. Manahan*,[80] where the 12-year old rape victim took five months before reporting the incident. The Court acknowledged the difficulty in predicting a person's reaction to traumatic experiences and that what is common for rape victims is "to hesitate, for varying periods of time, before reporting the incident."[81] Likewise, in *People v. Buates*,[82] where the Court held that "[f]ear of reprisal, social humiliation, familial considerations and economic reasons have been held as sufficient explanations"[83] in the delay in filing cases. In this case, the Court took notice that the delay was because the victim's life was threatened by the accused, her uncle, and that there were rumors about her sullied reputation which was fanned by the accused himself.

In fact, the issue of date rape had already been brought before the tribunal, and consistently, the Court has ruled that "[a] sweetheart cannot be forced to engage in sexual intercourse against her will. Moreover, proof even of a prior history of a common-law marital relationship will not prevail over clear and positive evidence of copulation by the use of force or intimidation."[84]

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77. *Id.* at 411.

78. People v. Padrigone, 382 SCRA 74 (2002).

79. *Id.* at 80-83.

80. People v. Manahan, 408 SCRA 255 (2003).

81. *Id.* at 263.

82. People v. Buates, 408 SCRA 278 (2003).

83. *Id.* at 287 (citing People v. Lusa, 288 SCRA 296, 305 (1998)).

84. People v. Corea, 269 SCRA 76 (1997) (citing People v. Cabilao, 210 SCRA 326 (1992); People v. Ayuda, 412 SCRA 538 (2003); People v. Sorongon, 397 SCRA 264 (2003); People v. Padrigone, 382 SCRA 74 (2002)).

In 2003, another important law for women was passed. The Anti-Trafficking in Persons Act provided that a woman in prostitution is a victim of trafficking who cannot be penalized as such, even if the acts of trafficking were done with her consent.[85] In its implementing rules and regulations, the law also mandated the DOH to make available its resources and facilities in providing health care for victims of trafficking "which shall, at all times, be held confidential."[86]

The amendments in the rape law and the new law on trafficking lent support to the empowerment of women and bolstered the continuing recognition of a woman's right to self-determination; to decide on matters concerning her body;[87]of her right to invoke that a violation of her bodily integrity is a violation of her person, not merely her chastity; and of her right to confidentiality especially when seeking health services regarding such violation. Rape and trafficking are heavily stigmatizing in Philippine society, with the woman bearing the brunt of shame and humiliation of these acts. Thus, the provision on confidentiality was intended to ensure that they would actually avail of the necessary health services provided by law, by imposing the duty on the providers of such services to observe the confidentiality required in handling these matters. This rule is supplemented by the provision of the law where the investigation and trial may be conducted in a closed-door proceeding to protect the privacy of the victim and accused. In this case, any form of publicity is also prohibited.[88] A violation of this provision on confidentiality is punishable by imprisonment of six years and a fine of not less than 500,000 Pesos but not more than 1,000,000 Pesos.[89]

Privacy and confidentiality are essential to encourage women to prosecute against their traffickers. Indeed, in the Medium Term Plan report, the Population Commission cited the 1993 Safe Motherhood Survey, where it found that one woman out of 10 experiences physical abuse even while pregnant and that about three percent said they were physically forced to have sex with a man. More than 60 percent of these women did not seek help.[90]

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85. ANTI-TRAFFICKING IN PERSONS ACT, § 17.

86. Rules and Regulations Implementing the Anti-Trafficking in Persons Act of 2003, § 18(d).

87. REBECCA J. COOK, ET AL., REPRODUCTIVE HEALTH AND HUMAN RIGHTS 156 (2003).

88. ANTI-TRAFFICKING IN PERSONS ACT, § 7.

89. *Id.* § 10(d).

90. Country Report 2002, *supra* note 49, at 39.

On March 27, 2004, the Violence Against Women and their Children Law[91] took effect, enumerating the different acts of violence against women that are criminalized. Broadly, the acts of violence are categorized under physical, sexual, psychological, and economic abuse.[92] Under this law, the term woman includes the wife, former wife, someone with whom the person accused has or had a sexual or dating relationship, or with whom he has a common child.[93] The law also provides for the issuance of a protection order where, among others, the accused can be removed from the residence where the woman stays regardless of who owns such residence.[94] Although this is a new law, efforts at raising awareness on the issue of violence against women and sexual harassment were already being done at the community level and the institutional level, including the judiciary. For the judiciary, updating on new laws on women is part of its Strategic Gender and Development Plan for the Philippine Judicial System which was approved in 2003.[95]

The 2004 Philippine Country Report mentions that one of the results of the efforts at gender mainstreaming is that government agencies were forced to examine the gender dimension and impact of their own programs, projects, and activities.[96] This is also reflected in the Migrant Workers Act, which states:

> The State affirms the fundamental equality before the law of women and men and the significant role of women in nation-building. Recognizing the contribution of overseas migrant women workers and their vulnerabilities, the State shall apply gender-sensitive criteria in the formulation and implementation of policies and programs affecting migrant workers and the composition of bodies tasked for the welfare of migrant workers.[97]

Prior to the passage of this law and the adoption of the PPGD, the CEDAW Committee, which at that time had made its concluding observations on the second periodic report of the Philippines, inquired about additional information on female overseas workers. In response, the Philippine representative admitted that the statistical data on overseas workers were not gender sensitive but were in the process of being amended. Furthermore, measures such as pre-departure orientation programs

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91. VIOLENCE AGAINST WOMEN AND CHILDREN ACT, § 3.

92. *Id.*

93. *Id.*

94. *Id.* § 8.

95. *See* Supreme Court Memorandum Order No. 32-2004.

96. Progress Report, *supra* note 15, ¶ 447.

97. MIGRANT WORKERS ACT, § 2(d).

were partially successful in protecting migrant workers, though it was difficult to assess the situation of those in the domestic service.[98] In the third and fourth periodic reports, the country representative informed the Committee that most women migrant workers were entertainers and domestic workers and acknowledged that the women were vulnerable to violent abuse. The representative further recognized that more effort was needed to establish an effective system to address the needs and problems of migrant workers. [99] The Committee strongly recommended for the Government to "strengthen agencies that provide information and support services to women before they depart for overseas work, as well as in the receiving countries in cases of need."[100]

The importance of the comments, recommendations and observations of the monitoring bodies of the human rights conventions cannot be underestimated. They articulate both a States-Party's accomplishments and failures in realizing human rights; most importantly, they set the standards against which States-Parties' compliance is measured.[101]

With the passage of the Migrant Workers Act and the formulation of the PPGD, Framework Plan for Women and Gender and Development Policies, there was reasonable expectation that POEA and the Welfare Administration will carry out, or at the very least, reflect in their programs, gender-sensitive measures that would respond to the twin goals of women's empowerment and gender equality embodied in the PPGD. This change seemed timely since as stated earlier, the women who leave for overseas work were continuously increasing, outnumbering the men by 3 to 1.[102]

Alongside the legislative and policy developments on women and migrant workers, concern was raised on the problem of trafficking in women. In 1993, Belgian journalist Chris de Stoop, who went undercover for a year to document trafficked women, came out with the English version of his book, They are so Sweet, Sir: the Cruel World of Traffickers in Filipinas and Other Women. The book described how Filipino and Thai women were trafficked to Belgium and other parts of Europe. Accordingly, a parliamentary inquiry in Belgium was made soon after the book came out, which eventually paved the way for the Belgian Administration for Development Cooperation in the Philippines to fund a research project on

98. CEDAW A/46/38 (1991), at ¶ 212, *available at* http://www.bayefsky.com/./html/philippines_t4_cedaw.php.

99. *Id.* at ¶ 278.

100. *Id.* at ¶ 298.

101. COOK, *supra* note 87, at 215.

102. Overseas Statistics, *supra* note 4.

trafficking in women,[103] the results of which were presented before the NCRFW and POEA. Another research commissioned by the International Organization for Migration showed that majority of Filipino women who worked as entertainers in Japan were forced into prostitution.[104] At this time, there was already a Performance Assessment being carried out by the POEA for entertainers. However, as a reaction to reports on trafficking, stricter regulations were imposed on OPAs by the POEA, mainly concentrating on their documentation, skill, and eligibility requirements.[105]

In 2001, the accreditation of OPAs was transferred from POEA to the Technical Education and Skills Development Authority, ostensibly to strengthen accountability of all those involved in the overseas entertainment sector.[106] This, however, did not stem the wave of hopeful women applicants, especially since POEA, in the same year, lowered the age requirement for OPAs from 21 to 18,[107] luring even younger women to apply overseas. Eventually, the accreditation program was transferred back to POEA and at present, it is expected to be handled by the Welfare Administration, as an integral part of the pre-departure seminar.[108]

E. The Law on HIV/AIDS

In 1998, Republic Act No. 8504 was enacted into law, otherwise known as the Philippine AIDS Prevention and Control Act of 1998 (AIDS Law). Among others, it provided for HIV/AIDS education for OFWs with regard to its cause, prevention, and consequences, before they are allowed to leave.[109] Thus, this has also become a component of the pre-departure seminar. It also declares as a policy the eradication of conditions that aggravate the spread of HIV infection, including poverty and gender

103. *See* MA. CHRISTINA BAUTISTA, ET AL., THE PHILIPPINE-BELGIAN PILOT PROJECT AGAINST TRAFFICKING IN WOMEN (1999).

104. *See* EMMA PORIO, TRAFFICKING IN WOMEN TO JAPAN FOR SEXUAL EXPLOITATION: A SURVEY ON THE CASE OF FILIPINO WOMEN 2 (1997) [hereinafter PORIO, TRAFFICKING IN WOMEN TO JAPAN].

105. Bautista, *supra* note 103, at 52-53.

106. Expansion of Learnable Trades, DOLE Department Order No. 1 (2001).

107. POEA Resolution No. 3, Series of 2001.

108. DOLE D.O. No. 48-03, *supra* note 10.

109. An Act Promulgating Policies and Prescribing Measures for the Prevention and Control of HIV/AIDS in the Philippines, Instituting a Nationwide HIV/AIDS Information and Educational Program, Establishing a Comprehensive HIV/AIDS Monitoring System, Strengthening the Philippine National Aids Council, and for Other Purposes [AIDS Law], Republic Act No. 8504, § 7 (1998).

inequality. This is consistent with HIV/AIDS and Human Rights International Guideline which states that an enabling and supportive environment should be promoted by States "for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups."[110]

This important policy statement should be seriously implemented, taking into consideration not only poverty and gender inequality as isolated conditions, but as two interrelated factors. The most susceptible to HIV/AIDS are the poor, 70% of which are women.[111] They are more vulnerable to the disease because they have lower income and less secured jobs, less access to health care, less entitlement to property, and little power to negotiate sex.[112]

Within the context of women migrant workers, it is poverty – due to lack of employment opportunities (which can also be aggravated by lack of education) – that pushes them to apply for overseas work. At the same time, because of their unequal status with men in the family and society, they have been socialized to work in the house, tend to the children, and cater to the needs of the male head of the family. This powerlessness brought about by poverty and gender subordination render them more vulnerable to HIV/AIDS because they end in jobs overseas which are the least monitored in terms of working conditions, and are the most predisposed to sexual abuse. In this situation and without the need-based and rights-based approaches in providing information on HIV/AIDS, it is unlikely that they can assert themselves and insist on no sex or safe sex, when confronted by a situation which calls for such assertion. The powerlessness of these women also impacts on their access to health services. They may not want to avail of medical services because of fear of losing their jobs, fear of being stigmatized and discriminated; or simply, because they do not have adequate information on how to access health and medical services. Thus, implementation of the policy should carefully examine the interrelation of these factors. As pointed out by the Special Rapporteur on Health of the Commission on Human

110. OHCHR and UNAIDS, HIV/AIDS and Human Rights International Guidelines (2003), *available at* http://www.unaids.org/html/pub/Pulications/IRC-pub02/JC905-Guideline6_en_pdf.pdf (last accessed Jul. 30, 2005).

111. Solveig Freudenthal, *A Review of Social Sciences Research on HIV/AIDS*, *at* http://www.somanet.org/youthproject_files/SAREC%20%20AIDS%20report.htm (last accessed Jul. 30, 2005).

112. *Id.*

Rights, Paul Hunt, "poverty is associated with inequitable access to both health services and the underlying determinants of health."[113]

The law further prohibits discrimination in the workplace, schools, health institutions, etc.,[114] prohibits compulsory HIV testing as a general rule,[115] and guarantees the right to privacy[116] and confidentiality.[117] It also imposes the "civic duty of health providers in the private sector to make available to the public such information necessary to control the spread of HIV/AIDS and to correct common misconceptions about this disease."[118]

The reality, however, for migrant workers is that they have no choice with regard to the mandatory AIDS testing that receiving countries require. Theoretically, mandatory testing affords the person a choice because he or she may not go through the test, which is made a necessary condition for a certain undertaking. Thus, unless the person decides that he or she wants to undertake the same, he or she may not go through with the testing. Compulsory testing, on the other hand, is done either without the consent of the person being subjected to the test or against his or her will.[119] However, given the situation of women migrant workers, there are only two choices for them: to work or not to work. Thus, they are left with no recourse but to undergo the mandatory AIDS testing.

Both the Center for Disease Control and Prevention Guidelines and the HIV/AIDS and Human Rights International Guidelines do not promote mandatory or compulsory testing. What the former promotes is voluntary counseling, testing, and referral;[120] while the latter mandates States to strengthen anti-discrimination laws that protect vulnerable groups, in both private and public sectors and to ensure the development of codes of conduct as regards HIV/AIDS issues by the government and private

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113. Paul Hunt, *United Nations – Economic, Social and Cultural Rights: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mr. Paul Hunt*, E/CN.4/2004/49 at ¶ 14 (2004).

114. AIDS Law, § 2(b)(3).

115. *Id.* § 2(b)(1).

116. *Id.* § 2(b)(2).

117. *Id.* § 42.

118. *Id.* § 5.

119. COOK, *supra* note 87, at 168.

120. *See* MMWR Recommendations and Reports (November 2001), Revised Guidelines for HIV Counseling, Testing, and Referral (2001), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm (last accessed Jul. 30, 2005).

sectors.[121] On the other hand, the guidelines issued by the International Labor Organization (ILO) called the Code of Practice on HIV/AIDS proscribes HIV testing as part of any routine medical testing prior to employment or for workers on a regular basis.[122]

These guidelines should equally apply to migrant workers. In a recent conference on migrant labor practices in Asia, an ILO specialist expressed alarm on the practice of some 60 countries in requiring migrant workers to undergo mandatory testing as a condition for hiring and re-hiring them; and classifying migrant workers as a "high-risk group."[123]

Mandatory AIDS testing stigmatizes migrant workers because it creates the false impression that they are carriers of HIV/AIDS, since there is data that can show that a certain percentage of their group is infected. They are also denied work once a positive test results. This discriminatory policy also has the effect of further hindering women migrant workers from availing health and medical services on-site, although such services are part of their contracts.

As a policy, mandatory testing is not an effective means of preventing the spread of HIV/AIDS; nor can it be a protection strategy for people who are not infected. There is no guarantee that those who tested negative are or will remain uninfected because the test does not detect HIV in people who acquired it recently. Testing negative can also give a false sense of security and people may not change their risky behavior.[124] Most importantly, however, is the discriminatory impact of mandatory testing on migrant workers, especially women. As noted by the ILO,

> Mandatory HIV testing is particularly problematic when it comes to female migrant workers. Overall female migrant workers are more discriminated against than male migrant workers, especially in third world countries. Many women are forced to keep their health "behind a curtain." In general female workers tend to be denied treatment more than male migrant workers, especially in Asia. There are an estimated seven million migrant workers women in Asia. There has been a noted increase of HIV infection in the ranks of migrants [sic] is spread increasingly due to drug use and

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121. OHCHR AND UNAIDS, HIV/AIDS AND HUMAN RIGHTS INTERNATIONAL GUIDELINES, *supra* note 110.

122. THE ILO CODE OF PRACTICE ON HIV/AIDS, § 8.1 (2001).

123. Marwaan Macan-Markar, *HIV Testing of Migrant Workers Fuels Pandemic (2 July 2003), available at* http://archives.healthdev.net/sea-aids/msg00782.html (last accessed Jul. 30, 2005).

124. AIDS Action, *HIV Testing: A Practical Approach (1999-2003), available at* http://www.aidsaction.info/ht/section1.html#1.5%20What%20problems%20are%20associated%20with%20mandatory%20testing? (last accessed Jul. 30, 2005).

> unprotected sex. Therefore, mandatory HIV testing not only forces many of these women to leave, but denies them the necessary treatment.
>
> In many cases, because of mandatory HIV testing, female migrant workers are forced to work in the prostitution and entertainment industries, especially in Asian nations. Female migrants who are HIV infected will simply pass over many jobs and instead enter into the sex industry of a nation.... It is often documented that the majority of women who work in the sex industries of other nations do so because they were denied other jobs, often due to mandatory HIV testing....
>
> It is also to be noted that mandatory HIV testing is often unnecessary, because being HIV positive does not physically inhibit an individual from working. Nations are denying individuals economic opportunities for unsound reasons, and thereby exacerbating the spread of HIV that mandatory testing sought to slow.[125]

F. International Commitment on HIV/AIDS

The country's commitment to the prevention of HIV/AIDS, as well as to gender equality and empowerment of women, is also embodied in the Millennium Development Goals, which is the result of a decade of conferences and world summits culminating in the Millennium Summit Declaration in 2000.[126] The Philippines also committed to the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS in 2001 which includes an undertaking to "develop and begin to implement national, regional, and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services" by 2005.[127]

Thus, in examining the pre-departure measures instituted by the government for the protection of migrant workers, the pre-departure seminar appears as its single most important component; and it becomes especially crucial for women in the domestic and entertainment sectors

125. International Labor Organization, *Migrant Workers and Disease*, *available at* http://www.munuc.org/old/2003pdf/ILO_UpdateA.pdf (last accessed Jul. 30, 2005).

126. United Nations Development Programme, *Millennium Development Goals Frequently Asked Questions, available at* http://www.undp.org/mdg/faqs.html (last accessed Jul. 30, 2005).

127. United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS in 2001, § 50, *available at* http://www.unaids.org/html/pub/publications/irc-pub03/aidsdeclaration_en_pdf.pdf (last accessed Aug. 29, 2005).

because it is they who are most vulnerable to abuses and human rights violations.

III. GENDER SOCIALIZATION, SEXUALITY AND SEXUAL ABUSE

Despite developments in law and jurisprudence toward the empowerment of women through efforts in eliminating *de jure* discrimination, *de facto* discrimination persists, as seen in the failure by the executive branch and its agencies to fully implement gender-sensitive policies and programs, and the continued gender stereotyping of their roles in the job market and within their homes which are carried through in their overseas work.

Even the laws have not been fully divested of the remnants of gender inequality as seen in the provisions of the *Family Code* on property decisions by the husband and wife. Although they both have to decide, the law favors that of the husband, with the burden of contesting the same before the courts being passed on to the wife. This provision does not help in eradicating gender inequality especially with regard to the woman's exercise of property rights. Criminal law is no better. For instance, women in prostitution are penalized as vagrants, but their clients are not.[128] This provision has, in the past, been used to harass the women on the streets or sometimes to round them off in raids conducted in prostitution houses and forcibly hoard them like cattle in the police vehicle, not even allowing the women to clothe themselves. In the Labor Code, the general prohibition of nightwork against women is still in force.[129] Courts at the trial level have also yet to fully conduct their proceedings and promulgate decisions in a gender-sensitive manner, especially cases involving gender-based violence. Even at the barangay level, the officers sitting as mediators of the barangay justice system recommend that they be given further training on Gender/Women's Rights, among others.[130]

Women should be able to feel confident that they are taken seriously when they initiate complaints against their spouses; and they must not fear reprisals from them, owing to a reliable law enforcement and court

128. An Act Revising the Penal Code and Other Penal Laws [REVISED PENAL CODE], Act No. 3815, art. 202 (1930).

129. A Decree Instituting a Labor Code Thereby Revising and Consolidating Labor and Social Laws to Afford Protection To Labor, Promote Employment And Human Resources Development And Insure Industrial Peace Based on Social Justice [LABOR CODE OF THE PHILIPPINES], art. 130 (1972).

130. eZ Publish Admin, *A Study on the Efficacy and Efficiency of the Barangay Justice System (Katarungang Pambarangay) Action Program for Judicial Rejorm (11 March 2004), available at* http://www.apjr-sc-phil.org/filemanager/download/176 (last accessed Jul. 30, 2005).

system.[131] This is important because eventually, the women's willingness to assert their rights depends on their past experiences in trying to do so. It is then not enough that they are informed about their rights; they must believe that there will be institutional support for the exercise of these rights as well.[132]

Gender sensitivity cannot simply be imposed, neither can it be taught within a short period of time. In the context of government institutions and agencies, it is a process that must continuously be reinforced by pursuing an agenda that mainstreams gender. The NCRFW defines *gender mainstreaming* as "a set of processes and strategies aimed at recognizing and addressing gender issues in legislation, policies, programs, and projects and institutional mechanisms of the government on a sustained basis."[133]

Hence, efforts by the POEA, must take into account the women migrant workers' gender socialization, views on sexuality and sexual abuse. Gender socialization provides an understanding of how these women view themselves in relation to their position within the context of the family and society. It also shapes their sexuality and the way they would rationalize sexual abuse. Sexuality, as defined by Gupta, is

> the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior and is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality.[134]

Gupta further elaborates that in many societies, good women are those who ought to be ignorant about sex and passive in bed. Virginity is also a traditional norm in many of these societies. Accordingly, these factors make the women more vulnerable to HIV/AIDS because it restricts their ability to

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131. *See* Sally Engle Merry, *Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence*, 25 Hum. Rts. Q. 343, 381 (2003).

132. *Id.*

133. *See* NCRFW, *Gender Mainstreaming* (2004), *at* http://www.ncrfw.gov.ph/insidepages/gendermainstream/gendermainstream.htm (last accessed Jul. 30, 2005).

134. *See* Geeta Rao Gupta, Approaches for Empowering Women in the HIV/AIDS Pandemic: A Gender Perspective (Paper presented to the Expert Group Meeting on HIV/AIDS Pandemic and its Gender Implications, 13-17 November 2000), *available at* http://www.un.org/womenwatch/daw/csw/hivaids/Gupta.html (last accessed Jul. 30, 2005) [hereinafter *Gupta*]. (*citations omitted*)

ask and access information on risk reduction. It also makes it difficult for them to negotiate for safer sex.[135]

The above assessment rings true for Filipino women, and as far as migrant workers are concerned, the following findings provide a fair assessment of their socialization, sexuality and reaction to sexual abuse:

> Gender roles and socialization in Philippine society are highly-based on values informed by patriarchy.... Before marriage, men are expected to gain sexual experience or sow their wild oats since they are supposed to be the main initiators in the marital bed. Meanwhile, Philippine society has two categories of women: the *good* and the *bad*. The *good* woman is chaste (a virgin or *birhen*), well-mannered, thoughtful, kind, helpful, and obedient to her parents. The *bad* woman, on the other hand, is one who has lost her virginity and does not do her nurturing and domestic responsibilities....
>
> Given this socialization and molding of her personality, she is not likely to call attention to or publicly reveal experiences that are deemed to have made her less of an ideal Filipina. This partly explains why Filipino women do not complain to authorities when they find themselves in trouble while working overseas. More importantly, she does not want to bring shame to herself and to her family who has sacrificed and invested so much for her migration, and who expect a return on their investment a thousand fold.[136]

In a study analyzing Supreme Court decisions on child sexual abuse, it has also been observed that in court proceedings, the victim suffers the ordeal of having to prove her good character and sexual purity she had prior to the incident; while "[d]elving into the worthiness of the perpetrator's character hardly occupied the talents of the courts." The study concludes that court proceedings cause great embarrassment and social censure to both the victim and her family because being raped "places a stigma on the victim despite the fact that she was unwillingly violated" and that in effect, an accused who had been acquitted suffers less social repercussions.[137]

These findings, in fact, are acknowledged no less by the Supreme Court. Thus, in the case of *People v. Melivo*,[138] the Court held:

> With all the attendant social consequences such a classification brings, many rape cases go naturally unreported, and those which manage to reach the

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135. *Id.*

136. EMMA PORIO, THE SOCIO-CULTURAL PERSPECTIVE IN THE PHILIPPINE-BELGIAN PILOT PROJECT AGAINST TRAFFICKING IN WOMEN 95-96 (1999).

137. EMMA PORIO, CHILD ABUSE AND THE COURTS: A SOCIOLOGICAL PERSPECTIVE IN HUMAN RIGHTS TREATISE ON CHILDREN: AN INTERDISCIPLINARY ANALYSIS OF PHILIPPINE JURISPRUDENCE ON CHILD SEXUAL ABUSE 25-26 (1999).

138. People v. Melivo, 253 SCRA 347 (1996).

> authorities are routinely treated in a manner so demeaning to the victim's dignity and the psychological ordeal and injury is repeated again and again in the hands of inexperienced, untrained and oftentimes callous investigators and courtroom participants....[139]

Hence, any program designed to address the reduction of risk in contracting HIV/AIDS, and thus, reducing their vulnerability should carefully look into the social environment of these women, how they assess their worth as social beings and what have been their experiences with dealing with government whether in terms of accessing services or judicial redress. The information derived from these considerations could provide a rich context in planning strategies and approaches for empowering women and addressing their need to deconstruct the underlying conditions of their gender subordination. As Gruskin correctly puts it, priority must be given to what a woman perceives as her needs for her health and well-being.[140] An acute discernment of needs must accommodate those which are desired by women, but due to existing constraints that they perceive to be impregnable, are not articulated as such. Thus, what the Population Commission categorizes as *unmet needs* would come within the purview of unarticulated needs. However, before ascertaining what these needs are, it is important to recognize that women should first be capacitated to understand and make informed decisions about their lives, particularly in the exercise of their reproductive health[141] and sexual autonomy.

IV. LEGAL ANALYSIS OF LAWS AND POLICIES ON HIV/AIDS EDUCATION FOR WOMEN MIGRANT WORKERS

A. The Legal Mandate

As pointed out earlier, the basis for requiring HIV/AIDS education to migrant workers is found in the AIDS Law. The state takes it upon itself to "positively address and seek to eradicate conditions that aggravate the spread of HIV infection, including but not limited to, poverty, gender inequality, prostitution, marginalization, drug abuse and ignorance." [142] In its Implementing Rules and Regulations (IRR), the policy considerations of the law are further articulated, one of which is:

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139. *Id.* at 359.

140. Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights,* 44 Am. U.L. Rev. 1191 (1995).

141. *Id.*

142. AIDS LAW, § 2(d).

> Section 3. Declaration of Policies
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> x x x
>
> f. Consistent with the above mentioned policies and in consonance with the Philippine National HIV/AIDS Strategy, the State, further, recognizes that:
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> x x x
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> 2. People should be empowered to prevent further HIV transmission. Empowerment for all Filipinos will come through access to appropriate information and resources for prevention...[143]

Further, the "standard basic information on HIV/AIDS shall be the minimum content of an HIV/AIDS education and information offering."[144] As defined by the IRR, standard basic information includes a discussion on "the particular vulnerability of women."[145] Furthermore, if there are additional topics to be discussed, one of the criteria to be followed is gender sensitivity, which means content that portrays "a positive image or message of the male and female sex; it is neither anti-women nor anti-homosexual."[146]

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143. Implementing Rules and Regulations of AIDS Prevention and Control Act [IRR of AIDS LAW], § 3(f)(2).

144. *Id.* § 7.

145. Philippine National Aids Council, Resolution No. 1, § 4 (39) (1999).

146. *Id.* § 7(e). The criteria under the implementing rules are as follows:

> (a) Accurate - Biomedical and technical information is consistent with empirical evidence of the World Health Organization, the DOH, or other recognized scientific bodies. Published research may be cited to establish the accuracy of the information presented; (b) Clear - The target audience readily understands the content and message; (c) Concise - The content is short and simple; (d) Appropriate- Content is suitable or acceptable to the target audience; (e) Gender-sensitive - Content portrays a positive image or message of the male and female sex; it is neither anti-women nor anti-homosexual; (f) Culture-sensitive - Content recognizes differences in folk beliefs and practices, respects these differences and integrates, as much as possible, folkways and traditions that are conducive to health; (g)Affirmative - Alarmist, fear-arousing and coercive messages are avoided as these do not contribute to an atmosphere conducive to a thorough discussion of HIV/AIDS; (h) Non-moralistic and non condemnatory - Education and information materials or activities do not impose a particular moral code on the target audience and do not condemn the attitudes or behaviors of any individual or population group and (i) Non-pornographic - Content or activity informs and educates and do not titillate or arouse sexual desire.

It is clear from the above law and IRR that empowerment is not only an end-goal but also a strategy in order to prevent vulnerability to HIV/AIDS. This is achieved through information; and for women, there is special focus on their vulnerability because there is a tacit recognition by the law that there are underlying conditions of gender inequality, which aggravate the spread of the disease for women. As stated earlier, this Article identifies one of them as gender subordination.

The Migrant Workers Act also recognizes the vulnerability of women migrant workers and has its own mandate to apply gender-sensitive criteria to its programs. It defines gender-sensitivity as "cognizance of the inequalities and inequities prevalent in society between women and men and a commitment to address issues with concern for the respective interests of the sexes."[147]

In light of the legal and regulatory framework, HIV/AIDS education must be given to women migrant workers with the end in view of achieving gender equality and empowerment. Applying a gender-sensitive approach to HIV/AIDS education with the objective of empowering women is not an easy task, especially when it is given as part of pre-departure seminar.

First of all, it would require the identification of the women's needs in relation to their vulnerability to HIV/AIDS that the program can address.[148] To do this does not simply mean asking the women what they need. In fact, this approach may not yield the best results. Women who believe that requesting their spouses or partners to use a condom would offend the feelings of their spouses or partners and would invite distrust in their relationship will not see their inability to insist on its use as a need. In fact, they may not see any need for anything that relates to HIV/AIDS, especially the married women who would completely discount the possibility of having an extra-marital affair overseas. Understandably, the women also do not anticipate any sexual abuse that might happen to them that would open the possibility of contracting HIV/AIDS.

Thus, one way of identifying the women's needs is for the pre-departure seminar to look into studies and related literature on female migration that offer insights on their gender socialization, views on sexuality, sexual abuse, and migration realities that are likely to face them in their work. For instance, studies have shown that migrant workers suffer from extreme loneliness and isolation such that they seek comfort through sexual

147. MIGRANT WORKERS ACT, § 3(b).

148. Geeta Rao Gupta, *OPINION: Gender and HIV/AIDS: Transforming Prevention Programs*, *available at* http://www.fhi.org/en/hivaids/pub/archive/articles/aidscaptions/volume2no3/cap232.htm (last accessed Jul. 30, 2005).

relationships or affairs that they did not think possible before they went overseas.[149] It has also been found that one of the push factors for desiring to work abroad is social mobility and power,[150] which have been constricted back home. This could lead, in turn, to sexual activities and involvements that expose them to risk of contracting HIV/AIDS.[151] Making the women recognize these realities is important to make them acknowledge the urgency of the need to learn about HIV/AIDS and its prevention, and the importance of being able to insist on safe sex or to refuse it altogether.

Given the implications of how they may acquire the disease, these possibilities must be discussed in a non-judgmental and sensitive manner so that like men, the women can freely talk about these concerns without being constrained. This should eventually lead to their ability to assert their right to sexual autonomy and the ability to avail of support or other services offered on-site without hesitancy. In this way, the pre-departure seminar can place women in an equal position with men, which also helps to ensure that they would enjoy equal access to the benefits or services available for achieving their potential for health.[152] In this context, it is the potential to be free from HIV/AIDS. In the example given, a gender-sensitive approach enables the seminar provider to recognize that the needs of women must be identified but at the same time, that it is not a matter of merely asking the women what their needs are. This discernment is possible because there is also an acknowledgment that gender inequality within their marital or intimate relationship undermines the capacity of women to perceive that certain inabilities need to be addressed in order to make them less vulnerable to HIV/AIDS.

Since there is recognition that the women are particularly vulnerable because of gender inequality, the pre-departure seminar must discern the underlying conditions which make them vulnerable, that is, it must take into account their gender socialization, which plays an important role in their predisposition to the risk of HIV/AIDS. This is especially true for women engaged in the domestic and entertainment work, because they are the ones more likely to be confronted with "unequal power balance in heterosexual interactions,"[153] that is, sexual encounters with men against whom they have

149. *See* APILADO, *supra* note 13, at 10; *see also* AMPARITA STA. MARIA, ET AL., MAID FROM THE PHILIPPINES (1998) [hereinafter STA. MARIA, ET AL., MAID FROM THE PHILIPPINES].

150. BAUTISTA, *supra* note 103.

151. APILADO, *supra* note 13, at 10.

152. Leslie Doyal, *Gender Equity in Health: Debates and Dilemmas*, *available at* http://www.cwhn.ca/resources/g-equity/ (last accessed Jul. 30, 2005).

153. *Gupta*, *supra* note 134.

to assert their sexual autonomy. Assuming that they understand the risks and consequences of unprotected sex, if they are not empowered to assert their rights to refuse sex or insist on safe sex, then they remain vulnerable. Hence, it is vital that the women are empowered in order to protect their health,[154] particularly their vulnerability to HIV/AIDS.

On a broader scale, the mandate to address gender socialization in order to eliminate stereotyping of roles for women and men can be found in the CEDAW, which states:

> States Parties shall take all appropriate measures:
>
> (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women....[155]

Thus, ideally, women should not be hearing about their rights and equal status with men for the first time in the pre-departure seminar. This seminar, even if conducted in a gender-sensitive manner, could not possibly alter the underlying conditions that have long perpetuated their subordination to men. Gender-sensitivity is a good approach, but it would not suffice for the purpose of changing the power balance in gender relations.[156] The women should have learned of these concepts in school and other institutions, with the end in view of addressing gender constructs that perpetuate the inferiority of women. Unfortunately, as pointed out by the CEDAW report, sex role stereotyping remains a stumbling block to women's development because the "institutions of socialization – home, school, media, church, and even government ... adhere to beliefs and practices that restrict women's access to opportunities for personal development...."[157]

The teaching of women's rights has not been really integrated into the curriculum unlike the rights of the child, which is already part of secondary education.[158] The past initiative towards complying with the CEDAW took the form of reviewing textbooks used in schools and making them more gender-sensitive. To date, however, there is still much to be done in this area and the CEDAW report considers this a challenge, not only in terms of

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154. *See* LAWRENCE GOSTIN, THE AIDS PANDEMIC (COMPLACENCY, INJUSTICE AND UNFULFILLED EXPECTATIONS) 301 (2004).

155. CEDAW, *supra* note 26, at art. 5.

156. *Gupta*, *supra* note 134.

157. Progress Report, *supra* note 15, at 39.

158. *See* Philippines, *Second Country Report on the Implementation of the Convention on the Rights of the Child* (1995-2000), at ¶ 67.

revising the content of textbooks, but in training the educators as well. Thus, it states:

> [i]n terms of eliminating stereotyped roles of women and men, government must ensure that gender reforms in the educational system are continuously pursued through the reviews of textbooks, instructional materials and school curricula as to their gender-responsiveness. Gender-sensitive ideas (such as shared parenting, reproductive rights and non-violent forms of handling conflict) should be included in textbooks, materials and curricula. At the same time, teachers and school administrators in all levels need more training for a more gender-sensitive approach to education so they can act as change agents in modifying socio-cultural patterns that are friendly to women and girl-children.[159]

This is not to say that pre-departure seminar cannot achieve empowerment for these women for the purpose of reducing their vulnerability to HIV/AIDS. With the proper programs supplementing it and by utilizing a gender-sensitive approach, it can empower them with the information necessary to specifically address prevention, including information about safe sex,[160] and their right to sexual autonomy. However, the first challenge HIV/AIDS education faces is the limiting environment imposed by the very laws from where it derives its mandate and the implementing tool *operationalizing* it.

B. The Context of Pre-departure Seminar and its Time Frame

Despite the unequivocal mandate from both the Migrant Workers Act and the AIDS Law to use gender-sensitivity as an approach, it is unrealistic to expect that within the context of pre-departure seminar, such approach, even if applied, would achieve the desired result of empowering women in every aspect of their lives as migrant workers. As far as HIV/AIDS education is concerned, it is important to bear in mind that the mere fact that it is implemented through the pre-departure seminar already presents barriers to its effective implementation, as will be demonstrated in the following discussion. What it can hope to achieve in the least is empowerment that would translate to a behavior that would reduce the women's vulnerability to HIV/AIDS.

It may be said then that the HIV/AIDS component in the pre-departure seminar should have three objectives: firstly, to give a general information on the nature, cause and consequences of HIV/AIDS; secondly, to address prevention within the context of the women's socialization, discussing in an open environment the conditions on why these women could remain

159. Progress Report, *supra* note 15, at ¶ 174.

160. *Gupta*, *supra* note 134.

vulnerable despite a comprehension of the nature of the disease and its modes of transmission; and thirdly, ensure that the open discussion with the women will empower them to exercise their right to sexual autonomy and to access health services on site without hesitation. In order to achieve these, it is not only crucial to recognize the underlying conditions of their gender subordination, but it must also take into consideration the structure of the pre-departure seminar and its other components with their attending constraints. One of the major constraints is the time frame in which the pre-departure seminar is conducted.

The term pre-departure orientation seminar itself indicates that it is an orientation for departing overseas workers. Hence, even if it attempts to dissuade women from leaving, there is little that the seminar can do. By this time, women migrant workers have definitely decided that they are going to work abroad. The value of the pre-departure seminar, then, lies on its ability to inform these women with important matters that would help in preventing their abuse and exploitation; prevent their unwanted entanglement with the laws of the destination country; learn surviving and coping mechanisms to ease the burdens of overseas work; acquire a basic knowledge of the country and make money remittances when they are able to.

Given the quantity of information that these women are expected to absorb, a one-day seminar is hardly sufficient. Unfortunately, HIV/AIDS education, as an added component, has to fit into this one-day seminar. At present, there are already some reports that the pre-departure seminar is only conducted for half a day, three hours or not at all.[161] This situation is even aggravated when the seminar is conducted right before the departure date. ACHIEVE, an NGO which focuses on migrant workers with HIV/AIDS and which has also done case studies found that "participants barely remember whether the pre-departure seminar included a session on health."[162] The same observations were made by other organizations like DAWN, which reported that most of what the OPAs "could recall were the lectures on basic travel requirements and some reminders."[163]

If the government is really sincere about empowering people with education about HIV/AIDS, it should seriously evaluate the propriety of including in it the pre-departure seminar. Either the latter is extended for a

161. *See* DAN ABRIL & MA. LOURDES MARIN, LABOR MIGRATION AND HIV/AIDS: UNDERSTANDING THE INTERSECTIONS 14 (2002) [hereinafter ABRIL & MARIN].

162. MARIA LOURDES MARIN, ET AL., FOR GOOD: LIFE STORIES OF FILIPINO MIGRANT WORKERS LIVING WITH HIV/AIDS 170 (2004).

163. DAWN, *supra* note 7.

longer period of time, or HIV/AIDS education for overseas-bound women is conducted separately and at a much earlier date. If the problem of time is not addressed, then on this factor alone, it is doubtful whether protection of these women from vulnerability to HIV/AIDS can be achieved.

C. HIV/AIDS Education and the Problem of Content

The IRR defines the *Standardized Basic Information* which, under section 7 of the same IRR, should be the minimum content of HIV/AIDS education.

> Standardized Basic Information – The amount of knowledge on HIV/AIDS deemed sufficient by the Department of Health, the Department of Labor and Employment, the Department of National Defense and the Civil Service Commission, that enables individuals to take action for their own protection. It includes information on the nature of HIV/AIDS, its mode of transmission and causes. It discusses the issues of medical confidentiality, the dignity of the person afflicted with HIV/AIDS, the rights and obligations of employers and employees towards persons with HIV/AIDS, and the particular vulnerability of women.[164]

Although the vulnerability of women is specifically mentioned, the determining body mandated to assess the sufficiency of the information *does not include* the NCRFW and the Department of Social Welfare and Development (DSWD), two of the government offices that cater to women issues the most, compared to the other government offices. They are likewise excluded from the partnership and consultation among government entities and some private offices and NGOs as regards the development of a prototype module or instructional design on HIV/AIDS.[165] Their exclusion is a serious lapse in the law especially since there is a legal mandate to give special attention to the vulnerability of women.

The DSWD has five program bureaus, one of which is the Bureau of Women's Welfare, which focuses on the "prevention or eradication of exploitations of women in any form, such as but not limited to prostitution and illegal recruitment...."[166] The NCRFW, on the other hand, is the national machinery for the advancement of women and is the main implementor of the PPGD. It focuses on gender mainstreaming and

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164. IRR of AIDS LAW, § 4(39).

165. *Id.* § 8.

166. Department of Social Welfare and Development, *Historical Background*, *available at* http://www.dswd.gov.ph/history.php (last accessed Jul. 30, 2005).

development concerns in the bureaucracy,[167] and is also in charge of monitoring the country's compliance with the CEDAW.

In terms of implementation, the IRR further provides that the prototype is to be developed within six months from the effectivity of the IRR.[168] This was in 1999. In the report of the mission to the Philippines by Special Rapporteur Gabriela Rodriguez Pizarro, she made the observation regarding the pre-departure seminar that "the content of the seminars is inadequate and outdated and the way topics are handled mainly depends on the body giving the PDO. This is particularly the case with regard to issues such as HIV/AIDS."[169] This was in 2002.

However, the most serious concern raised by this Article is the manner by which HIV/AIDS education is carried out because of the provisions on deregulation found in the *Migrant Workers Act*. The law provides for the comprehensive deregulation plan on recruitment activities[170] and the gradual phase-out of the regulatory functions of the POEA within five years.[171] The rationale of these provisions is that migration of workers should strictly become a matter between the worker and the foreign employer. There was also an assumption that the Philippines by then would be able to absorb into its workforce returning migrant workers. As much as the POEA has been accused of inefficiency, there is grave concern from different sectors that its deregulation will further expose migrant workers to exploitation.

Deregulation has also resulted in the devolvement of the pre-departure seminar from the POEA and a number of accredited NGOs to the recruitment agencies themselves. As of 2001, the POEA had accredited 396 licensed private recruitment agencies, three recruitment associations, and six NGOs to conduct the pre-departure seminar.[172] However, there is no monitoring body that assesses the qualifications of the seminar providers or

167. *See* National Commission on the Role of Filipino Women, *Background*, *available at* http://www.ncrfw.gov.ph/insidepages/aboutus/aboutus.htm (last accessed Jul. 30, 2005).

168. IRR of AIDS LAW, § 8.

169. United Nations - Migrant Workers: Report of the Special Rapporteur, Ms. Gabriela Rodríguez Pizarro (Mission to the Philippines) (2002), E/CN.4/2003/85/Add.4, at ¶ 52 (Addendum), *available at* http://www.hri.ca/fortherecord2003/documentation/commission/e-cn4-2003-85-add4.htm (last accessed Jul. 30, 2005) [hereinafter Special Rapporteur].

170. MIGRANT WORKERS ACT, § 29.

171. *Id.* § 30.

172. Sol Jose Vanzi, *Deployment of OFWs now Stabilized - Dept of Labor*, *available at* http://www.newsflash.org/2001/10/hl/hl014435.htm (last accessed Jul. 30, 2005).

the content of the module for HIV/AIDS. The IRR only mentions that the DOH, "in collaboration with its partners, shall assure the quality of the prototype through an annual review or as often as the need arises."[173] It should be noted that the IRR allows for modifications to be made on the prototype depending on the target audience,[174] but only the *prototype* is subject to review, not the actual *modules* given by the recruitment agencies or the modifications that have been made assuming that these agencies have used said prototype. There is, therefore, no assurance that HIV/AIDS education is carried out according to the content that the law mandates or that a gender-sensitive approach is applied to the manner of its dissemination to the women migrant workers.

In this regard, it is worthwhile to remember that CEDAW General Recommendation No. 24 on Women and Health states: "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women...."[175] It also acknowledges that "HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health"[176] and that "[a]s a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices."[177] Thus, it declares that "States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls...."[178]

HIV/AIDS education, therefore, must not only be viewed as a measure for empowering the women in order to reduce their vulnerability; but its importance must also be understood within the context of their right to sexual health. Thus, the quality of the content, the service provider and the process of dissemination must not be compromised. HIV/AIDS education is not a matter of privilege for these women who will be exposed to risk overseas. Receiving education regarding HIV/AIDS is a part of their right to sexual health.

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173. Philippine National Aids Council, Resolution No. 1, § 8 (1999).

174. *Id.*

175. CEDAW, General Recommendation No. 24, at ¶ 6 (1999), *available at* http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/CEDAW+General+recom.+24.En?OpenDocument (last accessed Jul. 30, 2005).

176. *Id.* ¶ 18.

177. *Id.*

178. *Id.*

D. Skills Upgrade and Deregulation vis-à-vis the Vulnerability of Women Beneficiaries

The policy consideration of the *AIDS Law* to empower people in order to prevent the disease is particularly difficult for target beneficiaries such as the domestic workers and OPAs. Domestic workers fall under the category of low-skilled workers. As such, they often feel marginalized even among migrant workers. Some of them are predisposed to the idea that they will receive some form of maltreatment because they are merely domestic workers. In a way, the *Migrant Workers Act* validates this sentiment when it states that it recognizes that possession of skills is the ultimate protection of all migrant workers; and that "as soon as practicable, the government shall deploy and/or allow the deployment only of skilled Filipino workers."[179] The assumption here is that migrant workers who are unskilled or low-skilled cannot expect ultimate protection, because it is not possible to accord the same to workers like them. It is, therefore, not surprising that domestic workers generally do not have high expectations about the government being able to protect them. Their optimism in landing with a good employer hinges more on reliance with divine providence and luck, but the state of powerlessness, remains within them.

For OPAs, the above policy statement in the *Migrant Workers Act* has had more detrimental effects. In the wake of reports about trafficking in women for sexual exploitation, there were rules and guidelines that sought to address the problem by imposing more requirements for the OPAs mainly dealing with eligibility and proper documentation.[180] This followed the same rationale that the OPAs were vulnerable to exploitation and abuse because they were not really skilled as entertainers. Thus, instead of focusing on the recruitment and employment agencies, which were responsible for the placement of these women, the policy concentrated on imposing the restrictive regulations on women themselves.[181] For traffickers who did not care to work within the framework of the new rules, this development provided them with additional enticement for those who feared that they would not pass the auditions for singers and dancers, to leave everything to their recruiters. This was bolstered by POEA's lowering of the minimum age for OPA eligibility from 21 to 18 in 2001,[182] further increasing the number of potential victims of trafficking.

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179. MIGRANT WORKERS ACT, § 2(g).

180. BAUTISTA, *supra* note 103, at 52–53.

181. *Id.* at 62.

182. *See* POEA Resolution No. 3, Series of 2001.

This patently misdirected approach to the problem of illegal recruitment and trafficking discriminates against women and reinforces their gender subordination by sending the message that it is they who should change and upgrade their skills so that they will not be left vulnerable to illegal recruiters and traffickers. The women were made the targets of change and restrictions instead of intensifying the investigation and prosecution of illegal recruiters and traffickers.

Furthermore, because of the provision of the law on deregulation and the fact that efforts were directed at improving the women rather than monitoring recruitment agencies, the latter were allowed to apply for accreditation to operate and maintain training centers.[183] Thus, deregulation facilitated the *skilling* of the women in the hands of recruitment agencies. This created more problems for the women.

In the research conducted by DAWN,[184] which involved interviewing OPAs who admitted that they were only 15-17 years old when they were first sent to Japan, the women revealed that it was the recruitment and promotion agencies that processed their documents and advanced their documentation expenses. Since they were already indebted to these agencies and because they were waiting for their bookings, they were told to continue their training.[185]

The respondent OPAs went through rigorous training, mostly in ballet, singing, and academics as a requirement for the acquisition of the Artist Record Book (ARB) for their visa application. Notably, close to one-fifth of the respondents underwent training in different clubs and karaoke bars that were known as exclusive clubs for Japanese guests in Makati, Pasay, and Quezon City. The women's training lasted from as short as one week to as long as one year or 48 weeks while they waited for their bookings in Japan. Four respondents said that they were made to dance while two were trained in singing in these venues. But majority of them admitted that they did the work of a "typical guest relations officer."[186]

The reality is that whether they are skilled or not in singing or dancing has little to do with the abuses they suffer as OPAs. As the special rapporteur had observed:

> 27. R.A. 8042 identifies the possession of skills as the best defence against abuses. However, the labour export industry is demand driven and the demand is mainly for unskilled work, often unregulated and involving hard

183. DOLE Department Order No. 10, Series of 2001.

184. DAWN, *supra* note 7.

185. *Id.* at 6.

186. *Id.*

> working conditions. The Special Rapporteur was concerned to learn that OFWs are often overskilled and overqualified for the jobs they are assigned, which results in the loss of skills.
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> x x x
>
> 29. The Philippines sends abroad an average of 35,000 entertainers each year, about 95 per cent of them to Japan. The Special Rapporteur was informed that upon arrival in Japan, Filipina entertainers are often required to surrender their documents to the employer and are obliged to work as hostesses, stripteasers and sex workers....
>
> 30. ...DOLE recently revised guidelines for the training, testing, certification and deployment of overseas performing artists, transferring the responsibility for determining who may or may not work abroad as OPAs to the same people who recruit the applicants, with considerable profit to themselves. The Special Rapporteur believes that even though strong economic interests undermine the effectiveness of the Government's protection efforts, it is essential that such efforts continue and be strengthened.[187]

For the women who have found themselves in the situation described above, the combination of the policy on skills upgrade and the legal provision on deregulation manifestly worked against their empowerment. Ironically, what these restrictions have accomplished is to discriminate against them and reinforce their subordination as they could only earn an accreditation card required for overseas employment[188] once they have passed the training. In other words, their validation as artists would only come when the recruitment agencies in charge of their training become satisfied that they have become skilled in entertaining men.

The appreciation of the background of both the domestic workers and OPAs is vital in putting into context HIV/AIDS education for these women. It should be emphasized that OPAs are not oriented with HIV/AIDS until they have gone through their accreditation and, by the time they are taught about HIV/AIDS, they would have completed and passed their training as entertainers.

Thus, HIV/AIDS education faces a huge challenge with the domestic workers and OPAs as beneficiaries. Not only must it take into account the underlying conditions that have reinforced their subordination before they decided to work, but also those which have been reinforced in the process of their application as migrant workers.

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187. ABRIL & MARIN, *supra* note 161, at 14.

188. DOLE Department Order No. 67-04, Series of 2004.

V. ASSESSING HIV/AIDS EDUCATION IN TERMS OF ITS GOAL OF EMPOWERING WOMEN MIGRANT WORKERS AND REDUCING THEIR VULNERABILITY

A. On HIV/AIDS Information

The right to education and information of women migrant workers regarding HIV/AIDS is founded both under international human rights law and domestic law. This is in recognition of the key role that accurate and adequate information plays in the prevention of the disease. With the ratification by the country of the ICESCR, the obligation to provide HIV/AIDS education must be understood within a human rights framework. Access to HIV/AIDS education is not merely an accommodation granted to migrant workers by the government for working abroad, it is a right that women migrant workers are entitled to claim. As articulated by the Committee on ICESCR on the right to health:

> 11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to … health-related education and information, including on sexual and reproductive health….
>
> 12. …Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
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> x x x
>
> *Women and the right to health*
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> 21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services … The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health….
>
> x x x
>
> 36. The obligation to *fulfill* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health…Further

> obligations include … information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health.…[189]

Articulating this obligation at the domestic level, the *AIDS Law* declares as a matter of public policy the eradication of conditions that aggravate the spread of the disease including poverty and gender inequality.[190] In its implementing rules, it further states that the standard basic information should include a discussion on the particular vulnerability of women.[191] It is also clear that such education and information aim at empowering people and communities with the end in view of changing their behavior in order to reduce the risk of contracting HIV/AIDS. Thus, the IRR provides:

> Provision of timely, accurate, adequate, appropriate and relevant HIV education and information shall empower persons and communities to think and act in ways that protect themselves from HIV infection, minimize the risk of HIV transmission and decrease the socio-economic impact of HIV/AIDS.[192]

In order for the pre-departure seminar to have accomplished risk reduction, it should have conducted HIV/AIDS education in a manner that would lead to gender empowerment so that the women can assert their right to sexual autonomy and access health services available to them on-site. In order for HIV/AIDS education to achieve this, the pre-departure seminar should have addressed the underlying conditions that perpetuate gender subordination. This Article has shown such underlying conditions to be poverty, patriarchy, [193] women's socialization and sexuality. [194] Their socialization is reinforced by existing laws and policies that still discriminate against women, and treat them in a degrading manner, like those experienced by some OPAs in the hands of their trainers.

In HIV/AIDS education, addressing these conditions is important in order to identify what these women need as far as reducing their

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189. General Comment No. 14, *supra* note 34.

190. AIDS LAW, § 2(d).

191. IRR of AIDS LAW, § 39.

192. *Id.* § 6.

193. This explains why even though 81% of women want to space or limit their children, men's preference not to practice contraception prevails.

194. This involves the following: that they are not equal with men in terms of deciding about their family life, including sexual practice preferences and family planning; and that their chaste character and prudish behavior bear heavily on their value as a "good woman," contrary to the men who are expected to be well-experienced in bed and can freely talk about their sexual exploits without being censured; and the stigma attached to a violated woman, who seems to suffer more social reprobation than her violator

vulnerability to HIV/AIDS is concerned. It is important to bear in mind that because of subordination, they may not easily articulate such needs. In fact, these needs may be unarticulated, unmet, or simply not recognized as needs.

The assumption of this Article is that if the needs of the women in terms of reducing their vulnerability to HIV/AIDS are identified and addressed by HIV/AIDS education, it would eventually result in the change in their behavior and empower them, thereby reducing the risk of contracting the disease. Conversely, if the information given does not respond to their needs, then it would not bear any change upon their behavior. Women's human rights education should also be factored in because it serves as the basis for asserting equal rights with men, especially in sexual relations either inside or outside a marriage or family life, and for gender empowerment.

For domestic workers and OPAs, even if the orientation focuses on their destination country, the general feedback is that most of them do not recall what has been taken in the pre-departure seminar, at least, not all of them. In an earlier research conducted on domestic workers in Hong Kong and Singapore,[195] the Author had received feedback from the women that the only thing they specifically remembered about the pre-departure seminar was how to remit money to the Philippines. This was echoed two years later by a survey done by Kalayaan and Caram-Asia,[196] where it found that the pre-departure seminar usually concentrated on salary remittances and bank transfers. As mentioned in the first part of this Article, the same findings were observed by ACHIEVE in 2004, where the participants barely recalled whether there was something about health that was given in the pre-departure seminar; and DAWN, stating that the OPAs could only remember that the lectures were about travel requirements and some reminders. Suffice is it to say that based on these studies, there was very little remembered by these women from the pre-departure seminar. Mostly, it was the procedure on sending money.

Unless the pre-departure seminar is restructured in order to give HIV/AIDS education the appropriate time it requires to accomplish its target goals, not only to give information on the nature, cause, and consequences of the disease, but also to address gender subordination which hinders their empowerment, women migrant workers would derive little

195. This resulted in the publication of Maid from the Philippines, *supra* note 149, which provided information on laws and practical tips for domestic workers in Hong Kong, Singapore and Malaysia.

196. SAHLEE C. BUGNA & RIZA FAITH YBANEZ, SURVEY OF KNOWLEDGE, ATTITUDE, BEHAVIOR, AND PRACTICE RELATED TO HIV/AIDS AMONG FILIPINO MIGRANT WORKERS, LABOR MIGRATION AND HIV/AIDS 15 (2000).

benefit, if at all, in an HIV/AIDS education within the present set-up of the pre-departure seminar.

The lack of knowledge about HIV/AIDS adds to migrant workers' vulnerability. For one, the popular but mistaken belief that only homosexuals, women in prostitution, and intravenous drug users can be infected must be corrected so that they would not engage in unprotected sex just because they are not homosexuals, drug addicts or are not in the flesh trade. Furthermore, it has been documented that even though the law mandates both pre- and post-test counseling, the latter is hardly done because of the sheer number of migrant workers tested. Thus, without the benefit of counseling, a negative result creates a false impression that the prospective migrant worker "can never be infected by HIV/AIDS or that they are 'safe' from infection and are therefore free to engage in risky sexual behaviors."[197] Hence, it is vital that HIV/AIDS education for migrant workers, especially for women is not taken for granted, and should be given priority in the orientation of departing workers.

The *AIDS Law* provides for HIV/AIDS education not only to OFWs but also in schools, in the workplace, and to communities. It also makes it a component of health service.[198] Thus, for pre-departure seminar to realistically achieve gender empowerment in its HIV/AIDS education, basic information on the disease must already be given *prior* to the pre-departure seminar itself. In this way, the women would have already acquired information on its nature, mode of transmission, and causes and prevention by the time the seminar is conducted.

In this regard, aside from the HIV/AIDS education in the community level that is conducted in pursuance to law, the government should start looking at the potential of the Pre-Employment Orientation Seminar, as a complimentary tool to gender empowerment of women migrant workers. This seminar is given by the POEA to local government units, other government and non-government institutions, and also prospective migrant workers who are not yet decided but merely contemplate working overseas.

While it is claimed that this is complementary to the pre-departure seminar,[199] there is no evidence that there is actual coordination between the two programs. The pre-employment seminar is usually conducted for three

197. APILADO, *supra* note 13, at 10.

198. AIDS LAW, §§ 4, 5, 6, & 9.

199. Manuel G. Imson, *The Experience of the Philippines* (Paper presented at the Labor Migration Ministerial Consultations for Countries of Origin in Asia, Sri Lanka 1-2 April 2003).

days, depending on the allocated budget,[200] and heavily focuses on illegal recruitment. To be truly complimentary to the pre-departure seminar, this program should not only emphasize prevention of illegal recruitment but also focus on the social aspects of migration and introduce the process of gender empowerment by starting to address the underlying causes of the women's subordination, especially in terms of how such subordination could affect their vulnerability to HIV/AIDS. The pre-departure seminar, in turn, can reinforce this in a longer seminar, integrating it with the program's other components.

The pre-employment seminar must also be made a pre-requisite to the pre-departure seminar. Furthermore, it would be desirable if at the time the pre-departure seminar is given, the women could already relate their own vulnerabilities to the disease, and assess their own capacities to deal with the problem.[201] For instance, they might already be aware that they are in a better position to refuse having sex rather than insisting on condom use.

B. On Change in Behavior

While it is reasonable to assume that adequate knowledge on HIV/AIDS can be acquired if there is more time to disseminate the information, it is highly doubtful if, by the mere extension of said time, an effective HIV/AIDS education could result in the reduced vulnerability for the women. As stated earlier, unless it is able to address the underlying conditions of their gender subordination that hinders the exercise of their rights to sexual autonomy and access to health services, then there can be no empowerment for these women which is the key to the reduction of their vulnerability.

Another finding in the conduct of HIV/AIDS education within the pre-departure seminar is that the information on the subject is not linked to migration realities; and that it is "AIDS 101 without any link to migration."[202] Earlier discussions have pointed out that migrant workers suffer from extreme loneliness and isolation, and that this has resulted in

200. RIZA FAITH YBANEZ, ET AL., LABOR MIGRATION AND HIV/AIDS: VULNERABILITY OF FILIPINO MIGRANT WORKERS 15 (2000) [hereinafter YBANEZ].

201. *See* Charles F. Turner, et al., AIDS, Sexual Behavior, and Intravenous Drug Use (1989), *available at* http://www.nap.edu/openbook/0309039762/html/259.html#pagetop (last accessed Jul. 30, 2005).

202. JONATHAN COHEN, THE PHILIPPINES UNPROTECTED: SEX, CONDOM AND THE HUMAN RIGHT TO HEALTH 55 (2004).

extra-marital affairs.[203] The women also experience sudden independence and freedom from constrictions borne out by their subordinate position in the family. Thus, this has also led to sexual activities and involvements that they did not anticipate.[204]

In the research conducted by ACHIEVE,[205] it was shown that although both the men and women migrant workers were vulnerable to HIV/AIDS, the difference in their vulnerability had to do on how they expressed their sexuality. The women, who had sexual encounters within intimate relationships either did not insist on safe sex because they could not, or because they did not think HIV/AIDS was a real threat to their relationships; while the men had unprotected sex with women they paid.[206]

It is worth emphasizing that under the Migrant Workers Convention, States Parties are mandated to "maintain appropriate services to deal with questions concerning international migration of workers and members of their families," including "the provision of information and appropriate assistance to migrant workers and members of their families regarding … conditions of work and life in the State of employment…."[207]

Thus, it is incumbent upon the seminar providers of pre-departure seminar (and its supporting programs) to be aware of situations which may possibly increase the women's risk and vulnerability. These women need to come to a realization that the risk they face in contracting HIV/AIDS depends on how they would deal with these real situations. The importance of being able to insist on safe sex or no sex at all must be contextualized, such that learning about HIV/AIDS and why they should not engage in risky behavior becomes relevant to them.

Accordingly, knowledge of HIV/AIDS does not necessarily make people change their behavior, mainly because such knowledge has not been internalized.[208] A change in behavior can have several motivating factors, and this includes awareness of the need for and the benefit brought about by

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203. *See* APILADO, *supra* note 13, at 10; *see also* STA. MARIA, ET AL., MAID FROM THE PHILIPPINES, *supra* note 149.

204. *Id.*

205. MARIN, ET AL., *supra* note 162.

206. *Id.*

207. MIGRANT WORKERS CONVENTION, *supra* note 28, art. 65.

208. Lucy Edwards, *HIV and ABC: A Duel between Western-Christian Morality and African Patriarchy*, *available at* http://www.gwsafrica.org/knowledge/lucy%20edwards.html (last accessed Jul. 30, 2005).

such change.[209] Furthermore, HIV/AIDS education should refer to a specific social and cultural context so that people could identify with the information given, using culturally appropriate language, idioms, and metaphors.[210] Venue and the social environment where these concerns are discussed are also important.

For instance, domestic workers face deportation in Singapore when they are found to be pregnant. This could be discussed within the reality that, because of loneliness and isolation, the women develop intimate relationships that they never anticipated. This problem must be approached in a sensitive manner so that the women are not constrained to avail of support or other services offered on-site to address these concerns. It is important to discuss this part of their sexuality because it has a great potential of actually happening, but most of them will be intimidated if the pre-departure seminar is conducted in the presence of men who they think will perceive them as interested in sex or anticipating an affair overseas. Whereas the men can freely talk about the possibility of having extra-marital affairs because of loneliness and isolation without suffering the same public censure, the same does not hold true for women. Furthermore, men are not deported when they have impregnated a domestic worker. Thus, although both men and women may need the same information and support systems to deal with this problem, a more gendered approach is to discuss this separately, so that information and access to health and other counseling services on site can be grounded contextually, starting with an approach inquiring how the women feel about the issue and how would they negotiate themselves when confronted with an actual situation.

As far as OPAs are concerned, since the lowering of the age requirement to 18, many of the women who should have been in school just opted to work in Japan. As reported by the Population Commission, their ages range from 20-29 and that 56% were unmarried. Yet, because of their situation there, some of them had to go through abortions because of pregnancies arising from sexual contact with clients who did not want to use a condom.[211] As a coping mechanism, a number of these women had developed intimate relationships with their clients, leading to exclusivity in their availability. This has sometimes resulted in having a child.

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209. Dorothy Onyango, *Communications for Prevention and Behavior Change* (Paper presented at the VIII Communication for Development Roundtable, Managua, Nicaragua, 26-28 November 2001), *available at* http://www.comminit.com/pdf/dorothy-onyango.pdf (last accessed Jul. 30, 2005).

210. *Freudenthal*, *supra* note 111.

211. MARIN, ET AL., *supra* note 162, at 172.

Unfortunately, for those whose relationships did not last, this often leads to the woman being left alone to tend the child. As DAWN reports,

> The returnees admitted that despite the material gain, their failed relationships with Japanese men brought them more problems upon their return since many of them and their Japanese-Filipino children were abandoned by their partners.[212]

There should be a clear delineation, however, between emphasizing the need to practice safe sex in order to avoid contracting HIV/AIDS, and an apparent endorsement of promiscuity and infidelity. Thus, the programs for HIV/AIDS prevention should stress that government is not sending the message that it is acceptable to be unfaithful or sexually adventurous as long as one practices safe sex. In a society where acts of infidelity are criminalized and both the institutions of the family and marriage are Constitutionally protected,[213] a program that is perceived to be against existing norms will not be effective. A change in behavior should be patterned on what is perceived to be the norm.[214] Furthermore, while the insistence on safe sex can be grounded on the women's right to sexual autonomy, the gender-neutral approach of promoting fidelity can actually complement the program, and should be helpful to both men and women because "they do not reinforce gender stereotypes like using macho images to sell condoms."[215] As a matter of fact, the AIDS Law declares as a matter of policy, that information campaigns "shall promote value formation and employ scientifically proven approaches, focus on the family as a basic social unit."[216]

Another concern is sexual abuse and the possibility of being infected because of this. As described earlier, because of the stigma that attaches from being sexually violated, some women will choose not to complain to the authorities not only because of fear of reprisal, but also because of their fear of social reprobation and their desire to protect their families from humiliation. Some women who may have been initially forced into prostitution will choose to stay on-site and continue with their fated trade because of heavy indebtedness, and also because they do not want to experience the social censure awaiting them at home. These women are

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212. DAWN, *supra* note 7.

213. *See* PHIL. CONST. art. II, § 12 & art. XV, §2.

214. Steven C. Mobley, *Social Marketing Assessment and Behavior Change [Social] Marketing Strategy Design, available at* http://stevenmobley.com/Brazil%20Final%20Report.htm (last accessed Jul. 30, 2005).

215. COOK, *supra* note 87, at 335.

216. AIDS LAW, § 2(a).

then exposed to the risk of HIV/AIDS infection and will very much be unable to negotiate for safe sex. That they choose to remain, instead of pursuing a complaint, is already indicative of a certain degree of powerlessness. It is, therefore, not difficult to assume that they are likewise in no position to negotiate for safe sex and assert their right to refuse customers who do not want to wear condoms.

The change in behavior for these women is much more difficult because the situation they have found themselves in is completely unexpected. However, at the root of their inability to pursue a claim, and their desire not to cause humiliation to their family, is gender subordination, brought about by their socialization that much of a woman's worth as a human being is dependent on her virtue. Hence, in order to correct this mindset that invariably impacts on her decision whether or not to assert her right to sexual autonomy, the pre-departure seminar must undoubtedly also include women's rights literature which can be the basis of a creation of a norm introduced in the seminar[217] – that being sexually abused is a violation of woman's bodily integrity; that there is no shame in wanting to vindicate this right and that her worth as a human being has not, in anyway, been diminished by this violation.

It is quite obvious that with the complexities of the process involved in reducing the women migrant workers' vulnerability to HIV/AIDS, the pre-departure seminar, by itself, and especially with its present structure could not provide these women with the necessary tools for empowerment and behavioral change. The pre-departure seminar needs restructuring, not only in terms of time but also of content. It needs to be given within a longer time-frame, with its subject-components linked together in such a way that a gender-sensitive approach is consciously adopted and the theme of empowerment is mainstreamed. The government must also look into the HIV/AIDS education at the community level and the pre-employment seminar and link these initiatives with the pre-departure seminar. Moreover, a risk reduction strategy focusing on behavior modification and remedy of situations with risk of HIV infection must be adopted.[218]

A recent study conducted in Malawi, Southeastern Africa (Malawi Study),[219] regarding behaviors related to HIV/AIDS, identified and utilized, among others, risk perception and efficacy beliefs as two primary determinants of health behavior change. This Article adopts these determinants as useful tools in effecting behavior change for women migrant

217. *Mobley*, *supra* note 214.

218. COOK, *supra* note 87, at 332.

219. DR. R. RIMAL & M. TAPIA M.A., EXPLORING COMMUNITY BELIEFS, ATITUDES, & BEHAVIORS RELATED TO HIV/AIDS 72 (2004).

workers for the purpose of reducing their vulnerability to HIV/AIDS. While this Article acknowledges the complex process of behavioral change and recognizes that there may be myriad factors that should be examined in order to ensure that there is indeed a change in behavior and a sustained one at that, this Article has limited the determinants to two categories that can be utilized by the pre-departure seminar and its supplementing program for the purpose of giving the required education and information to women who are bound for overseas work. In other words, this Article has adopted these determinants because it is realizable within the context of a pre-departure seminar.

1. Risk Perception

The primordial consideration in using this determinant is to identify the needs of women in order to reduce their vulnerability to HIV/AIDS. These needs may not be easily articulated as such, unless the women are able to perceive their own vulnerability or susceptibility to the disease. In the Malawi Study, it was observed that "the individuals are optimistically biased in their assessments of personal vulnerability: they tend to believe that others are generally more vulnerable than themselves."[220] The research opines that a moderate rather than low level of perceived susceptibility is required for individuals to take preventive action.[221]

In the context of Filipino migrant workers, the same attitude was found to be pervasive.[222] This belief is reinforced by poor information on HIV/AIDS, especially if they think that they do not belong to the "risk groups."[223] Hence, it is important that the women migrant workers see themselves as being susceptible to the disease, and to such an extent that they will consider adopting behavior leading to risk avoidance. As earlier discussed, the various possibilities where they may find themselves at risk should be laid out to them. HIV/AIDS transmission must be presented in the way that would relate to their susceptibility as migrant workers in order to dispel any myths about who or what groups are only likely to be affected.

2. Efficacy Beliefs

After establishing their risk perception, the women's efficacy beliefs must be examined in order to determine their capacities for addressing their vulnerability. The women must be able to identify which options they are

220. *Id.* at 69.

221. *Id.*

222. APILADO, *supra* note 13, at 9.

223. *Id.*

most likely to take. For instance, if they feel that they are more able to refuse sex altogether than to insist on safe sex through the use of condoms, then this option might be the best approach to behavioral change. In the Malawi Study, this was one of the findings. Thus,

> …participants reported higher levels of efficacy in remaining abstinent and limiting their number of sexual partners, as compared to using condoms consistently. Even though the focus group discussions revealed that young people were particularly lacking in their ability to be abstinent or to limit their number of sexual partners, individuals' perceived abilities in both domains were only moderate in strength. Another component of efficacy pertains to outcome expectations, the belief that enacting specific behaviors will confer benefits that people seek. We found that outcome expectations regarding condom use were moderate in strength. As was also found in the focus group discussions, many individuals seemed to believe that condoms are ineffective in preventing HIV/AIDS; others expressed various negative attitudes toward condoms. Use of condoms is strongly associated with gender roles. Many women, for example, expressed a sense of powerlessness in making decisions about using condoms and in persuading their partners to do so. Others noted that their partners did not believe in using condoms.[224]

Aside from identifying the best approach to behavioral change, HIV/AIDS education can also be useful in correcting misconceptions about the use of condoms. As in the study quoted above, if the reason women do not insist in using condoms is because they do not believe it will work, then information on its efficacy can be a useful input to them. On the other hand, if the reason is because they feel that they do not have the right to insist on safe sex, then this must also be addressed, using a rights-based approach in explaining women's right to sexual autonomy and health.

With the proper supporting programs that should be in place even prior to the pre-departure seminar, the latter could concentrate on an orientation program that focuses on increasing the women migrant's risk perception and the different ways where they may find themselves vulnerable are discussed. In addition, the women can also identify what their particular needs are in order to reduce their vulnerability in accordance with how they perceive themselves and make their own decisions as to the best way of addressing this concern.

It should be mentioned that counseling is one of the services offered by foreign posts under the jurisdiction of the Philippine embassy. This service has been generally focused on distressed migrant workers who have encountered problems with their employers. The scope of this service should be broadened to include counseling sessions that would reinforce what the

224. RIMAL, *supra* note 219, at 68.

women have learned in the pre-departure seminar regarding risk reduction in contracting HIV/AIDS so that the desired behavior to adequately respond to this concern can be sustained. Thus, the support programs must not only exist prior to the pre-departure seminar but also thereafter, when the women are actually on-site.

C. On Accessing Health Services

For women migrant workers, it is equally important to be able to access available heath services on-site. Under the Constitution, the State is mandated to "adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost."[225] Thus, in reviewing accessibility, this Article adopts the indicators provided in General Comment No. 14 issued by the ICESCR Committee. Consequently, it shall discuss accessibility in terms of access to health-related information, physical access to health facilities and services, economic access or affordability, and non-discrimination. Non-discrimination shall not be discussed separately but shall be treated in this Article as one of the underlying causes of women's inability to access health services.

The right of women migrant workers to access health-related information, facilities, and services is anchored on the Constitutional mandate to protect working women and provide them with healthful working conditions.[226] This means that in providing for their work environment, programs for this purpose that are either enunciated by law or policy, must ensure that women's health is taken into consideration. A similar pronouncement is found in the *Migrant Workers Act* which mandates the government to deploy workers only in countries where their rights are protected, one of the indicators of which is when a country "has existing labor and social laws protecting the rights of migrant workers."[227]

Within the international human rights legal framework, the ICESCR Committee has set the normative content of the right to the highest attainable standard of health in General Comment No. 14. It recognizes that since 1966, the year that the Convention was adopted, "the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and

225. PHIL. CONST. art. XIII, § 11.

226. *Id.* § 3.

227. MIGRANT WORKERS ACT, § 4(a).

gender differences."[228] In addition, it also states that formerly unknown diseases, one of which is HIV/AIDS, have created new obstacles for the realization of the right to health.

Aside from information accessibility which includes "the right to seek, receive and impart information" on health issues,[229] General Comment No. 14 further states that the right to health should contain the following interrelated and essential elements in regard to, among others, health facilities and services: availability, physical and economic accessibility, acceptability and quality.[230] Accordingly, *accessibility* means that facilities are provided without discrimination, "especially [to] the most vulnerable or marginalized section of the population, in law and in fact."[231] The Committee also sets out the core obligations under Article 12, stating that it is the obligation of States parties "to ensure the satisfaction of, at the very least, minimum essential of each of the rights enunciated in the Covenant, including essential primary health care"[232] and the first of which is "[t]o ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups."[233]

Thus, as in the case with the right to education and information on HIV/AIDS, access to health information, facilities and services of women migrant workers is also a human right, which according to the Committee should be provided in a non-discriminatory manner, and is non-derogable.[234]

Although the health facilities and services are found in the country of destination, the Philippine government has the obligation to exert every effort to ensure that there are health services and facilities which migrant workers can avail of. Through the pre-departure seminar, it has the concomitant obligation to put migrant workers, especially the women, in a position and capacity to access and enjoy such health benefits afforded to them in the work place.

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228. General Comment No. 14, *supra* note 34, ¶ 10.

229. *Id.* ¶ 12(b).

230. *Id.* ¶ 12(a, b, c, & d).

231. *Id.* ¶ 12(b).

232. *Id.* ¶ 43.

233. *Id.* ¶ 43 (a).

234. *Id.* ¶ 47.

1. Health-related Information

For domestic workers and OPAs who have undergone the POEA processing, they will have a standard employment contract that is country-specific.[235] At the very least, there would be a provision for minimum wage over and above other benefits, which should not be deducted from said minimum. Unfortunately, because of the deficiencies of the pre-departure seminar, many women migrant workers remain unaware of the benefits in their employment contracts, let alone of health provisions therein or health insurance coverage.[236]

POEA has already set up the mechanism for requiring a standard employment contract for OPAs.[237] This is also true for domestic helpers. Thus, the orientation seminar must see to it that the women migrant workers are acquainted with the benefits under their contracts, especially those concerning health services. This obligation to inform the women of the available health-related information is vital for their protection, so that they can claim and use such benefits, knowing that they do so as a matter of right. In addition, they must also be given a general orientation of the health care system in their destination country.

The importance of access to health-related information cannot be overemphasized. According to the World Health Organization (WHO), the "lack of information about what is available or about health matters in general is one of the reasons migrants most often give for not using health services effectively and for not taking action themselves to prevent illness."[238]

For the OPAs, not knowing their contract rights and benefits with regard to health puts them in a more vulnerable position, especially since as reported by the Population Commission, their ages range from 20-29, which is a highly reproductive age group. Furthermore, under their contracts, the responsibility of procuring health and hospital insurance falls under the employer at the worksite, and is not arranged until their arrival there. Hence, it is also very important that the women are empowered with the knowledge of their health rights. They must also possess the skill to negotiate the coverage of the insurance so that they can insist that their health needs, especially their reproductive health, are sufficiently covered.

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235. POEA Memorandum Circular No. 11, Series of 1999, § 6.

236. ABRIL & MARIN, *supra* note 161, at 18.

237. See POEA Memorandum Circular No. 21, Series of 2003, § IV.

238. World Health Organization, *International Migration, Health & Human Rights*, 4 Health & Human Rights 28 (2003).

The domestic workers, on the other hand, are generally in a less powerful position compared to other OFWs in relation to their employers. Often, they are discriminated against because their work is viewed as lowly and menial. This has been acknowledged in the Colombo Declaration which was adopted during the Regional Summit on Foreign Migrant Domestic Workers in 2002,[239] which states:

> [t]he experiences of foreign migrant domestic workers in the migration process reveal that domestic work is still to be recognized as a socio-economic activity and valued accordingly. This leads to a serious lack of protection, vulnerability and exploitation. Multiple discriminations based on gender, race, and class…and the isolated and individualized conditions of work, and lack of protection and appropriate services and information increases their vulnerabilities to exploitation and violence. It also compromises their health and human security.

Thus, more than any other category of workers, women OPAs and domestic workers are most disadvantaged when they cannot rely on the benefits provided in their contracts and other available health services onsite in order to meet their health needs. The government must see to it that the women are fully aware of what they are entitled to, and that access to these entitlements is not hampered by factors that could have been addressed by the pre-departure seminar given them.

2. Physical Accessibility

In a study by the Women in Development Foundation, it cited that domestic workers in Hong Kong cannot access health care services because medical clinics were usually closed during the weekends which is the only time that they are allowed time off.[240] These women face obstacles in accessing health services, despite the fact that they are provided health and other medical benefits in their contracts. They continue not to have access to facilities simply because they do not know where such facilities are, or the clinic hours do not coincide with their day-off.[241] There have also been reports on discriminatory policies of onsite health care facilities where hospitals have alleged that they do not cater to migrant workers.[242] These

239. CARAM Asia, Regional Summit – Colombo Declaration, *available at* http://caramasia.gn.apc.org/page_type_2.php?page=regional_summit/Regional_Summit-Declaration&title=CARAMASIA.ORG+%3A%3A+Colombo+Declaration (last accessed Jul. 30, 2005).

240. MARIN, ET AL., *supra* note 162, at 173.

241. *Id.*

242. *Id.*

findings were echoed by the WHO, acknowledging that the opening hours of health services, including the distance and location can be a problem for migrants;[243] and that, migrant workers, for varied reasons, may not be able to request time-off in order to seek health care.[244]

Added to this is the difficulty of communication due to the language barrier, especially when the concerns of the women relate to sexual and reproductive health.[245] Accordingly, they also did not want male doctors to treat them for these concerns.[246]

> Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS.[247]

Ideally, there should be a provision in the standardized contract for the domestic workers and OPAs that employers will guarantee the women's unimpeded access to health care services whenever circumstances require such services. The more pragmatic approach, however, is to empower these women so that they can have meaningful use of their health care benefits. In other words, to physically access health care services and facilities, the women must not only know the benefits in their contracts, but must also be able to insist that they be given time off during the working hours in order to see a doctor or other health care provider. Moreover, they should no longer be stymied by the fact that their concerns have something to do with their reproductive health. Thus, at the point where they require medical attention on-site, they should be empowered and capacitated enough to negotiate time off with their employer and avail of health services at any time they feel they might need it. Within the context of HIV/AIDS, they must be able to seek medical attention because of their desire to eliminate or reduce the risk of contracting the disease, and because they have the confidence to communicate their concerns about their reproductive and sexual health.

Once again, the importance of addressing gender socialization and subordination in the pre-departure stage comes into play with the problem of physical accessibility. Even if the women are aware of the facilities and they perceive that taking time off would not be a problem, if they remain

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243. *World Health Organization*, *supra* note 238, at 27.

244. *Id.*

245. MARIN, ET AL., *supra* note 162, at 173.

246. *Id.* at 171.

247. General Comment No. 14, *supra* note 34, art. 12(b).

reluctant because they are not comfortable talking about sexual and reproductive concerns, especially with a non-Filipino health care provider and a male at that, then most likely, they will forego seeking medical attention. As far as HIV/AIDS is concerned, if they think that they will not be able to insist on safe sex anyway or that they are in no position to refuse sex all together – without perceiving the risk as a consequence of such inability – then they might also pass off the opportunity of seeking counseling and medical advice, even before engaging in risky behavior.

Hence, aside from efforts at trying to negotiate for health facilities and services that are more accessible in terms of distance and time, the Philippine government – through the pre-departure orientation of women migrant workers – must apply gender-sensitive approaches and come up with gender-sensitive and empowering programs that would cater to the women's special needs before they embark for overseas work. Although men may require a different kind of orientation also, it is much more difficult with women, especially for those in the entertainment industry and domestic service, because of the very nature of their work. They usually deal with employers who are not expected to meet any labor standard or are unlikely to possess the willingness to come up with initiatives that would cater to their health needs.

Companies or corporations, on the other hand, will more likely have the resources and initiative to develop health programs for their workers. As the WHO reports,

> Encouragingly, there are positive initiatives occurring among some large transnational corporations to ensure affordable and accessible health care for migrant workers and their families. Some of these companies have understood the threat to productivity posed by poor health, especially HIV/AIDS and tuberculosis. In parts of southern Africa, for example, AIDS-related illness and death has reduced the workforce by 20%. Thus many corporations are collaborating with each other and with governments and civil society to tackle diseases such as HIV/AIDS. The southern African mining industry, which depends almost entirely on migrant work forces, has taken a lead in this field.[248]

Although the situation in Africa is quite different from the Philippines in terms of the HIV/AIDS crisis, the example is given merely to highlight the fact that initiatives such as the one mentioned above are more possible in industries which are more visible; unlike in the entertainment and domestic work, which tend to be more covert and private. It is also worth noting that for Filipino migrant workers, the men will generally be employed in corporations or companies with more possibility of having their own health

248. *World Health Organization*, *supra* note 238, at 23.

care programs than the women would. Hence, the need for the government to take into consideration their vulnerability in overseas work is more compelling.

3. Economic Accessibility

Just as problems have arisen with regard to physical accessibility, migrant workers have also been hampered by costs in the process of availing of health services. It has been reported that in some occasions, public hospitals were charging the domestic workers a higher amount for the same health care service provided to nationals. A similar finding was made by Tenaganita in Malaysia, where migrant workers were being charged double the amount paid by its nationals for the same kind of service.[249] In fact, there were also reports that some of the migrant workers were charged with "first class rates for third class services."[250]

Discrimination is the underlying cause of these experiences. This is more difficult to deal with, since neither the Philippine government nor the migrant workers themselves have control over how health care providers view them abroad. There is only so much that can be expected of migrant workers when they are confronted with this situation. That they are in a foreign country already makes it hard to assert their rights to access health services, more so when they suffer discrimination from its nationals. By being fully cognizant of their benefits and understanding that they have a right to access health services, women migrant workers might be more emboldened to assert themselves, especially when they are refused treatment. It also helps if they know they can rely on the Philippine Embassy or consulate to assist them in cases where they encounter discrimination. It is preferable that health centers and facilities for migrant workers are pre-determined in their contracts, or the Philippine foreign posts nearest to the worksite ensure that the health and medical centers they refer for services are willing to accommodate the workers, especially women, without discrimination.

4. Other Related Barriers in Accessing Health Services

Aside from discrimination, there are other factors serving as barriers in accessing health services. Language differences make communication between the women migrant workers and health providers difficult, especially when it concerns reproductive health. There is further unease

249. MARIN, ET AL., *supra* note 162, at 173.

250. *Id.*

when the provider is male. Moreover, there is also the claim that while the costs of services are first class the service itself is third class.

Article 12 [c] of General Comment No. 14 takes note of culturally appropriate service; while Art. 12 [d] refers to the quality of service. Thus,

> (c) *Acceptability*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
>
> (d) *Quality*. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Even the WHO acknowledges that culturally appropriate health care services are limited for migrant workers, as this requires not only resources but a general supportive attitude towards them. As a result, there have been cases of "wrong diagnoses, inappropriate treatment and poor compliance on the part of patients."[251]

Such observation brings to fore the fact that for women migrant workers, it is important to know the nature, benefits and coverage of their health entitlements, whether these are stated in the contracts or something which is provided by the laws of the destination country, or covered by an insurance policy as overseas workers. Whatever the source of these benefits, the women must know what they provide. It should further be emphasized that they are entitled to the services as a matter of right and accessing the same does not result and should not result in salary deduction. Non-diminution of agreed salaries is important especially considering that most of these women would rather save on their salaries than spend the same for health purposes.

For many Filipino migrant workers, there is also a tendency to self-medicate and follow instead the medical advice of friends and relatives.[252] The general attitude of giving low priority to one's health is reinforced by the high cost of medical and health care, and by the fact that the office hours of these facilities coincide with their working hours.[253] Therefore, all these factors must be discussed during the pre-departure seminar, with due regard to the vulnerable situation of the women. This is especially true for

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251. *World Health Organization*, *supra* note 238, at 27.

252. ABRIL & MARIN, *supra* note 161, at 11.

253. *Id.* at 11.

HIV/AIDS and other sexually transmitted diseases and infections where there is the added difficulty of not being able to discuss these subjects freely and openly because of their gender socialization.

While knowledge and familiarity with the provisions in their contracts are vital for the women in order to avail of health care facilities and services, unless the underlying causes that hinder their access to these benefits are discussed in the pre-departure seminar, then it is unlikely that they can fully exercise and enjoy their right to health as migrant workers. Realization of the right to health within their context does not only mean having sufficient information on what can be accessed; but also being capacitated to actually use the health benefits available to them.

D. Adopting a Rights-Based Approach

So far, this Article has shown that even if the contracts of the women provided for health services, these were rendered nugatory because they did not have physical access to the facilities; they could not afford the health service they needed, or that the quality was not acceptable for the amount they were asked to pay. There was also the question of preference for same-sex health care provider. All these conditions have effectively prevented the women from enjoying the health care service spelled out in their contracts. This is aggravated by their socialization that information regarding sexual matters should not be sought or discussed.

How then can the pre-departure seminar address these obstacles so that the program can truly protect women migrant workers and reduce their vulnerability to HIV/AIDS?

In the pre-departure seminar, aside from the topic of employment contract, migrant workers are also briefed on the laws and other rules that must be followed in order to avoid entanglement with the law and conflict with the employer. There is also some discussion on the benefits provided under their contracts but this would most likely be within the context of terms and conditions of work. This does not help in the empowerment of the women if the benefits are not discussed in the context of rights that can be claimed under the contract. It is expected that the recruitment agencies give more emphasis on compliance with the duties and obligations of a migrant worker rather than those that should be undertaken by the employer. Their main goal is to send workers who will not create trouble.

What the women need is a pre-departure orientation that enables them to fully comprehend, among others, the health benefits stipulated in the contracts. They also need to realize that these benefits belong to them as a matter of right. The fact that they are working in a foreign country is already difficult by itself in terms of trying to access health centers for their needs. The difficulty increases when they do not feel they have the right or power

to access the same, especially when they have to do it during their working hours. The pre-departure seminar must address this state of powerlessness so that these women would not vacillate in asserting their health rights.

A rights-based approach to explaining the importance of reading and knowing their entitlements in the contracts is an important strategy in empowering the women migrant workers and ensuring that they can negotiate their rights against their employers with certitude. For instance, domestic workers in Hong Kong are further entitled to free medical and sickness benefits.[254] Given the prospect of strenuous work, inadequacy of food and accommodation provisions and physical and sexual abuse,[255] it is important that they can claim these benefits whenever the need arises. Accordingly, there are cases where migrant workers did not seek help even when they were sick for fear of termination.[256] The domestic workers in Hong Kong are further entitled to maternity leave benefits so they should not fear being fired because they are pregnant. However, their fear of termination and the pressure to conceal the pregnancy could result in the failure to avail of prenatal care and services.[257] There are also reports that some of those whose jobs were jeopardized by the pregnancy have resorted to unsafe and expensive abortions.[258]

The OPAs in Japan are likewise provided with health and hospital insurance benefits.[259] Given the nature of their work and their relatively young age, knowing about their reproductive rights is important as this will invariably impact on the extent of the insurance coverage that they can insist on. This of course, will also largely depend on how empowered they are to be in a negotiating stance with their employer. Again, this underscores the importance of pre-departure seminar and the adoption of a rights-based approach in discussing the terms of their contracts.

The women migrant worker's right to health must also be discussed within the broader context of human rights, so that the their claim to its realization is seen as a positive obligation on the part of the government to fulfill, pursuant to its commitment both at the domestic and international

254. Labour Department, *Practical Guide for Employment of Foreign Domestic Helpers - What Foreign Domestic Helpers and Their Employers Should Know*, *available at* http://www.labour.gov.hk/eng/public/wcp/FDHguide.pdf (last accessed Jul. 30, 2005).

255. ABRIL & MARIN, *supra* note 161, at 18.

256. MARIN, ET AL., *supra* note 162, at 171.

257. *Id.* at 172.

258. ABRIL & MARIN, *supra* note 161, at 18.

259. *See* POEA Memorandum Circular No. 21, Series of 2003, s. IV.

levels to protect women migrant workers. Thus, adopting a human rights approach to health would re-frame basic health needs as health rights.[260] Furthermore, discussing the women's health problems within a human rights framework or presenting them as a social justice concern raises their visibility, which could pave the way for their treatment as an urgent policy concern for the government.[261]

VI. CONCLUSION

This Article has shown that the laws and policies which aim to protect women migrant workers from vulnerability to HIV/AIDS have failed for the following reasons: firstly, there are self-defeating provisions in the laws providing for their protection and education on HIV/AIDS that work to their disadvantage, especially to those engaged in the domestic service and entertainment; secondly, the implementing mechanism, which is the pre-departure seminar, is inadequate and fails to comply with its mandate to provide a gender-sensitive program, especially as regards HIV/AIDS education; and thirdly, because of these legal flaws, policy infirmities and the lack of a gender-sensitive approach by the implementing tool, HIV/AIDS education has not addressed the interactions between poverty, gender relations, and socialization of women, and their constricted views on sexuality, which serve as the underlying conditions of gender subordination. Thus, HIV/AIDS education has not led to the empowerment of women migrant workers, and to their ability to assert their sexual autonomy and access health services on-site.

Consequently, the Constitutional mandate to protect working women by providing safe and healthful working conditions,[262] the *Migrant Workers Act* directive to apply gender-sensitive criteria to its programs,[263] and the *AIDS Law* requirement to provide HIV/AIDS education to overseas-bound workers and its policy to eradicate conditions that aggravate the spread of HIV/AIDS, including gender inequality,[264] and to empower and effect a change in how people think and act in order to protect them from HIV infection[265] have not been met.

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260. JUDITH ASHER, THE RIGHT TO HEALTH: A RESOURCE MANUAL FOR NGOS 21 (2004).

261. *See* Adrienne Kols, *A Rights-Based Approach to Reproductive Health,* Outlook December 2003, at 3.

262. PHIL. CONST. art. VIII, § 3.

263. MIGRANT WORKERS ACT, § 2 (d).

264. *Id.* § 2 (d).

265. IRR of AIDS LAW, § 6.

Likewise, the country has failed to comply with its human rights obligation under Article 12 of the ICESCR on the right to health, particularly the right to seek, receive, and impart information on health issues,[266] and the right to access health facilities and services,[267] which must be available, accessible, affordable, and of acceptable quality. The inability to access is primarily imputable to the failure of the country to empower the women to exercise their health rights on-site.

There is also non-compliance with Article 65 of the Migrant Workers Convention insofar as the HIV/AIDS education in the pre-departure seminar has failed to provide information and appropriate assistance to migrant workers regarding conditions of work and life overseas which render them vulnerable to the disease.

The lack of gender-sensitive approaches in HIV/AIDS education in the pre-departure seminar has also prevented women from receiving adequate sexual health information and services, a right which is guaranteed under the CEDAW according to General Recommendation No. 24. Furthermore, the failure to address gender subordination in the HIV/AIDS education also breaches Article 5 of CEDAW, which requires the modification of social and cultural patterns of conduct in order to achieve the elimination of prejudices based on the idea of the inferiority or the superiority of either men or women.

Other non-treaty based commitments to gender equality and empowerment such as the Beijing Platform for Action, the promotion of reproductive and sexual health rights under the ICPD, and the UNGASS Declaration of Commitment on HIV/AIDS to implement strategies to facilitate access to HIV/AIDS prevention programs for migrants workers, including information on health and social services have also not been complied with satisfactorily.

In view of the above findings, this Article proposes the following recommendations for a more effective HIV/AIDS education for the pre-departure seminar:

A. Amending Law and Policy

1. Migrant Workers Act

a. Protection vis-à-vis Skills Upgrade

266. General Comment No. 14, *supra* note 34, ¶ 12(b).

267. *Id.* ¶ 12 (a, b, c, & d).

Both the *Migrant Workers Act* and the *AIDS Law* advocate the equality of men and women. In addition, the former recognizes the vulnerability of women as migrant workers while the latter recognizes their vulnerability to HIV/AIDS and seeks to address this through empowerment by education. Both laws also have a mandate to apply a gender-sensitive approach in their policies and programs.

However, as far as the *Migrant Workers Act* is concerned, its policy statement on possession of skills as the ultimate protection of migrant workers must be amended in order to remove its disempowering effect on domestic workers who fall under the category of low-skilled workers. It reinforces the women's feeling of subordination and sends the message that they cannot expect ultimate protection from the government because of their lack of skill. This is despite the fact that the feminization of migration for work can largely be attributed to the deployment of domestic workers.

Furthermore, this policy statement has resulted to stricter rules for accreditation of OPAs ostensibly as a solution to trafficking in women and illegal recruitment. This misdirected approach to trafficking and illegal recruitment is not only discriminatory against women; but in some instances, it has also facilitated their exploitation in the hands of their recruiters doubling as trainers. The effect of this policy statement in the law imposes a greater burden in teaching them about HIV/AIDS because of reinforced gender subordination that the experience of applying for overseas workers has caused them.

Thus, there have been proposed amendments to the *Migrant Workers Act*, and one of these espouses the abolition of this policy statement, and substitutes it with one which, although emphasizes the importance of skills upgrade, de-links the same from the ultimate protection that a migrant worker can expect from the State.[268] This Article agrees with this proposed amendment and suggests a re-wording of the policy statement that will not only de-link protection from skills upgrade but will articulate the contribution and work value of the service sector, including domestic work.

b. Deregulation

The Philippine government should heed the call from different sectors of civil society to amend the provisions on deregulation, in accordance with the *Migrant Workers Act*,[269] because there are serious repercussions on migrant workers, especially the women who engage in the entertainment sector. To opt out of the responsibility of regulating the hiring and recruitment of

268. *See* Resource for Legislators, Explanatory Note, House Bill No. 10595, *available at* http://erbl.pids.gov.ph/listbills.phtml?id=36 (last accessed Jul. 30, 2005).

269. MIGRANT WORKERS ACT, §§ 29-30.

workers in the face of mounting complaints of illegal recruitment against employment agencies, including those which have been accredited by the POEA,[270] would be imprudent, to say the least.

In addition, because of the deregulation provisions and the fact that efforts were directed at *improving the skills of the women* rather than monitoring recruitment agencies, the latter were allowed to apply for accreditation to operate and maintain training centers. Thus, deregulation facilitated the *skilling* of the women in the hands of recruitment agencies. This created more problems for the women.

Furthermore, the deregulation provisions not only make possible exploitation of OPAs in the process of their accreditation; it also undermines the HIV/AIDS education because it is through deregulation that recruitment agencies are able to assume the large part of giving pre-departure seminar to departing workers. Since the women migrant workers are more vulnerable to disease, they are also likely to lose more if the HIV/AIDS component is not given in a gender-sensitive manner and if it does not take into account the underlying conditions that perpetuate their subordination.

Stricter regulation and monitoring of recruitment agencies is obviously called for, in order to protect migrant workers from unscrupulous practices, such as exploiting their need to be trained as artists in order to be able to leave as entertainers.

The task of training the OPAs, and of giving the pre-departure seminars as a whole, should not be delegated to recruitment agencies. The government agency in charge with such training and seminars[271] should exclude those engaged in the business of overseas recruitment not only because of possible conflict of interest but also because of its potential for abuse and exploitation. Thus, there should be separate institutions for training as entertainers. This recommendation holds true for the pre-departure seminar, which must also be conducted by the proper government agency and by its chosen partners, like NGOs and other organizations which are not in the business of recruiting people for overseas work.

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270. *See* POEA.gov.ph, *Status of Recruitment Agencies*, *at* http://www.poea.gov.ph/cgi-bin/agList.asp?mode=all (last accessed Jul. 30, 2005).

271. Either the Technical Education and Skills Development Authority (TESDA) or the Overseas Workers Welfare Administration.

2. AIDS Prevention and Control Act

a. Standardized Module and Monitoring Body

The law should provide for a standardized *module* to be used for HIV/AIDS education for migrant workers. As currently phrased, the law only speaks of a *prototype* that is subject to review, but does not provide for the same review process in case of modifications to the prototype, which the law allows the service providers to adopt. While the Department of Labor and Employment identifies the use of a standard HIV/AIDS module for the pre-departure seminar as one of its *anti-AIDS* efforts,[272] it has been described as outdated at worse and not linked to migration at best. Thus, the law through its implementing rules must specify that standard modules for HIV/AIDS education be adopted (as against a mere prototype that is open to modifications without further scrutiny from the health department) which are suitable to their respective target audience, whether they be the community, school, workplace, or overseas-bound workers.

The modules must also be consistently reviewed in order to ensure that the information is not outdated. This is in keeping with the IRR criteria that the content of the HIV/AIDS education must be Accurate, meaning that "information is consistent with empirical evidence of the WHO, the DOH, or other recognized scientific bodies...." and that "[p]ublished research may be cited to establish the accuracy of the information presented."[273] Research should also include studies on risk reduction brought about by behavioral change. The IRR further mentions that the vulnerability of women must be taken into consideration; however, this is not spelled out in the criteria for the content of the module. The provision on content[274] only states that it should be gender-sensitive, meaning, that the module must depict "a positive image or message of the male and female sex; it is neither anti-women nor anti-homosexual." However, as this Article has shown, gender-sensitivity as applied to HIV/AIDS education must also address gender subordination because it impacts on the women's exercise of sexual autonomy and access to services on site. Therefore, the IRR must broaden the scope of *gender-sensitivity* as criteria for the content of the module. It should include being sensitive to the needs of the women and adopting empowering strategies in addressing these needs.

Section 7(g) of the IRR also provides, as a criterion, that the message to be conveyed must be *affirmative*, meaning, that it does not instill fear and

272. *See* DOLE, *Medical Test of OFWs Protects RP from AIDS*, *at* http://www.dole.gov.ph/news/pressreleases2005/march05/112.htm (last accessed Jul. 30, 2005).

273. IRR of AIDS LAW, § 7 (a).

274. *Id.* § 7 (e).

encourage coercion because such messages are not "conducive to a thorough discussion of HIV/AIDS." While this may be true, this criterion should nevertheless emphasize that the content must ensure the women's perceived susceptibility to the disease such that it would translate into change of behavior and result to risk reduction. Thus, as discussed in the Article, risk perception and efficacy beliefs must be used as determinants in effecting behavior change within the context of HIV/AIDS education.

As mentioned, there is no monitoring body to see to it that HIV/AIDS education is carried out in a gender-sensitive and empowering manner. Furthermore, the body that is also tasked to determine the standard basic information,[275] that is, "[t]he amount of knowledge on HIV/AIDS deemed sufficient" for the purpose of educating the people, has excluded two important government offices, which cater to women issues and needs. These are the NCRFW and the DSWD. They are also excluded in the development of the prototype module on HIV/AIDS. Their exclusion is a serious lapse in the law and work to the detriment of the women whose vulnerability has been recognized no less by the law itself. This Article recommends that the body that determines the sufficiency of the content of the module be further tasked to monitor the actual implementation of the module and see to it that education is carried out in a gender-sensitive manner. Likewise, the monitoring body should include a representative from both the NCRFW and the DSWD.

B. Law on Reproductive Health

While there is a law on HIV/AIDS, there is no Philippine law on Reproductive Health. As pointed out by the Population Commission, there is lukewarm support for a family planning program, including the use of contraceptives. Also, in connection with a recent campaign launched by the DOH called *Ligtas Buntis* (Safe Pregnancy), the Secretary of Health quoted a recent survey by the Social Weather Station that "only three out of ten adult Filipinos are practicing some form of family planning" and some of them are using antiquated and ineffective methods.[276] The Secretary further stated that a large number of the population is not aware of the family planning, and maternal and child health services available to the public. Thus, the DOH is currently embarking on a campaign to disseminate information on available family planning and maternal and child health services to communities,

275. This is the Special HIV/AIDS Prevention and Control Service headed by the DOH under § 8 of IRR.

276. Secretary Manuel M. Dayrit, *Open Letter to All Filipino Couples on the Ligtas Buntis Campaign, available at* http://www.doh.gov.ph/ (last accessed Jul. 30, 2005).

promoting the freedom to plan the size of the family and the freedom to choose methods based on informed choice.[277]

This is just one of the programs that the DOH is trying to implement on a national scale. Unfortunately, some programs on reproductive health, especially those pertaining to family planning, have not achieved its full implementation, not only because of lack of resources, but also because of lack of political will on the part of both the national and local governments. Despite the long-term plans and programs by the implementing departments and agencies, such programs are hampered by the lack of legal and institutional support. Without a law that will make it compulsory for local governments to implement reproductive health programs, they could independently pursue their own reproductive health agenda without necessarily adhering to the national policy. This is made possible by the devolution of health services to the local governments, by virtue of the Local Government Code of 1991.[278] Thus, campaigns such as *Ligtas Buntis* will probably not be implemented well in Manila, where the mayor has banned all forms of artificial contraception.

The poor implementation of programs dealing with family planning and contraception-use, and the infrequent access to reproductive health services because of lack of awareness of their availability impact heavily on women migrant workers and the effort to reduce their vulnerability to HIV/AIDS through education. For instance, it would be an arduous task for seminar providers to communicate the importance of accessing health services and the need to consult their reproductive health problems when these women have not experienced accessing the same services in the Philippines. It would be difficult to internalize the importance of safe sex by insisting on the use of condoms when there has not been any opportunity to insist on their use not only due to non-availability but because condoms have simply not been part of their options. As the availability and accessibility of reproductive health services are vital to the HIV/AIDS prevention program, particularly in terms of risk reduction, a consistent policy on reproductive health based on a law on comprehensive reproductive health care is most compelling.

Presently, there is a pending bill, House Bill 3773, entitled *Responsible Parent and Population Management Act of* 2005[279] which deals with women's reproductive rights, including the right to decide on the number and spacing

277. *Id.*

278. *See* An Act Providing for a Local Government Code of 1991 [Local Government Code of 1991], Republic Act No. 7160, chap. 1, § 17 (1991).

279. *See* Philippine Daily Inquirer, *at* http://news.inq7.net/common/print.php?index=1&story_id=29834&site_id=18.

of children, and reproductive health care services, including full and free access to information of reproductive health and human sexuality. The Bill is heavily opposed by the Catholic Bishops Conference of the Philippines, pro-life organizations, and some local governments who view the Bill as an endorsement of abortion despite a categorical declaration by the Bill that it does not. These sectors also oppose the use of all forms of artificial contraception methods.[280]

House Bill 3773 was originally called the *Reproductive Health Act of* 2004. Although essentially containing the same provisions, the new title takes the focus out of reproductive health and centers the same on responsible parenthood and population management. Whether or not this would actually make a difference in the policies and programs of the government is difficult to predict. There is always the possibility that reproductive health care and services would be heavily concentrated on family planning designed to address population management. It is encouraging to note that the Bill adopts the terms and definitions on Reproductive Health from the ICPD Programme of Action. Thus,

> SEC. 4. Definition of Terms. - For purposes of this Act, the following terms shall be defined as follows:
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> x x x
>
> c. Reproductive Health - the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. This implies that people are able to have a satisfying and safe sex life, that they have the capability to reproduce and the freedom to decide if, when and how often to do so, provided that these are not against the law. This further implies that women and men attain equal relationships in matters related to sexual relations and reproduction.
>
> d. Reproductive Health Rights - the rights of individuals and couples to decide freely and responsibly the number, spacing and timing of their children; to make other decisions concerning reproduction free of discrimination, coercion and violence; to have the information and means to carry out their decisions; and to attain the highest standard of sexual and reproductive health.
>
> x x x
>
> g. Reproductive Health Care - availability and access to a full range of methods, techniques and services that contribute to reproductive and sexual health and well-being by preventing and solving reproductive health-

280. Sr. Mary Pilar Verzosa, *The End of the Future of Nations* (2005), *available at* http://www.prolife.org.ph/?PrintableVersion=enabled.

> related problems in order to achieve enhancement of life and personal relations....[281]

There is no elaboration of sexual health in the Bill, unlike in the ICPD Programme of Action, which states that sexual health is included in reproductive health care, "the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[282] This is an important qualification because sexual health is almost always linked to reproductive health, and the programs designed to promote it seems to relate mostly to reproduction.[283]

The recognition of the distinction between the two terms is vital because it can assist in clearly delineating the services that must be provided in order to address them both. For the women migrant workers, achieving sexual health means that they would not only be free from HIV/AIDS and other sexually transmitted diseases and infections, but they will also have a pleasurable and safe sexual experience, which is free from coercion, discrimination, and violence.[284]

Any policy agenda on reproductive health must necessarily include sexual health in order for it to be a comprehensive program. In the above definition, it appears promising that the Bill refers to sexual health as a key factor in reproductive health care. It is also important that the latter has identified its objectives as enhancing life and personal relations, and then proceeds to enumerate the components in order to achieve these goals. In this way, the health service outcomes are established, and the needs, inadequacies, and successes of the program are measurable by such outcomes.[285]

Attention should also be geared towards the importance of formulating policies and programs on promoting contraceptives, with the end in view of not only preventing unwanted pregnancies, but in reducing risk to

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281. Responsible Parent and Population Management Act of 2005, House Bill 3773, § 4 (year).

282. *Programme of Action of the International Conference on Population and Development*, *supra* note 52.

283. *See* Alice M. Miller, *Human Rights and Sexuality: First Steps Toward Articulating a Rights Framework for Claims to Sexual Rights and Freedoms,* 93 AM. SOC'Y INT'L L. PROC. 288 (1999).

284. *See* Department of Reproductive Health and Research (RHR), Gender and Reproductive Rights, http://www.who.int/reproductive-health/gender/sexual_health.html#4 (last accessed Jul. 30, 2005).

285. *See* MILLER, *supra* note 283.

HIV/AIDS, sexually transmitted diseases (STDs), and sexually transmitted infections (STIs) as well.[286]

Under the proposed Bill, the elements of reproductive health care include: (1) Maternal, infant and child health and nutrition; (2) Family planning information and services; (3) Prevention of abortion and management of post-abortion complications; (4) Adolescent and youth health; (5) Prevention and management of reproductive tract infections (RTIs), HIV/AIDS and other STIs; (6) Elimination of violence against women; (7) Education and counseling on sexuality and sexual and reproductive health; (8) Treatment of breast and reproductive tract cancers and other gynecological conditions; (9) Male involvement and participation in reproductive health; and (10) Prevention and treatment of infertility and sexual dysfunction.

Although these components may require different approaches in terms of implementation, the services involving some of them should be integrated, [287] especially since the Philippines has limited resources. Furthermore, there is also poor awareness among the population about what is being offered by the DOH as far as available family planning and maternal and child health services to communities are concerned. Thus, these services should not be fragmented[288] and there must be a conscious effort to integrate them into one health service package.

This particularly becomes relevant in promoting family planning and preventing HIV/AIDS, STIs and STDs. For instance, to ensure the delivery of health care goods and services to provinces especially to the poor, section 9 of the Bill provides that each Congressional District shall be given a Mobile Health Care Service. These mobile clinics can reach women, even from the rural areas where health facilities are not readily accessible. They can offer family planning services particularly to couples, and at the same time, provide education on the proper use of condoms, ensure their availability by free distribution, and encourage the clients to test for STDs

286. *See* William R. Finger & Sarah Keller, *Barrier Methods: The Role of STDs*, Network (September 1995), *at* http://www.fhi.org/en/RH/Pubs/Network/v16_1/nt1614.htm (citing Dr. Ward Cates) (last accessed Jul. 30, 2005).

287. Willard Cates, Jr. & Katherine M. Stone, *Family Planning, Sexually Transmitted Diseases and Contraceptive Choice: A Literature Update – Part II,* Family Planning Perspectives (May-June 1992) at 125, *available at* http://links.jstor.org/sici?sici=0014-7354%28199205%2F06%2924%3A3%3C122%3AFPSTDA%3E2.0.CO%3B2-S (last accessed Jul. 30, 2005).

288. *Id.* at 125.

and STIs, once it becomes apparent that there is need for such tests.[289] In other words, promoting the use of condoms can be seen as serving a double purpose: preventing unwanted pregnancies and reducing the risk of contracting HIV/AIDS, STIs and STDs.

Achieving this, however, requires cross-training of health service providers in both fields of family planning and HIV/AIDS/STDs/STIs so that they will possess adequate information about the key issues in each area, the appropriate approach to take, and the sensitivity in assisting their clients arrive at an informed decision.[290] Section 11 of the Bill provides for capability building of *Barangay* Health workers by way of their "retraining on the delivery of reproductive health care services." This Article proposes that this provision further elaborate the need for these workers to be cross-trained in order to achieve the integration of family planning and prevention of STDs, STIs and HIV/AIDS especially in the rural areas, where women, who can very well be potential migrant workers, do not have ready access to reproductive and sexual health services. This Article also recommends that the conscious integration of family planning and HIV/AIDS and other forms of STD and STI prevention programs be part of the policy statement of the Bill.

As can been seen from the afore-stated enumeration, a key component of reproductive health care under the Bill is also "[r]eproductive and sexual health education including but not limited to counseling on the full range of legal and medically-safe family planning methods including surgical methods."[291] Again, this non-exclusivity of focus on family planning is a welcome development, notwithstanding the change in the title of the Bill. What must be ensured primarily is the promotion of reproductive and sexual health through the guarantee of services that address both these concerns; and whenever possible, that do so in an integrated manner.

If this Bill becomes a law, it would facilitate the education of women on reproductive and sexual health, including HIV/AIDS even before they decide to work overseas. First of all, the Bill recognizes that gender equality and women's rights are essential to the fulfillment of reproductive health rights.[292] Secondly, it adopts participatory and need-based approaches in formulating programs and policies by recognizing that the active participation of NGOs, groups, communities and people's organizations are

289. *Finger*, *supra* note 286.

290. *Cates Jr.*, *supra* note 287.

291. RESPONSIBLE PARENT AND POPULATION MANAGEMENT ACT OF 2005, § 6(e)(1).

292. *Id.* § 3(f).

imperative in ascertaining the needs of target beneficiaries.[293] Thirdly, as mentioned above, it defines reproductive health care, identifying as among its elements, the prevention and management of HIV/AIDS, other sexually transmitted infections, and reproductive tract infections;[294] the elimination of violence against women[295] and education/counseling on sexuality and sexual and reproductive health.[296]

In connection with sexual and reproductive health education, section 10 of the Bill makes it also mandatory for both public and private schools to integrate into the curriculum "Reproductive Health and Sexuality Education in an age-appropriate manner" starting from the Grade 5 until Fourth Year High School. Hence, potential women migrant workers who are still in their primary and secondary levels of education would benefit from this Bill if the latter becomes a law.

For those who are currently working in the country, the Bill also states that the employer shall provide "free delivery by the employer of reasonable quantity of reproductive health care services and devices to the workers, more particularly the women."[297] Then the Bill requires the Responsible Parenthood and Population Management Council to "initiate and sustain a heightened nationwide multi-media campaign to raise the level of public awareness of the urgent need to protect and promote reproductive health care and rights relative to human development and population management."[298]

It is also noteworthy to mention that one of the functions of the Council is to take active steps in expanding the coverage of the National Health Insurance Program, in order to include "the full range of sexual and reproductive health services, commodities and supplies as health insurance benefits."[299] To date, migrant workers have been placed within the coverage of this program so that any expansion in the areas of reproductive and sexual health services by the insurance scheme would necessarily benefit them, whether their medical confinement is in the Philippines or on-site.[300]

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293. *Id.* § 3(h).

294. *Id.* § 4(g)(5).

295. *Id.* § 4(g)(6).

296. *Id.* § 4(g)(7).

297. *Id.* § 13.

298. *Id.* § 15.

299. *Id.* § 6(k).

300. PhilHealth Board Resolution No. 760, s-2005.

Lastly, and what is most striking about the Bill, at least in the Philippine context, is that the guarantee of reproductive and sexual health services is reinforced by penal provisions, undoubtedly in recognition of the fact that the delivery of these services has always been a contentious and controversial issue. Thus:

SEC. 16. Prohibited Acts. - The following acts are prohibited:

a) Any health care service provider, whether public or private, who shall:

1. Knowingly withhold information, or restrict the dissemination thereof, and/or intentionally provide incorrect information regarding programs and services on reproductive health including the right to informed choice and access to a full range of legal, medically-safe and effective family planning methods;

x x x

3. Fail or cause to fail deliberately, or through gross negligence, or inexcusable neglect, the delivery of reproductive health care services as mandated under this Act, the Local Government Code of 1991, the Labor Code, and Presidential Decree 79, as amended; and

4. Refuse to extend quality health care services and information on account of the person's marital status, gender or sexual orientation, age, religion, personal circumstances, and nature of work: Provided, That all conscientious objections of health care service providers based on ethical and religious grounds shall be respected: Provided, however, That the conscientious objector shall immediately refer the person seeking such care and services to another health care service provider within the same facility or one which is conveniently accessible: Provided, finally, That the person is not in an emergency condition or serious case as defined in RA 8344 penalizing the refusal of hospitals and medical clinics to administer appropriate initial medical treatment and support in emergency and serious cases.

b) Any public official at both the national and local levels with power and authority over any subordinate who shall prohibit or intentionally restrict the delivery of legal and medically-safe reproductive health care services, including family planning;

x x x

SEC. 17. Penalties. - Any violation of this Act shall be penalized by imprisonment ranging from one (1) month to six (6) months or a fine of Twenty Thousand Pesos (P20,000.00) or both such fine and imprisonment at the discretion of the proper court. If the offender is a juridical person, the penalty shall be imposed upon the President, Treasurer, Secretary or any person or officer responsible for the violation. If the offender is an alien, he/she shall, after service of sentence, be deported immediately without further proceedings in the Bureau of Immigration. If the offender is a public officer or employee, the Court shall, in addition to the penalties hereinabove provided, order his/her dismissal from the government service.

> In addition to the foregoing penalties, violators of this Act shall be liable to the offended or injured parties, women and/or couples for civil damages the amount of which shall be subject to the discretion of the competent court.[301]

Given the benefits that women migrant workers and the Filipino female population, in general, could acquire from the enactment of this Bill, this Article recommends its passage into law. In the event that the Bill is not passed, this Article recommends that future Reproductive Health Bills nevertheless incorporate the provisions herein cited.

C. Implementing Mechanism: The Pre-departure Orientation Seminar

1. Restructuring the Seminar

This Article has shown that the pre-departure seminar as an implementing tool imposes its own constraints. First, it is conducted as a one-day seminar despite its mandate to orient migrant workers about several matters. HIV/AIDS is just one component. Although all migrant workers will lose out because of time constraints, the consequences for women are far more serious because they are more vulnerable not only to HIV/AIDS but also to sexual exploitation and abuse that can expose them to the risk of HIV/AIDS. Therefore, loss of adequate information will necessarily have a more negative impact on them; and such loss will be greatest to the most vulnerable even among the women: the domestic workers and the OPAs.

Therefore, this Article recommends that in order for the pre-departure seminar to serve as an empowering tool for women through delivery of effective HIV/AIDS education, the same should be extended to one week in order to cover all components of the program and to give more emphasis to HIV/AIDS risk-related behavior. Also, the rights of the women under their contracts must be well explained, especially the medical and health benefits available to them on-site. Another alternative is to conduct HIV/AIDS education separately, and at an earlier time than the rest of the components of the pre-departure seminar, in order for women to have more time in internalizing the contents of the subject-matter.

Unless the pre-departure seminar is restructured in order to give HIV/AIDS education the appropriate time it requires to accomplish its target goals to give information on the nature, cause, and consequences of the disease also to address gender subordination which hinders their empowerment, women migrant workers would derive little benefit, if at all,

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301. RESPONSIBLE PARENT AND POPULATION MANAGEMENT ACT OF 2005, §§ 16, 17.

in an HIV/AIDS education within the present set-up of the pre-departure seminar.

Furthermore, the seminar-providers that the POEA accredits should be limited to those organizations or entities that are not engaged in the *recruitment* of overseas workers. While the employment agencies may have useful inputs as regards the overseas employers that the women will be working for, their contribution, as far as the seminar is concerned, must be limited to these information, including the terms and conditions of their employment. However, as for other matters such as country background, cultural environment, and the other contractual provisions having to do with the women's rights and benefits, these must be discussed by people who can focus as much on the rights of women as workers, as the employment agencies do on their duties and obligations under the contract. Needless to say, HIV/AIDS education must be given by gender-sensitive trainers who will not only give a cursory lecture on what the disease is about, but will see to it that the information given produces a reasonable expectation on behavioral change that results in risk reduction.

In giving HIV/AIDS education, this Article also recommends that aside from grouping overseas-bound women according to country of destination when attending HIV/AIDS education, they should further be grouped according to their jobs so that vulnerabilities common to them by reason of their job descriptions can be better discussed.

2. Content of the Seminar

The *AIDS Law* only provides for a standard prototype but once modifications are made by seminar-providers on the education module, there is no further monitoring done by the Special HIV/AIDS Prevention and Control Service, if indeed, the modified module complies with the criteria set by the law. Thus, this Article recommends that the same body review the modified modules. It should also ensure that HIV/AIDS education is delivered in a gender-sensitive and empowering manner, according to the expanded meaning of gender-sensitive criteria recommended by this Article; and pursuant to the objective of the law to empower the people "to think and act in ways that protect themselves from HIV infection."[302]

Gender-sensitivity in the context of HIV/AIDS education especially for women migrant workers means that it will take into account the underlying conditions which make them vulnerable to HIV/AIDS. An understanding of the patriarchal society which shaped their gender socialization, views on

302. IRR of AIDS Law, § 6.

sexuality, and sexual abuse, plays an important role in addressing their gender subordination which impacts on the right to assert sexual autonomy and access health services and facilities on-site. Preliminary to this, but equally important, is the manner by which HIV/AIDS information can be conveyed, and related to their own vulnerabilities in a way that their needs and concerns are identified and freely articulated without fear of being judged as promiscuous or immoral.

This Article mentioned that based on interviews with women migrant workers, except for the procedure on how to remit money, there was very little that they remembered from the pre-departure seminar. The key, therefore, to ensuring that they will take to heart the session on HIV/AIDS, is to impress upon them the importance of the information and their vulnerability to contracting the disease. Thus, it is recommended that in discussing HIV/AIDS, risk perception and efficacy beliefs be used as determinants in effecting behavioral change.

Firstly, HIV/AIDS transmission must be explained in a way that relates to their susceptibility as migrant workers in order to dispel any myths about who or what groups are only likely to be affected. It is important that the women migrant workers see themselves as being susceptible to the disease, and to such an extent that they will consider adopting behavior leading to risk avoidance. The possibilities where they can be at risk should be laid out to them. Thereafter, a self-assessment must be made as to what measures are in their capacity to undertake in order to effect risk reduction.

These recommendations are in keeping with the *Revised Guideline 6: Access to Prevention, Treatment, Care and Support on HIV/AIDS*, issued by the United Nations High Commissioner for Human Rights and the UNAIDS. These guidelines aim to direct State responses to HIV/AIDS in ways that ensure the integration of international human rights principles and standards in said responses.[303] Guidelines 6e and 6n construed together, advocate for State programs that address obstacles to equal access to information on HIV/AIDS prevention, such as migration and other forms of discrimination; and for said information to be effective on its designated audience.[304]

3. Approaches (Integrative, Participatory and Rights-Based)

The ideal situation in giving HIV/AIDS education to women migrant workers is to discuss it not only in a separate session, but also to integrate it into the other components of the pre-departure seminar, specifically on

303. OHCHR AND UNAIDS, HIV/AIDS AND HUMAN RIGHTS INTERNATIONAL GUIDELINES, *supra* note 110.

304. *Id.*

sessions about the destination country's background and the terms and conditions of their contract. For instance, in giving the background of a destination country, a discussion on the people and place can emphasize the possibility of experiencing loneliness and isolation such that intimate relationships may develop that women never anticipated. Addressing this problem can include the importance of not engaging in risky behavior that would expose them to the possibility of contracting HIV/AIDS. The terms and conditions of their contracts should be explained thoroughly in order for the women to be aware of their duties and obligations, and more importantly, so that they know about their rights and benefits pertaining to medical and health services. Knowledge about their rights is an empowering strategy to facilitate their accessing available services and facilities on-site.

A rights-based approach in explaining the importance of knowing what they are entitled to, and what they can claim under their contracts and the applicable laws or policies in their destination country, is also a crucial strategy especially in the light of the tendency among Filipino migrant workers not to prioritize their health and just practice self-medication.

As far as identifying the needs of the women in order to effect risk reduction to HIV/AIDS, their voices should be heard and the seminar must have a facilitating environment in order to ensure their participation in identifying the concerns and issues which need to be addressed; and in arriving at solutions that best suit them, given their assessment of the risks and their capacity to address the same.

4. Women's Rights Education in Schools

The *AIDS Law* provides for HIV/AIDS education not only to OFWs but also in schools. However, as this Article has shown, gender empowerment is crucial in addressing the underlying conditions of women's vulnerability to the disease. Hence, this Article recommends that women's rights be integrated in the curriculum of secondary education (high school) just like the rights of the child.

As opined by Gupta, gender-sensitivity is a good approach, but it would not suffice for the purpose of changing the power balance in gender relations.[305] Women should learn about their rights to equality – both formal and substantial – in school, with the end in view of addressing gender constructs that perpetuate their inferiority. The right to health – particularly reproductive and sexual health of women – should also be incorporated, since it is in these areas that women's needs have been found as unmet. Beyond the concern for the ability to exercise sexual autonomy, are also the general reproductive health concerns of women which must be brought to

305. *Gupta*, *supra* note 134.

fore in order to emphasize that heath is a human right; and that it encompasses "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[306] Among Filipinos, there is a general conception that if one is not suffering from a serious illness, then he or she is healthy.

Thus, for pre-departure seminar to realistically achieve gender empowerment in HIV/AIDS education, it would be desirable if both basic information on the disease that is discussed within the context of reproductive and sexual health, and women's rights were given prior to pre-departure seminar. In this way, the women would have already acquired information on HIV/AIDS' nature, mode of transmission, and causes and prevention by the time the seminar is conducted; and a perspective of their own vulnerability as women.

5. Other Orientation Seminars

a. Pre-Employment Orientation Seminar

Seminars conducted under this program were started in 1991 but discontinued, and then restarted again in 2002.[307] The government should start looking at the potential of the Pre-Employment Orientation Seminar, as a complimentary tool to gender empowerment of women migrant workers and HIV/AIDS education. To be truly complimentary to the pre-departure seminar, this program should not only emphasize prevention of illegal recruitment but also focus on the social aspects of migration and introduce the process of gender empowerment by starting to address the underlying causes of women's subordination, especially in terms of how such subordination could affect their vulnerability to HIV/AIDS. The seminar should also emphasize that health is an important aspect in their lives as migrant workers and, therefore, they must not take it for granted and avail of the services and facilities on-site in order to maintain their health. This is also a good outlet for information materials which the DOH has published for dissemination on reproductive health concerns of women such as Women's Common Complaints, Breast Self-Examination, Reproductive Tract Infection, Menopause, Sexual Harassment, Sexual Assault and Domestic

306. *Programme of Action of the International Conference on Population and Development*, *supra* note 52, chap. VII, § 7.2.

307. Ricardo R. Casco, *Good Practices Documentation and Sharing Project*, *available at* http://www.hiv-development.org/text/Philippines_GPD/GPD_Document.pdf (last accessed Jul. 30, 2005).

Violence.[308] The pre-employment seminar must also be made a pre-requisite to the pre-departure seminar.

b. Post-Arrival Orientation Seminar

One of the recommendations made recently by Director Ricardo R. Casco, the POEA Focal Person on Philippine Migration and HIV/AIDS Vulnerability is to integrate reproductive health/HIV/AIDS in post-arrival orientations whenever the foreign posts in destination countries conduct these seminars. He also suggested making use of existing structures on-site for health education to facilitate implementation of such endeavor and to make it sustainable. This Article agrees with these recommendations and additionally suggests that the use of condoms, both for males and females, be reinforced in the post-orientation seminars and their availability ensured. This Article further suggests that the seminars be conducted as much as possible in destination countries where there are heavy arrivals of women migrant workers. These foreign posts should also make available information materials on HIV/AIDS and other reproductive and sexual health concerns, especially of women such as those distributed by the DOH.

c. Support from Philippine Diplomatic Posts

One of the services offered by the foreign posts is counseling, which has been generally focused on distressed migrant workers who have encountered problems with their employers. As of late, a primer has been launched through the support of UNAIDS, which is intended to guide Foreign Service Personnel on how to counsel migrant workers on HIV/AIDS issues.[309] No information can yet be gathered on its actual use. The guidebook, however, suggests that an environmental scanning be made in order to identify individuals and entities that can provide HIV/AIDS-related services.[310]

This Article recommends that the environmental scanning done by the foreign posts extend in general to health and medical facilities and services where the women migrant workers can go without suffering discrimination; and where they can consult with women health care providers, preferably in

308. *See* Safe Motherhood and Women's Health, Women's Health and Development Program IEC, *at* http://www.doh.gov.ph/safemotherhood/safemotherhood_alpha_smdp.htm (last accessed Jul. 30, 2005).

309. The guidebook entitled *Positive Response: A Guidebook on Handling Migration and HIV/AIDS Issues for Foreign Service Personnel* was published by ACHIEVE and launched late last year. It was intended to be disseminated to foreign posts. No feedback as of this writing can be gathered on its actual utilization by them.

310. APILADO, *supra* note 13, at 33.

their own language. This need to be able to consult with HIV/AIDS counselors in their native language, including the possibility of taking HIV tests any time, has already been voiced out by entertainers in Japan as early as 1997.[311]

In some destination countries, medical consultations within the embassy premises are already being conducted on a regular basis through the Philippine Overseas Labor Office (Labor Office) and the Welfare Administration.[312] In Riyadh, KSA, in particular, the Labor Office when necessary refers the workers to government hospitals and clinics for further medical attention or hospitalization. It also holds consultations specifically for male migrant workers.[313]

This Article recommends that this practice be replicated in other countries, especially the institutionalization of the referral system in order to ensure access to health and other medical services by the women migrant workers, as regards their reproductive health and HIV/AIDS concerns.

CONCLUDING STATEMENT

Amidst all these, however, the government should not lose sight that the most effective protection to migrant workers is to provide the conditions where migration for work will once again be merely an option for the Filipinos and not a necessity. To achieve this, it should prioritize its agenda on poverty alleviation and have the political will to effect the necessary changes in bringing about equal distribution of opportunities and resources to the people. This is a daunting task for any government, but must nevertheless be achieved, because in the end, it is the most viable alternative to migration.

311. PORIO, TRAFFICKING IN WOMEN TO JAPAN, *supra* note 104, at 44.

312. *See* Philippine Overseas Labor Office, Medical Assistance/Hospital Visitation, *at* http://www.eacomm.com/polo/report-btn.html#1 (last accessed Jul. 30, 2005) (the foreign posts mentioned to have medical consultations and other services on a regular basis are in Riyadh, KSA, Brunei and Rome, Italy).

313. *Id.*