

Volume 10 Number 1 November 2011

PHILIPPINE
POPULATION

REVIEW



PHILIPPINE POPULATION ASSOCIATION

The PHILIPPINE POPULATION REVIEW (PPR) is the official journal of the Philippine Population Association (<http://ppaphils.blogspot.com>) and is published annually. A peer-reviewed journal, PPR is listed in the Philippines Journal Online (<http://www.philjol.info>) and Ulrich's Periodicals Directory (<http://www.ulrichsweb.com>).

PPR seeks to strengthen the evidence-based discourse of population issues confronting the national, international and global communities. It provides a forum for the conceptual, methodological and empirical quantitative and qualitative analyses of the vital events of human population—fertility, mortality, morbidity and migration—including their movements, interrelationships, complexities, consequences and impact. Its scientific information base is expected to help improve population and population-related policies, programs, teaching and research, towards enhancing the quality of life and well being of all.

ISSN 1655-8049

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This special issue of the Philippine Population Review (PPR) featuring research on HIV is a joint project of the Philippine National AIDS Council (PNAC) Secretariat, the AIDS Society of the Philippines (ASP), the Philippine Population Association (PPA), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Philippines.

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VOLUME 10 NUMBER 1 NOVEMBER 2011

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A SURVEY OF RISKY BEHAVIORS AMONG EMPLOYEES IN OFFSHORE BUSINESS PROCESSING CENTERS

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ABSTRACT

There has been a dramatic increase in reported cases of HIV in the Philippines in recent years, veering away from so-called “low and slow” epidemic. The increase in new cases has focused on call centers that employ less than half a million young people in Metro Manila alone. We conducted a qualitative study to take an in-depth look at shiftwork, socialization patterns and sexual lifestyle that influence health status among young urban professionals particularly their vulnerability to HIV. A total of 10 focus groups and 15 in-depth interviews were conducted among young employees from 20 Business Process Outsourcing (BPO) centers in Metro Manila. We explored AIDS-related knowledge and risky behaviors of young employees and asked their recommendations on workplace health program. Knowledge about HIV/AIDS was found to be inadequate, and risky behaviors were described as common. A total health package at the workplace that embeds AIDS awareness intervention is recommended.

KEYWORDS: *workplace, HIV, young people, health, sexual lifestyle, shiftwork*

SEXUAL LIFESTYLE AND RISK FOR HIV AMONG YOUNG EMPLOYEES IN THE PHILIPPINES

The overall picture of HIV in the Philippines has changed its course in recent years. Based on the Department of Health - National Center for Disease Prevention and Control (DOH-NCDC) data, HIV prevalence has been rapidly increasing. In 2007, one new case was reported everyday; in 2009, two new cases were reported daily. This is in contrast to the 2001 figures that showed only one new case reported every three days.

Evidently, young adults in the age ranges of 25-29 years and 30-34 years are at heightened risk, as shown by the breakdown of current cases into age groups: 20-24 years (18%), 25-29 year (25%), and 30-34 years (19%) (National Epidemiology Center [NEC], 2011). Over the 16-year period of 1995-2011, 20 percent of the reported HIV cases were in the 20-24 years while 26 percent were in 21 to 29 age range (NEC, 2011).

In the previous decades since HIV reporting began, the spread of HIV was attributed mainly to heterosexual contact. However, in recent years there has been a shifting of transmission from heterosexual contact to homosexual and bisexual contacts. The latest NEC data of June 2011 showed that bisexual transmission accounted for 43 percent of recorded cases while homosexual transmission accounted for 40 percent. Manalastas (2006) found that among sexually active young men in 2003, 15 percent had male-to-male sex (MSMs), of which 40% were 15-24 years of age.

YOUNG EMPLOYEES IN CALL CENTERS

Next to India, the Philippines is Asia's second largest provider of outsourcing services to North America, Canada and Australia. In 2010, call centers provided 344,000 jobs and employed roughly 540,000 employees (Eruma, 2011). Almost all employees are recent college graduates with a mean age of 26 years. Employees who work in call centers are called agents. Call centers are defined as centralized physical locations that answer incoming telephone calls from customers and these calls are generally received in high volume (IBON, 2003). While the industry is concentrated in Metro Manila, new call centers are being established in key cities such as Cebu, Davao and Baguio.

Majority of call centers assign their agents to three to four shifts to cater to the time zones of overseas clients particularly in the United States. As such, young men and women who find employment in this sector, expectedly come to work during the evening shift. The conditions of work offered in call centers are relatively attractive to the young workforce because of high salaries at entry point (Hechanova, 2010). However, there are important concerns raised by young employees such as the impact of night work on their socialization with friends and bonding with family members. The negative effects of shift rotation on the general well-being of employees were studied previously (Hechanova, 2010; UPPI, 2010). Hechanova cited inadequate exposure to natural daylight, bad diet, lack of sleep, unhealthy smoking and drinking habits as among the negative outcomes of shiftwork. The University of the Philippines Population Institute [UPPI] (2010) similarly found high consumption of alcohol cigarettes, coffee, and food with high fat content among call center employees. Other studies on a smaller scale focused on specific health issue such as nutritional status (Adala, Bolingit, Echon, & Vinluan, 2007), prevalence of musculoskeletal disorders (Alfaro, de Leon, & Guieb, 2005), ergonomic stresses and reproductive health problems (Occupational Safety and Health Center [OSHC], 2006) and sleep patterns and daytime sleepiness (Ho, Ples, & Sia, 2008; Palabay & Jorge, 2007).

HIV RISK AMONG NIGHT SHIFT WORKERS

In 2009, a survey of young call center employees was conducted with a purposive sample of 650 call center agents from 20 Business Process Outsourcing (BPO) companies in Metro Manila (Melgar, Ofreneo, Kintanar, & Canoy, 2009). Results showed that of the 334 male respondents aged 15-39 years, 72 percent had sex with a female and 48 percent had sex with a male. Among female respondents, 8 out of 10 were sexually attracted to the opposite sex. Among respondents less than 25 years old, 9 of 10 males and 7 out of 10 females have had sex. In general, more males had multiple sex partners than females. Half of the males and a third of the females were under the influence of alcohol while having sex for the past three months. Condom use was low and inconsistent.

The study also found that technology frequently mediated the face-to-face mode of initiating and sustaining frequency of social interaction. The

internet was used for finding and meeting potential dates. Commonly used platforms were chat rooms, social networking site and dating sites. Joining online games was also reported as an alternative way of making dates. Two out of five agents used text messaging for interacting with casual acquaintances and partners. The study also found that more men than women use cyberspace and cell phones for networking and dating. Respondents likewise reported that they often relied on the internet when they wanted to get more information about HIV and STIs. The other sources of information for HIV were television, books, magazines and textbooks.

In 2010, the University of the Philippines Population Institute conducted a lifestyle study among call center employees and compared this with a comparable group of non-call center employees. It focused on general consumption, expenditures and savings, diet, sleep, sex-related behaviors and leisure activities of these employees. Call center respondents had higher prevalence of casual sex, early sexual debut, and premarital sex. The study hypothesized that in this context, sexual risk behaviors such as prevalent unprotected casual sex may be due to two factors. One is the effect of the unconventional work hours, which encourages close camaraderie among co-workers who have common leisure time in contrast to the hours of other workers. The second factor has to do with higher pay of call center employees that affords greater access to bars, out-of-town trips and other forms of entertainment. In general, the practice of unprotected sex was significantly higher among casual sex and with non-romantic sexual partners. Only 45% of respondents gave correct answers to all five questions on HIV transmission following the United Nations General Assembly Special Session (UNGASS) recommended indicators of knowledge about HIV prevention.

From November 2009 to January 2010, the Philippine General Hospital conducted voluntary HIV testing among 406 male respondents and found that 12 percent were HIV positive. More than half (26 male respondents) of those who tested positive were call center agents (Ruiz, 2010).

OBJECTIVES OF THE STUDY

The three surveys on workers in BPO centers cited above and their results showing vulnerability to a host of sexual and other health problems prompted us to conduct a qualitative study to acquire a deeper

understanding on the extent to which young people put themselves in sexually risky situations. Nightshift work appears to create a social environment that increases the vulnerability of young employees to sexually risky outcomes like HIV.

The specific objectives of this study are: (1) to identify and understand the sexual risk behaviors of young employees in call centers; (2) to explore perceptions, attitudes and practices in relation to intimate sexual relationships; and (3) to assess interest in and describe desired components of workplace AIDS prevention interventions. Through interviews and focus group discussions, this study explores commonalities, as well as diversities, of experiences and perceptions among participants of this target group.

METHOD

Participants

A total of 86 young professionals working in Metro Manila participated in the study. Before the FGDs and interviews started, the research team sought the approval for the study protocol from the National Ethics Committee of the Department of Science and Technology and the University of California San Francisco Committee on Human Research. The criteria for participation to either FGDs or interviews were that participants should be within 20 to 30 years of age and currently working in a BPO company. All participants were asked to sign an informed consent form before the start of either the FGD or the interview. Participants who are Men Having Sex with Men (MSM) were identified through the demographic profile sheet that all participants completed before the start of either FGD or interview.

A total of 10 focus group discussions were conducted. The FGD participants were recruited through purposive sampling. The top management officers of three companies verbally agreed to our request and asked its available employees and managers to join the three FGDs. The remaining seven focus groups were arranged through the help of two research assistants who had personal contacts with call center agents. The mean age of all the FGD participants was 24 years, and the age range was 23 to 30 years. There were 19 female participants and 32 male participants; of the male participants, 22 were MSM. FGD participants obtained at least high school diplomas and college degrees. All were working on nightshifts except for one group of five women.

In terms of job position, eight of the 10 focus groups were composed of junior employees while two groups were composed of managers and supervisors. In terms of gender composition, there were three FGDs with female participants, two FGDs with male participants, two FGDs with MSM participants and one mixed with male and MSM participants.

On the other hand, the interview participants were recruited through snowball sampling. In all there were 15 interviewees who came from seven call centers. The mean age was 24 years, and the age range was 21 to 29 years. Of the 15 participants, two were high school graduates, four had post secondary short course certificates, and the rest were college graduates. There were seven MSMs, five females, and three males. All were working on night shifts.

Measures

We administered a questionnaire on demographic background to the participants before starting either the FGD or the interview. All the researchers were briefed on the questions to be asked during the FGD and the interviews.

The FGD guide questions revolved around several domains namely the work experience of participants at the BPO centers, work-related stress, health issues, dating and sexual relationships and general issues related to HIV and AIDS.

The in-depth interview guide questions consisted of ten open-ended queries about working in a call center, dating and sexual relations, and HIV and sexually transmitted infections (STI). The interview guide questions were pretested on two call center employees who were also part of the sample.

Procedure and Data Analysis

Six researchers facilitated the 10 focus group discussions (FGDs). These were held in various venues within Metro Manila. All the participants received a consent form and an information sheet that provided general objectives and importance of the study, length of FGD or interview, risks involved and assurance of confidentiality. The FGDs were conducted after participants completed the information sheet, read and signed the consent form. One researcher facilitated the FGD while another was assigned as observer/documenter.

The interviews were arranged through the assistance of two researchers who had personal contacts with the target participants. Interviews were conducted by the researcher after shift hours and outside of the office.

To analyze the qualitative data the research team, with the help of seven Psychology students, conducted a thematic analysis of the FGD and interview transcriptions. Common themes across all data were then identified and discussed.

RESULTS

The primary themes that emerged from this study were: (1) dating and sexual relationships; (2) awareness and attitudes about HIV and AIDS; and (3) AIDS awareness strategies in the workplace. To provide context, secondary themes such as the BPO as a workplace and its health implications are explored.

BPO as a workplace

Participants described working in a BPO to be fun and the “in” thing to do. Apart from salaries, the informality and youthfulness of the organization were the main reasons that attracted many young people to this sector. Through their work, they met peers, officemates with same sex orientation and acquaintances with similar interests.

As someone who is gay, I feel more accepted in this industry because majority are gays. People here are more open-minded about things you can't normally do outside. I can have a crush on anyone because it is acceptable. (Male agent)

In a typical corporate setting, you come to work daytime and obligated to wear office attire... they would expect you to be a traditional employee...I can't grow my hair. (Male agent)

The BPO is one industry that provides a decent paying job for recent college graduates and undergraduates as well. According to one manager, the starting salaries ranged from P15,000 to P25,000 depending on the experience of the agent. Other companies paid low salaries but offered better incentives like bonuses and allowances. An agent from a large

company recounted a list of benefits he received such as transportation allowance, voice allowance, night differential of around 15 percent to 20 percent of basic salary, performance incentives and life insurance. Among the benefits, the health card was most valued by participants. Salaries usually were spent on gimmicks, travels, gadgets, shopping, dates, and support for the family.

Health Implications

Participants reported that coping with working on nightshifts was a major challenge. Many expressed concerns over their physical health mainly attributing to sleep deprivation and the nature of their work. Many participants complained about being unable to sleep and forcing themselves to sleep through the day. When they are at work, some reportedly have to fight off drowsiness. A few said that they only slept two to three hours a day. A male interviewee exclaimed, “Like four hours is yehey!”

Ang hirap kasi matulog sa umaga especially na dito sa Philippines na napaka-init, unless na may aircon ka sa bahay, ang hirap din talagang mag-adjust na yong natutulog ka na may liwanag. (I find it difficult to sleep in the morning because it's very hot in the Philippines unless, of course, you have an air conditioner in your house. It's also difficult to sleep if it is too bright) (Male agent)

Inadequate sleep during the working week was perceived to lead to other consequences that have negative impact on their health.

We lack sleep and our eating habits are out of whack. People in the call center, they tend to be obese. Because what we do right after work is... we catch up on sleep, so we don't get much of exercise because uhm... once we go to out of work, we sleep, and then we get up, we go back to work... And what we lack in sleep, *binabawi sa kain*. (We lack sleep and our eating habits are out of whack. People in the call center they tend to be obese. Because what we do right after work is... we catch up on sleep, so we

don't get much of exercise because uhm... once we go to out of work, we sleep, and then we get up, we go back to work... And what we lack in sleep, we compensate by eating.) (Female manager)

There were also some healthy habits that changed dramatically because of stress, work pressures and nightshift schedule. They observed that they tended to snack on chips and other junk food, smoked more cigarettes and drank more alcohol.

Speaking for myself, I mean, my smoking habits got worse when I worked in a call center. I used to smoke, what, 2-3 sticks a day. Now I consume half to one pack a day. (Male manager)

After *ng shift, diretso inom.*(After my shift, we'll go and drink alcohol.) (Female agent)

Health issues also included voice or throat problems, eye strain, lack of exercise and common colds and cough.

'Yung sa eyes, ganun. Kaya-kasi kanina nagpapa-annual check up kami, so na-findings lang na medyo malabo na daw yung mata ko sabi. Dahil lang siguro sa radiation ng computer, since four years na akong nakatututok sa computer. (The eyes. We've undergone our annual check up a while ago and we found out that my vision is starting to blur. Maybe it's due to computer radiation since I am always in front of the computer for four years now.) (Female agent)

Tapos break nanaman, kakain nanaman. Kaya siguro maraming nagtatabaan sa call center. Kaya lumobo ako ng ganito. Tapos, pagkakain mo, uupo ka nanaman for eight hours. (Then, it's break time again, I'll eat again. Maybe this is the reason why many call center agents become fat. This is why I became this fat. After you eat, you'll sit down again for eight hours.) (Female agent)

Apart from the adverse effect of the work shift on the body, nightshift workers also expressed a type of health-related stress they encountered before, during, or after work. For most voice agents, they complained about having to deal with irate foreign customers.

Dating and Sexual Relationships

We probed about social interactions within the BPO as a workplace, the meaning of dating, forms of dating, and casual sexual relationships. In this section, we classified the examples according to the sexual orientation of the agent being quoted. The MSM agents, for example, revealed distinct patterns of dating and hooking up with men.

On the subject of dating, the individual interviews and the FGDs revealed a relative agreement on what dating meant. Participants said that in general, the traditional meaning of dating was a “getting to know” process. Dating meant going out in groups or in pairs. It meant eating out, watching movies or joining group night outs.

Whereas the term “dating” conventionally implies a process between opposite sexes towards the possibility of a relationship or marriage, its current definitions among MSM participants seem to be more complex. The meaning of dating from the MSM perspective deviated from this traditional concept to something that had more sexual connotation. For the MSM participants, traditional dating is not applicable to their social world. As one interviewee commented, “If you say dating, it is not appropriate to use the term for a man going out with another man.” There were more appropriate terms being used. The term “date” is more differentiated and less generic. For example, one’s “date” could be a fucking buddy or FUBU¹, fucking buddy who is ugly or *FUGLY*², a young *boylet*³, a steady *johwa*⁴, a one-night stand⁵, or a sideline⁶. The gradation of relationship becomes more and more sexually differentiated as it veers away from the generic meaning of a date. One participant succinctly described how it would become more complicated: “You are my boyfriend when I am in the bar, ‘cause you’re always there. And when I get there, you are my partner. And when we get outside, no more.”

Among straight heterosexual men and women, there were allusions made to monogamous and non-monogamous relationships that characterized

ongoing relationships. Thus, some relationships were described as closed and exclusive, open or multiple; some were described as complicated. Depending on the nature of a relationship, a partner may be a boyfriend or girlfriend, a fling, a friend with benefits (FWB)⁷, and many others.

Most participants, particularly the straight males and females reported that they met their partners through friends, friends of friends, or through the office. Interviewees and FGD participants shared different stories about how a casual acquaintance at work could develop into a sexual relationship.

Pagstart pa lang ng day na nag-work ako dyan meron akong pinag-buddy sa akin ng ka-team ko. Yung TC (Team Coach) namin, kasi siya na yung magaling sa amin so dun ako hanggang sa naging close kaming dalawa. Wala na, may nangyari na sa amin na hindi ko na alam. (They assigned me a buddy when I began working. Our TC (Team Coach) happens to be the most competent in the team so I was assigned to him. From there, we became close and then things happened.) (Female agent)

It's like changing shirts. You'll see them with one shirt now and it depends. It's because your shift changes, your co-workers, your seatmates change...sometimes *pinapasa sa ka-shift*, endorsement. (It's like changing shirts. You'll see them with one shirt now and it depends. It's because your shift changes, your co-workers, your seatmates change...sometimes they "give" the person to another agent with the same shift, like an endorsement.) (Female manager)

For both gays and male heterosexuals, sexual liaison could start out with a dare, a peer challenge or a light joke from officemates and friends.

Actually sa gays, naguumpisa sya as a joke. Joke lang, joke lang talaga... like po, kunyari, halimbawa, type niya si guy. Tapos magkakaran ng tuksuhan, tuksuhan. Parang ipapaalam mo in public na "crush ko siya". (For gays, it starts as a joke. For instance, if he likes another guy, his officemates will start to tease them. It's like letting others know that he likes him.) (Female manager)

The social networking sites, chatting, and texting among participants, were commonly used in meeting up dates. MSM participants preferred on-line modes of hooking up because they found this safe and discreet. However, face-to-face meetings or eyeballing reportedly complemented these internet platforms.

It's so rampant. *Makipag-chat ka lang, makipag-text ka lang, tomorrow may ka-sex ka na.* (It's so rampant. Just chat or text and tomorrow you'll have a sex partner.) (Female agent)

Sa chat, back in 2005, ang trend is kami-kami lang magkikita 'yung mga ano, mga discreet. Mga mukhang lalake, maghuhook-up. Ayaw namin ng parlorista. Ayaw namin ng effeme. After 3 years, aba ano na, sa chat di na exclusive. Meron na ring transsexual. And then may naghahanap din ng bayaran. And mayroon ding mga masseurs, who offer extra service. Nag-iba yung pattern. (The trend in 2005 was through chat, closet gays meet and hook up. We don't like effeminate gays. After 3 years, it wasn't exclusive anymore. There are transsexuals. There are those who look for people who get paid for sex. And there are even masseurs who offer extra service. The pattern has changed.) (MSM agent)

We probed on the issue of multiple partners among young people at work. We asked whether this was rampant and whether this happened across genders. FGD participants and interviewees, males and females alike, were quick to confirm the practice of open relationships and temporary multiple relationships among peers.

Nagiging past time lang siya talaga. O kaya may hinahanap ka sa asawa mo or sa partner mo na hindi mo nakikita ngayon na nakikita mo sa iba, so hanggang meron iko-consume mo. Pag wala na rin, babalik... Hindi siya tumatagal, bibihira lang po yung talagang tatalaga. (It becomes a past time. Or maybe you are looking for something that you cannot find in your partner and you see it in another person. So you consume it but when it

eventually dies out, you'll come back. It does not last long. Only a few last long.) (Female manager)

Yung dati kong boss. Married na yung babae, single yung boss ko, pero they're playing. Hindi rin kasi maiwasan yung ganun...yung boss ko is single, yung babae na agent is may asawa. (My previous boss. The woman is married and my boss is single but they are playing. It's difficult to prevent these things from happening.) (MSM agent)

Pero pinaka-common ngayon is gay-to-gay relationships tapos meron ding boyfriend mo, boyfriend din nung isa. I don't know, sharing? (The trend today is gay to gay relationship. There are also cases where your boyfriend is also a boyfriend of another person. I don't know, sharing?) (Female agent)

I had boyfriends na executives and they have wives. I don't mind. I'm getting what I want. (Female agent)

The next question we asked was, "If sex is so rampant, where do people have sex?" Participants named places such as sleeping quarters at the office, office floor, toilets, parking area, park, house, snooze box, motels, anywhere "*basta libre*" (as long as it is free) and other convenient venues.

However, some participants particularly women, still held conservative values about keeping a relationship that is long lasting and faithful. A few were emphatic in saying that family values have kept them from engaging in pre-marital sex. In contrast, family values, for others, did not protect young people from engaging in sex.

Lagi ko po iniisip ano ang sasabihin ng family ko, ano po ang mangyayari sa akin kapag ginawa ko yun, yun po talaga lagi ang motivation ko. (I always think about what my family is going to say about me and what will happen to me if I engage in such things. These are my primary motivations.) (Female manager)

She was actually afraid at first because she's still in the first year of college and she was actually looking to making sure that she do everything correct. She was really surprised that she will do it. I

mean, to think that she came from , like, a very, what you call this, ahh... ahh... strict family, very Filipina, so they're not into young relationship or engaging into that activity. So, she was surprised herself that was able to do that with me. And to think that we don't have any relationship at the time. (Male agent)

Awareness and attitudes about HIV and AIDS

Participants reported that AIDS and sex are never talked about at the level that informative exchange is possible.

Parang it's ...it's a myth... parang kasalanang pag-usapan about it. (It is like... a myth. Like it is a sin to talk about it. (MSM agent)

It's really a private matter, almost taboo. (Male agent)

Ewan ko nga sa pamilyang Pilipino kasi hindi naman napapag-usapan yung sex... Wala yan, wala sa bokabularyo ng pamilyang Pilipino yung sex. (I don't know but Filipino families don't talk about sex. Sex is not in their vocabulary. (MSM agent)

Many participants admitted that they did not know enough about the nature of AIDS but they knew that the virus could be transmitted sexually and that it was fatal. Many recognized AIDS as a problem in the country. The negative feelings associated with the disease were quite strong. They believed the public looked at persons with AIDS with blame and disdain. We also heard several stigmatizing remarks against people living with HIV.

Siya kasi hindi nag-iingat. Siguro, itong tao `to, flirt siya kaya nagka-kakuha niya yan. (That person is not careful. Maybe that person is flirtatious that's why s/he was infected) (Male agent)

Walang cure. Ayun yung nakakatakot. Nakakatakot siya na parang unti-unti kang pinapatay. Parang, ay nakakatakot. At the same time, tingin sila ng mga tao, nakakadiri ka. (There is no cure. It's scary because it kills you slowly. At the same time, people will think that you are disgusting.) (Female agent)

Mamatay na lang siguro ako sa ibang kaso, sa ibang sakit, wag lang yun. Kasi pag-uusapan ka nun eh. Yung pangalan mo nakamarka yun. (I'd rather die due to a different disease. Not AIDS. Because people will talk about you, it will be associated with your name.) (MSM agent)

However, during the individual and group interviews, we were confronted with curious questions desiring answers and confirmations from us.

Is it airborne? (Male agent)

Is there a cure? (MSM agent)

How about the saliva, it –well let's say you have HIV and then your saliva applies to me, do I already have HIV? (Male agent)

It came from a monkey? Magic Johnson? The disease of prostitutes? (Male agent)

Pareho ba STD sa HIV? (Is STD and HIV the same?) (Female agent)

Participants and interviewees gave diverse views of who were at risk and who should get tested. One manager believed that men were at risk because “they have more experience about sex.” He thought that men had a higher chance of carrying the virus than women. MSM participants believed that they were at risk for HIV and they worried about the younger MSMs. Women pointed their fingers at men who were perceived as more promiscuous. In spite of this observed risk, not everyone avail of HIV testing. The reasons varied from fear of diagnosis to apprehensions about breach of confidentiality. It was important for the participants to receive social support like that from friends when they need to go for HIV testing. The anxieties towards getting the test results were commonly expressed.

I am afraid. I don't wanna face sudden realities... because people who are positive or who have AIDS, have lost support from their families. I don't want that to happen to me. (MSM agent)

Feeling ko naman wala. I don't even know the symptoms. *Pero ayaw ko na malaman kasi baka mamaya maparanoid ako.* (I feel that I don't have it. I don't even know the symptoms. I don't want to know because I might get paranoid.) (MSM agent)

When participants were probed on how and who should get HIV testing, different opinions came out. Some felt it should be mandatory to all employees. Some discussions led to the need to cover different groups like teenagers, young couples and parents because they felt they were not the only ones who were at risk. MSM interviewees were worried about sexually active adolescent MSM whom they perceived as more vulnerable. While some opined that the employer should subsidize testing services, they preferred that the testing be done outside the company because of confidentiality concerns. Quite a few did not feel they should shell out personal money to undergo testing.

Siguro isama nila sa annual check-up. (Include it in the annual check up.) (Female agent)

School maybe? Or office. Well if they're going to test *yung mga* kids or *yung mga* teens, young yuppies, might as well test the old ones... some of the parents are so liberal. (School maybe? Or office. Well if they're going to test kids or teens, yuppies, might as well test the old ones... some of the parents are so liberal.) (Female agent)

Consistent use of condoms remained a challenge. Condoms were not consistently used as the relationships evolved into something more serious and steady. One participant did not believe that condoms could give total protection. None of the participants and respondents mentioned about the influence of the Catholic Church on their negative attitudes on condoms.

“Uhm, I—I just don't think it's safer. *Kasi parang* it's so uncomfortable using *yung mga* types of con-, contraceptives. (Uhm, I—I just don't think it's safer. It's like it's so uncomfortable using different types of contraceptives.) (Female agent)

Participants had little or no knowledge about treatment and care for people with HIV. Some non-pharmacological or sometimes non-traditional treatments were brought up to prevent transmission.

I have no idea how people are treated with HIV because I don't have enough knowledge on that sickness. (Male agent)

Tide powder, mix it with hot water, then drink. Or coconut juice, mix with soap. (Male agent)

Participants were also unaware of company policies about employees who are diagnosed with HIV.

AIDS Awareness Strategies in the Workplace

Managers felt that the best way to inform people of HIV is through the internet. However, one agent who faced the computer all day long opposed this suggestion, "*Computer na naman? Sirang sira na ang mata ko.*" (Computer again? My eyes are already damaged.)

According to one group, advertisements and media campaigns would also be helpful. The discussion provided by our FGD was also cited as a useful forum. An open seminar where attendance would be voluntary rather than mandatory might work with young people. Others, however, felt that it should be compulsory.

Participants cautioned that seminars should not be preachy. The messages should catch the interest of the young audience. Demonstrations, colorful visuals, stimulating pictures should be used. Seminars should be interactive. Providing freebies might work. Flyers should be handed personally to the person. People would not read if papers were just left in a corner according to one participant. Relating the issue to an experience that is easily relatable, like the sharing of information through social networks, has been suggested a strategy that may gain momentum on its own. Also, in the discussion, the inadequacy of the government to deal with the AIDS problem was cited.

Further suggestions included having an interesting mix of resource persons such as a doctor or a person of authority, a person living with HIV, and an entertainment personality in any public information campaign. A peer educator could also be equally effective.

Like if kagaya ni Vice Ganda, if you watch Showtime, kahit walang sense yung sinasabi nya, may times na makikinig ka. (Like Vice Ganda, if you watch Showtime, even if he talks nonsense you'd still listen.) (MSM agent)

Parang kainan lang tapos maya-maya, drinking session. And then may information. (Like a luncheon then a drinking session afterwards. And then information.) (MSM agent)

Kasi kapag, kapag parang HIV versus showtime. Showtime ka na lang. (If it's HIV versus showtime. I'll choose showtime.) (MSM agent)

Why don't you have an STD party? Something like that. (Male agent)

Leaflets? No it's not effective. Cause I'm going to, just stressful, you know. *Makalat lang yon.* Text brigade. It's effective because many Filipinos are using cellphones. (Leaflets? No it's not effective. Cause I'm going to, just stressful, you know. The leaflets might just end up being thrown away. Text brigade. It's effective because many Filipinos are using cellphones.) (MSM agent)

Well you can make an awareness, concert *ka*, after that *pag nagiinuman magsesex pa rin yan* after and they're gonna you know, make fun out of it. (Well you can make an awareness, organize a concert, after drinking they'll still going to have sex. They're gonna you know, make fun out of it.) (Female agent).

DISCUSSION

This study explored the nature of working in a BPO by looking into some of the social patterns and work challenges call center agents faced. It identified the sources of physical and environmental stresses at work; the health consequences of these stressors; the prevailing patterns of dating and sexual relationships among male, female and MSM groups; the level of awareness about HIV and AIDS and finally the recommendations of participants on how to increase AIDS awareness at the workplace.

We discovered a number of factors and unique work situations that made young BPO workers more vulnerable to HIV and other lifestyle diseases. First, we found that we have a group of predominantly single, young people at work who are experiencing some stress in and out of work; whose usual socialization patterns and health lifestyle are disrupted by their work schedule; and whose social activities may be confined to a circle of officemates. Second, the popular modes of releasing stress after work is no longer through exercise or through some traditional stress relievers. It appeared that casual sex, cigarette smoking, and alcohol use or other group gimmicks foster the sense of feeling good and feeling relaxed after a stressful day. Third, the practice of open and uncommitted relationships among young professionals provides us a striking picture in the shift in meanings of dating and intimate relationships among call center agents.

Pre-marital sex, multiple sexual relationship and unprotected sex were among the behaviors reported by the participants and respondents of this study. We also found the significant role of social networking and cell phones in meeting the relational and sexual needs of young adults today. It is the technology that provides a rapid mode for facilitating the spread of the AIDS virus for this particular group of people in the Metropolitan area. The same technology, however, can be used to provide solutions to these problems it has caused. The cost of investing in an AIDS awareness program for this target sector is much lower.

Furthermore, knowledge about HIV and AIDS was not adequate. This is corroborated in our previous survey of call centers (Melgar et al., 2009) which reported an AIDS awareness of 80 percent, and the survey conducted by UP Population Institute (2010), which showed that only 45 percent of survey respondents had comprehensive knowledge about HIV based on the UNGASS indicators. A more in-depth discussion of AIDS revealed that many participants were still in doubt about their current stock of knowledge and we realized this by the numerous questions we received during the FGDs and interviews.

CONCLUSION

We found through this study that the confluence of age, income, mobility, work structure and environment, technology, and a permissive youth culture prevailing in BPOs are all significantly influencing the vulnerability of call center agents for HIV infection.

It appears that there is a need to think about more creative ways to impart essential information to this target group with this background and context. The strategy should be able to compete with all the other information and new knowledge that catch the attention of young people today. The effective platform for AIDS education must go beyond the traditional means using the standard information and educational materials and face-to-face seminars. It must consider new modalities and technology in order to effectively reach out to specific groups of young people or professionals.

Currently, there is no existing systematic HIV and AIDS prevention program in the workplace. The results of this study banner warning signals that this health issue is not to be taken lightly, and that it is not enough to just focus on HIV and sexually transmitted diseases in the workplace. This study confirms the high prevalence of pre-marital sex, multiple sexual relationship, and unprotected sex among young employees reported in the previous study conducted by Melgar et al. (2009). Explaining the interrelatedness of negative health consequences (e.g., stress-related symptoms, sleep disorder, unhealthy coping behaviors, and risky sexual practices) to all stakeholders would hopefully elicit better cooperation among BPO companies. The call centers, in particular, felt that they have been unfairly branded as the hotbed for AIDS (Nasol, 2010; Pareja, 2010). The HIV program, must therefore be embedded in the comprehensive health package that address other health needs of young workers.

Lastly, it is very crucial to know what interventions will work for this target group in this industry. Guided by the strengths of previous research, both the private and public sector should make a conscious effort toward designing interventions with relevant methods and outcomes. Since the primary route of HIV transmission in the Philippines is through the sexual route, we are still faced with the challenge that behavior change is the only means to curb the spread of this epidemic.

NOTES

¹ FUBU is a slang word to refer to “fuck buddy”, or a partner that readily engages in casual sex.

² FUGLY is a slang word to refer to “fuck buddy who is ugly”.

³ Boylet is a slang word to mean a young adolescent boy that one flirts with or has a casual sexual relationship with.

⁴ A *johwa* is a slang term to refer to a boyfriend.

⁵ A one night stand is a casual sexual partner.

⁶ A sideline is another slang term for casual sexual partner.

⁷ An FWB is an acronym for friend-with-benefits, which carries the same meaning as “fuck buddy”.

REFERENCES

- Adala, K.B., Bolingit, E.A.B., Echon, M.A.P., & Vinluan, K.C.J. (2007). *Nutritional status of call center agents aged 20 to 35 years at a selected company* (Unpublished master's thesis). University of the Philippines, Manila.
- Alfaro, R.O., de Leon, C.A.C., & Guieb P.C. (2005). *Analysis of factors influencing work performance in a call center*. (Unpublished master's thesis). De La Salle University, Manila.
- Department of Health National Center for Disease Prevention and Control [DOH NCDC] – National AIDS/ STI Prevention and Control Program. (2010). *STEPS: Outpacing the epidemic* (Vol. 1, Series 1). Manila: Department of Health.
- Eruma, R. (2011, March). *State of the Philippine Contact Center Industry*. Lecture conducted at the College of Public Health, University of the Philippines, Manila.
- Hechanova, M.R. (2010) *1-800-Philippines: Understanding and Managing the Filipino Call Center Worker*. Manila: Institute of Philippine Culture.
- Ho, H., Ples, M., & Sia Su, G. (2008). Sleep problems, work-stress and health complaints in call centers in Quezon City, Philippines. *eHealth International Journal*, 4, 20-23.
- IBON. (2003). *Call Center: is I.T. for real?* (IBON Facts and Figures Vol. 26, Series 2). Manila: IBON.
- Manalastas, E.J. (2006). Filipino men's condom use during gay sex: Findings from the 2003 National Geographic and Health Survey. *Philippine Population Review*, 5(1), 81-92.
- Melgar, I. E., Ofreño, M. A., Kintanar, N. S., & Canoy, N. (2009). *Risky health behaviors among young urban professionals in the Philippines*. Unpublished manuscript, Department of Psychology, Ateneo de Manila University, Quezon City.
- Nasol, R.M. (2010, February 5). Steady rise in HIV cases noted; BPOs as high risk denied. *The Philippine Daily Inquirer*, pp. A1, 10.

- Natividad, J.N., & Marquez, M.P.N. (2004). Sexual risk behaviors. In C.M. Raymundo & G.T. Cruz (Eds.), *Youth sex and risk behaviors in the Philippines* (pp. 70-94). Quezon City: Demographic Research and Development Foundation and the University of the Philippines Population Institute.
- Palabay, C., & Jorge, M. (2007). Comparative study of sleeping patterns and daytime sleepiness of call center employees and regular office workers. *Philippine Journal of Internal Medicine*, 45, 45-49.
- Palabrica-Costello (2004). Global research studies on adolescent sexuality, reproductive health and fertility. *Philippine Population Review*, 3(1), 19-54.
- Pareja, J. (2010, February 6). Call center employees say "Be fair, do not single us out". *The Philippine Star*. Retrieved May 6, 2010 from <http://www.philstar.com/Article.aspx?articleid=547157>
- National Epidemiology Center [NEC] (2011). *Philippine HIV and AIDS Registry*. Retrieved November 11, 2010 from Department of Health website: <http://www.doh.gov.ph/node/2598>
- Occupational Safety and Health Center [OSHC]. (2006). *Examining health and safety in contact centres*. Retrieved May 10, 2010 from Occupational Safety and Health Center website: <http://www.oshc.dole.gov.ph/page.php?pid=332>
- Raymundo, C. (2004). Sexuality and reproductive health of Filipino adolescents, *Philippine Population Review*, 3 (1), 55-78.
- Ruiz, J. (2010, February 10). No link between call centers and HIV spread? *ABS-CBN News*. Retrieved May 5, 2010 from <http://www.abs-cbnnews.com/lifestyle/02/09/10no-link-between-call-centers-and-hiv-spread>
- University of the Philippines Population Institute [UPPI]. (2010). *Lifestyle, Health Status and Behavior of Young Workers in Call Centers and Other Industries: Metro Manila and Metro Cebu*. Quezon City, Philippines: University of the Philippines Population Institute.

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MEN WHO EVER INJECTED DRUGS IN METRO MANILA JAILS: A SURVEY OF THEIR KNOWLEDGE, ATTITUDES, AND PRACTICES RELATED TO HIV INFECTION

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ABSTRACT

This study's main concern was to describe the profile, knowledge, attitudes and practices in relation to HIV of 218 men who ever injected drugs (MWID) from 17 Metro Manila jails. Information and support services for HIV at city jails were also included. The personal interview survey method was utilized and was carried out in February to March 2010. The findings showed that a majority of the respondents had been in prison for around three years. These men were mostly in their thirties, Metro-Manila born, had some secondary education, married or had living-in arrangements, and had worked in the informal sector prior to detention. Although most jails had no HIV and AIDS information and support services, the MWID were generally well informed about HIV transmission and prevention. A sizeable proportion, however, held erroneous knowledge about the disease. The respondents had not injected drugs in the past month prior to the survey. They did not share their syringes and tools the last time they had injected drugs. Most had tattoos and they reportedly bled when these were put

with the use of non-sterilized tools which were shared with others. Before detention, most MWID smoked, drank alcohol, and used other prohibited drugs. In the past 12 months before the survey, the majority reported that they either abstained from sex or had only one familiar female sexual partner, and they did not utilize condoms. Close to half of the sexually-active men had multiple sexual partners and about a considerable proportion were engaged in paid and unprotected sex. Few men who had sex with men did not use condoms. A majority were never tested for HIV but were willing to be tested. They aspired to leave the prison, have stable jobs and rejoin their families.

KEYWORDS: *men who ever injected drugs, knowledge, attitudes, practices, HIV, AIDS, sexually transmitted infections*

INTRODUCTION

In January 2010, former Secretary of Health Dr. Esperanza Cabral, was alarmed over the rapid rise of HIV cases since the disease emerged in the country 26 years ago. She reported that there were 60 new monthly cases from January to November 2009. In December 2009, the number of new HIV cases doubled to 126. This further increased to 143 in January 2010. The new cases were mostly males who were infected through sexual contact with other males and they fell between the ages of 25 and 29. With this sudden upsurge, Dr. Cabral predicted that within three years, there would be 30,000 new HIV infections in the country (Philippines HIV cases spike to record in January, Manila, 2010 March 4).

The National Epidemiology Center of the Department of Health (NEC-DOH) reported that since 1984, the Philippines has had 4,424 reported HIV cases. From this total, 832 had developed into full-blown AIDS and 314 had died. In the past three years, male-to-male and bisexual intercourse became the dominant HIV transmission mode, followed by heterosexual intercourse, mother-to-child transmission, blood exchange and exchange of blood products, and by injecting drug use (Philippines HIV cases spike to record in January, Manila, 2010 March 4).

The NEC-DOH also reported that since 2005 the HIV cases among men who have sex with men (MSM) have risen to epidemic proportion. The MSM hailed mostly from Metro Manila. Of the total number of 1,097 HIV-infected cases from 1984 to 2008, fifty per cent were reported from 2005 to 2008; around 10 per cent have died while over a quarter were reportedly with AIDS.

In 2005, the DOH National Epidemiology Center Behavioral and Serologic Surveillance found that one percent of the 243 injecting drug users in Cebu City were HIV positive and three fourths were sharing needles; 81 percent had Hepatitis C. These alarming results served as the trigger for greater attention to injecting drug users not only in Cebu City but in other parts of the country. The country's 4th AIDS Medium Term Plan 2005-2010 specified that people who inject drugs (PWID) alongside registered and unregistered sex workers and MSM are the three priority population segments for intervention.

The need to know the PWID's situation in different cities and in locations where they are likely to cluster is deemed essential before appropriate interventions could be undertaken. Natural communities, drug treatment and rehabilitation centers, and correctional institutions/jails/prisons are the possible sites where current and ever users of injecting drugs could be found.

Prior to detention, many male offenders in city jails are known to have engaged in risky behaviors such as substance abuse, unprotected sex, and had utilized unsterilized tools for tattooing or had injected drugs that could predispose them to acquiring HIV. There is a general notion that these offenders sustain their risky behaviors inside the prison. However, there is hardly any systematic study in the Philippines about the risky behaviors of male offenders particularly among those who have ever used injecting drugs while in detention at city jails.

A review made in recent years by Dolan, Kite, Black, Aceijas, and Stimson (2007) concerning the prevalence of HIV, HIV-risk behavior and injecting drug use in correctional institutions in 152 middle and low-income countries, noted that HIV is a serious problem in several countries where injecting drug use is practiced. However, because of the scarcity of available data, the role of HIV within correctional institutions was difficult to establish in many middle and low-income countries. It was recommended that data should be systematically collected to determine what appropriate HIV prevention strategies would be applied in prison.

The Philippine National AIDS Council (PNAC), the country's highest HIV/AIDS policymaking body comprising of 17 governmental agencies, including local government units, the two houses of the legislature, seven nongovernmental organizations (NGOs), and an association of people

living with HIV & AIDS—in partnership with the United Nations Development Programme (UNDP), developed a three-year project which aims to “support leadership and capacity development to strengthen national and local responses and mitigate the negative impact of HIV and AIDS on human development.” An important component of this initiative is the “development of strategic information to promote a deeper understanding of HIV and AIDS.”

To be able to design a strategic information program, it is essential that scientific studies are undertaken to generate “knowledge-based information” of populations that are most vulnerable and at risk of acquiring HIV. People who inject drugs (PWID) are among those population segments that are at greatest risk yet there is hardly any systematic study about them in many urban centers including Metro Manila.

Thus PNAC and UNDP commissioned The Philippine NGO Council on Population, Health, and Welfare, Inc. (PNGOC) to conduct the Knowledge, Attitudes, & Practices (KAP) survey of ever users of injecting drugs in Metro Manila city jails.*

OBJECTIVES OF THE STUDY

The objectives of this study are as follows:

1. To describe the background characteristics of the male ever users of injecting drugs from Metro city jails
2. To determine the MWID’s knowledge and attitudes about HIV transmission and prevention;
3. To describe the MWID’s history of injecting drug use and other related experiences that place them at greater risk to HIV prior to and during imprisonment particularly their usage of needles and syringe, acquisition of tattoos, and sexual practices;
4. To identify the current health and other support services extended to PWID in selected Metro Manila DTRC and city jails; and
5. To elicit issues and recommendations for improved health and support services for MWID in these institutions.

* PNGOC was also assigned to include clients from the drug rehabilitation & treatment centers (DRTC) and female inmates from women’s city jails. Because there were very few DRTC clients (6) and female prisoners (8), the findings of these respondents are excluded in this article.

IMPORTANCE OF THE STUDY

This KAP survey is significant because it fills a major research gap about HIV-risk behavior of male ever-users of injecting drugs in total institutions like the city jails in the country's largest metropolis. The research results could provide vital information for the development of appropriate HIV and AIDS policies and programs not only for the government and its partner agencies but also for other stakeholders that are concerned about the MWID's health and well-being.

The 2010 MWID KAP utilized the United Nations General Assembly Special Session (UNGASS) Survey 2010 core indicators in its queries on sexual and injecting drug risk behaviors. Indicators from the three-city survey on male sexual risk behavior and HIV and AIDS (Ramos-Jimenez & Lee, 2001) were likewise used for the MWID survey instrument. The findings for these selected indices could provide useful information for the country's behavioral surveillance of MWID at city jails. They could also be utilized for comparison with other studies on injecting drug users in different social settings.

METHODOLOGY

This section describes the sampling design, the research methods and instruments as well as field procedures of the study.

The sampling design

The KAP survey respondents were MWID from 16 city jails and one municipal jail in Metro Manila. Because the use of injecting drugs is illegal and highly stigmatized, no official estimate about the number of MWID in the country was available especially at correctional institutions/city jails. In the absence of a sampling frame, the survey utilized a purposive sampling design with a targeted quota of 100-150 ever users of injecting drugs from city jails. The study eventually interviewed a total of 218 ever users of injecting drugs.

To avoid coercion of city jail detainees (i.e., persons who are imprisoned temporarily for alleged crimes and who are waiting for the judicial courts' decision) into admitting that they were ever users of injecting drugs, a filter questionnaire was administered to detainees who were charged of violating Republic Act 9165 or *The Comprehensive Dangerous Drugs Act of 2002*. The offenders were asked to fill out the questionnaire in designated areas by the

jail administrators and to voluntarily admit that they had used injecting drugs and were willing to be interviewed for the study.

The filter questionnaire had eight questions—1) name(optional), 2) nickname, 3) age, 4) civil status, 5) sex, 6) prohibited drugs used, 7) ever-used injecting drugs, and 8) if an injecting drug ever user—willingness to be interviewed. The filter instrument's language was in Filipino. A total of 4,286 filter questionnaires were administered in 17 male jails. The Manila city jail had the most number of respondents who filled out the filter questionnaire (a total of 1,189). They also had the largest number of detainees (close to 4,000) for all types of crimes.

The number of detainees in each city jail varies every day because there are usually new entrants and releases. It was observed that most city jails were congested because they accepted more detainees than what their facilities could usually accommodate.

Only 204 jail detainees (4.8%) admitted that they were ever users of injecting drugs. Of this number, only 153 agreed to be interviewed. Fifty-five males (who were mostly from Manila's jail) who did not fill out the questionnaire voluntarily admitted that they had ever used injecting drugs and were willing to be included in the study. These men were charged for index crimes (e.g., murder, rape) rather than for drug use. They were identified through the assistance of a religious leader who regularly visited and counseled detainees.

Research method and instrument

Face-to-face interview was the method used in this survey. The research instrument was an interview schedule which comprised of 107 questions (35 open-ended and 72 closed-ended questions). It utilized core indicators from UNGASS 2010 and from the Ramos-Jimenez and Lee (2001) three-city survey on male sexual risk behavior and HIV and AIDS. The main topics of the survey instrument are: a) background characteristics, b) tattoos and injecting drugs, c) knowledge about HIV transmission and prevention, d) sexual practices and condom use, e) sexually-transmitted infections (STI), f) support services, and g) life aspirations. The interview schedule was initially written in English. It was translated into Filipino and back translated into English to determine whether the Filipino translation was close to the English version.

The research instrument was reviewed by some PNAC members before it was administered at city jails. It was not pre-tested at Metro Manila's city jails because of the project team's apprehension that there might not be enough MWID in these facilities. There was a plan to do the pre-test in a nearby province but because of time constraints and bureaucratic requirements, the PNAC experts' review was deemed sufficient for the study.

An interview guide was developed for key informants comprising of knowledgeable personnel of the city jails. The guide focused mainly on the available HIV & AIDS information and services for detainees and the informants' interest to have an intervention program in their facilities.

Data collection procedures

The following procedures were undertaken by the project team comprising of five members (two males and three females) during data gathering:

1. Endorsement letters were first obtained from the Secretary of Health and from the Department of Interior and Local Government (DILG)-Bureau of Jail Management & Penology (BJMP) NCR Director & Assistant Regional Director for Administration-Concurrent Chief for Health Services, to facilitate the entry of the project team to the city jails.
2. Courtesy calls were made by the PNGOC executive director, research leader and project team members on the wardens or their deputies at the city jails to make all the necessary arrangements prior to data collection.
3. Because the MWID were not identified at the city jails, the records sections willingly provided the project team with lists of detainees who were charged for drug-related cases (which reportedly comprise 30 to 60 percent of the total number of detainees at city jails). Arrangements were made with the jail authorities on the schedules of the administration of the filter questionnaire.
4. Filter questionnaires were administered in whatever available space that was provided by the city jail administrators
6. The security protocol of the city jails was observed by the project team during data collection (e.g., no cellular phones inside the jail; all pencils must be taken out after the administration of the

questionnaire because these could become potential weapons; interviews must be conducted in a secure space, and others.).

7. The objective of the filter questionnaire was carefully explained by the project team to the detainees prior to its administration to assure them of confidentiality.
8. Informed consent was sought from each respondent prior to the face-to-face interview. The interviewer affixed his/her signature on the interview schedule in front of the respondent to signify the latter's approval of the interview. The respondent was not asked to sign the interview schedule or any document to ensure anonymity.
9. Simple snacks (soda and cookies) were provided to the detainees who filled out the filter questionnaire. Respondents of the face-to-face interview were given simple token of appreciation (i.e., small face towel, sachets of toothpaste, toilet soap) after the completion of the interviews. These tokens were not shown to the respondents before the face-to-face interviews.

The administration of the filter questionnaire was most challenging because of the large number of detainees who answered the filter questionnaire at different places of the jails. Some jails had no large rooms that could accommodate several detainees so the administrators offered their chapels as the venues for the administration of the filter questionnaire.

Some inmates who came from other provinces and spoke other languages and dialects had difficulty understanding or reading Filipino. The project team in collaboration with other detainees who spoke the same languages helped explain the questions to these respondents.

In Manila's male city jail, a considerable number of potential respondents who filled out the filter questionnaire and who signified that they were ever users of injecting drugs, refused to be interviewed. Because the project team stayed in this facility for three days owing to the large number of interviewees, they were able to identify new respondents through the intercession of a religious adviser who was not a detainee. This spiritual leader requested the prison cell leaders to help locate other MWID in their respective cells. Several ever users of injecting drugs who committed index or serious crimes such as rape and murder volunteered to become survey respondents. This experience indicated that there could be more injecting drug users at city

jails who are charged for other serious crimes. The additional detainee-respondents did not fill out the filter questionnaire anymore.

The face-to-face interviews lasted for 15 to 35 minutes. Interviews were shorter for those respondents who were not aware of HIV & AIDS and among those who were not sexually active in the past 12 months prior to the survey. In general, the city jail respondents were cooperative and showed interest in the study. Some expressed their gratitude for having someone to talk with about their life aspirations and other experiences.

Limitations of the study

While knowledge and attitudes could be generated from the face-to-face interviews, it was not possible to validate or verify the reported practices of the respondents from city jails. The respondents' answers to the questions on behavior were accepted at face value.

DISCUSSION

The conduct of the PNAC and UNDP-supported KAP survey took place in early 2010 at a time when the prevalence rates of HIV began to escalate especially among men who have sex with infected men. It covered 218 MWID from 17 Metro Manila jails who voluntarily agreed to be interviewed for the study. The main objective of the survey was to describe the MWID's background characteristics, knowledge, attitudes and practices about HIV and AIDS including experiences in the acquisition of tattoos, use of injecting drugs, sexual relationships, and sexually-transmitted infections. Support services obtained from the respondents' institutions and their life aspirations were also included in the study.

The respondents were in their thirties, had varying civil status and they have had some secondary education. Before detention, the majority worked in the informal sector as construction workers, vehicle drivers, laborers/domestic workers, and vendors, indicating that they belong to society's lower socioeconomic strata. The correctional institution detainees were languishing in jail for an average duration of three years because of their inability to post bail and to the slow process of review and decision by the judicial courts. The respondents aspired to leave the correctional institutions to re-unite with their families and find reliable sources of livelihood.

The following discussion of the findings cover the respondents' knowledge about HIV and AIDS, their attitudes about the disease, their safe and unsafe sexual behavior and other practices that could predispose them to HIV and Hepatitis C virus (HCV).

Knowledge about HIV & AIDS and STI

A large majority of the respondents were aware of HIV and AIDS, a finding that is similar to those found in other studies (National Statistics Office & ICF Macro, 2009; Action for STD and AIDS Philippines, Inc., 2007; Ramos-Jimenez & Lee 2001). Those who had heard of both HIV and AIDS could distinguish the major differences between them. As found in other surveys, the media, particularly television, newspapers, and the radio were the main HIV and AIDS information sources.

The majority knew about the correct HIV transmission routes, by: a) having sex with female sex workers without using condoms, b) having sexual intercourse with a person who you don't know much about without using condoms, c) injecting drugs using syringe used by others, and d) having anal sex with unfamiliar men without using condoms.

However, a considerable percentage (from 22% to 55%) held incorrect notions about HIV, a pattern that also surfaced in other research (e.g., National Statistics Office & ICF Macro, 2009; Ramos-Jimenez and Lee 2001). The persistence of the erroneous knowledge about the transmission routes of HIV implies the need for providing correct information to the general public including at-risk populations through the media and other information outlets. Refer to Table 1.

The MWID in this study also knew about the different ways to prevent HIV transmission by: a) having sex with only one unaffected partner, b) not using injecting drugs syringe used by others, c) not having sexual intercourse with strangers, d) always using condoms, e) decreasing the number of sexual partners, and f) abstaining from sexual intercourse. While the respondents' knowledge about HIV prevention appears high, the reported practice is not consistent with what they knew because a majority of the sexually-active men in this study did not use condoms with their sole or multiple partners the last time they had sex.

Table 1. Knowledge of MWID respondents about HIV transmission route

Transmission route	Percent agreed
CORRECT	
1. Having sexual intercourse with female sex workers without using condoms	95.8
2. Having sexual intercourse with a person who don't know much about without using condoms	88.0
3. Injecting drugs using syringe used by others	92.2
4. Having anal sex with men you don't know much about without using condoms	89.2
INCORRECT	
5. Getting bitten by mosquitoes	55.1
6. Using glass of someone with HIV	47.9
7. Sharing food with someone with HIV	43.6
8. Swimming in the pool used by someone with HIV	25.5
9. Using the public toilet	36.5
10. Holding someone with HIV	22.9

The proportions of MWID who have heard of HIV and AIDS were much higher than those who were aware of STI, a pattern akin to those found in other surveys (Ramos-Jimenez & Lee 2001; Ramos-Jimenez, Marco, Santos-Acuin, Sanchez, & Factora, 1997). Pain felt during urination and pus were the common symptoms mentioned. Few respondents reported that they had STI, and they either self-medicated or received treatment and got well.

Table 2. Perceived symptoms and experiences about sexually-transmitted Infections (STI)

Topic	Number	Percent
Ever heard of STIs	(n=218)	
Yes	132	60.6
No	86	39.4

Topic	Percent
If Yes, R's perceived STI symptoms (Multiple response)	(n=132)
Painful urination	49.2
Pus	46.2
Lower abdominal pain	19.7
Painful genitalia	14.4
Fever	13.6
Itchiness	5.3
Wound	0.8
Other	35.6
Ever experienced STI (n=132)	
Yes	29.5
No	70.5
STI, symptoms experienced (Multiple response)	(n=39)
Pus	79.5
Painful urination	64.1
Lower abdominal pain	15.4
Painful genitalia	10.3
Fever	7.7
Others	12.8
Whether R received treatment for STI	(n=39)
Yes	97.4
No	2.6
If Yes, who provided treatment	(n=39)
Self-medication	31.6
Private health providers	29.3
Friend	24.4
Public health providers	15.8
Others(relative Pharmacy)	5.2
If Yes, whether R got well	(n=39)
Yes	92.3
No	2.6
Not sure	5.1

Attitudes related to HIV

Three fourths of the respondents who knew the difference between HIV and AIDS (a total of 167) agreed that a healthy-looking person could have HIV in his/her system (Table 3). Few respondents, however, had personal knowledge of people living with HIV and those who died of AIDS. The majority perceived that they had zero to little chance of acquiring the disease; a finding similar to those found by the Male Sexual Risk Behavior Survey among mainstream men in three cities (Ramos-Jimenez & Lee 2001).

Few respondents (about 11%) had got tested for HIV and knew the results. No one, however, disclosed that he has HIV. The majority wanted to be tested, implying that the MWID are interested to ascertain whether they are afflicted with this incurable disease.

Table 3. Awareness and attitudes of MWID in Metro Manila city jails about HIV & AIDS

Topic	Percent
Whether a healthy-looking person can have HIV	
Yes	76.0
No	24.0
Whether R knows anybody who has HIV	
Yes	22.8
No	77.2
Whether R knows anybody who died of AIDS	
Yes	32.9
No	67.1
R's Possibility of R getting HIV	
None	53.7
Little	32.9
Moderate	8.5
Great	4.9
Whether R has been tested for HIV	
Yes	11.4
No	88.6

Topic	Percent
Whether R knew results of HIV test	
Yes	84.2
No	15.8
Whether R is willing to undergo HIV test	
Yes	95.8
No	4.2

Practices related to HIV and other diseases

The MWID admitted that they had utilized other substances particularly cigarettes, alcohol and illegal drugs (mostly shabu and marijuana) which could predispose them to other serious health problems. They first tried injecting drugs in their early twenties, implying an experience of over a decade because most of the respondents are in their mid-thirties and even older. They, however, claimed that they did not share their paraphernalia with others the last time they had used injecting drugs. The few who shared their syringe and needles said that these were sterilized or bleached.

Because most MWID were detained for violating Republic Act 9165 or *The Comprehensive Dangerous Drugs Act of 2002*, it is not surprising that they (except for one new entrant) had not used injecting drugs a month prior to the survey. Violation of the law within the correctional institutions could further aggravate their charges and could reduce their chances of leaving these facilities. Needless to say, their detention in a total institution appeared as a major deterrent to the continued use of injecting drugs.

Tattoos of varying sizes and design were found to be common among the MWID and these were obtained prior to detention and within the correctional facilities. The tattooed MWID said that they bled while having their body marks. Most of them recalled that the tools (needles, ink, and tattoo machines) used in putting their tattoos were used by others and these were not sterilized (Table 4).

Table 4. Tattoo experiences of MWID detainees from Metro Manila city jails

Topic	Percent
Whether R has body tattoo	(n=218)
Yes	87.6
No	12.4
Whether body tattoo was acquired prior to entry to correctional	(n=191)
Yes	57.6
No	41.0
Tools/equipment used for body tattoo	(n=200)
Needles	64.4
Tattoo machine	35.6
Ink	14.7
Others	18.3
Whether R bled while having the tattoo done	(n=191)
Yes	92.7
No	7.3
Tools used by others who had tattoo done	(n=175)
Yes	84.6
No	15.4
Were tattoo tools sterilized	(n=171)
Yes	29.1
No	70.9

These practices have implications for another serious blood-borne disease, i.e., Hepatitis C virus. A study conducted in one of the prison camps at the Bureau of Prison in Muntinlupa City, Metro Manila over a decade ago, found that the seroprevalence of hepatitis C virus (HCV) infection was 5.0% among 502 inmates who were examined (Gloriani-Barzaga & Alipio, 1996). The prevalence of anti-HCV was higher among the convicted prisoners with tattoos, those with blood transfusion, pierced ears, implants, and self-inflicted wound although these were not found to be statistically significant.

The MWID had experiences of both safe sexual practices and risky sexual practices at various points in time. Their coital debut took place in their adolescence mostly with female sexual partners who were familiar and slightly older than them. No money was exchanged and condoms were not used. These findings are likewise similar to those found in the 2001 Ramos-Jimenez and Lee three-city survey of urban mainstream men.

In the past 12 months, slightly over one half of the MWID reported that they did not have sex. Among the sexually-active respondents, more than one half had sex with only one partner either with their wives or live-in partners and no money and condoms were utilized. There was an assumption that the sole sexual partners who occasionally visited these detainees were faithful to them. Few male detainees claimed that they had same sex partners who were familiar to them; they also did not use condoms (Table 5).

Close to half of the sexually-active respondents had two and more sexual partners and these were mostly females who were known to them. About one third paid for sex. These MWID were reportedly able to access several sexual partners because of the apparent variations in the admission practices of outsiders by the correctional institutions.

Although the MWID in this survey knew that using condoms with multiple partners could protect them from acquiring the disease, the reported practice did not match this knowledge because most of the sexually-active respondents never used condoms during sexual intercourse. The incongruence between the MWID's knowledge about HIV protection and the application of their knowledge for safer sex is not unique to this study because it was also found in previous KAP and other behavioral surveillance surveys for other segments of the population.

Although a few MWID at correctional institutions were found to have same sex practices, their unprotected sexual practice could predispose them to acquiring HIV and HCV especially when they would have sex with infected men. The 1996 Gloriani-Barzaga & Alipio study at the Bureau of Prison in Muntinlupa City found that homosexual activities and parenteral-drug utilization were significantly associated with HCV. The NEC-DOH and PNAC, however, have yet to determine the prevalence of HIV cases at Philippine correctional institutions partly because of the absence of HIV and AIDS program in these facilities.

Table 5. Respondents with two or more sexual partners in the past 12 months

Topic	Percent
Sex of sexual partners	(n=48)
All females	81.3
All males	6.3
Some females, some males	12.5
Whether R knew sexual partners well	(n=48)
Yes	70.8
No	2.1
Some yes, some no	27.1
Payment for sexual partners	(n=48)
No	62.5
Yes for some partners	27.1
Yes for all partners	10.4
Whether R paid or was paid for sex	(n=18)
R paid for all sexual partners	38.9
R paid for some	33.3
R was paid by some sexual partners	27.8
Whether R used condoms	(n=47)
No	85.1
Used condoms for all partners	10.6
Used condoms for some partners	4.3

Support services including HIV & AIDS information

Health services (free medical consultation, medicine and dental care) as well as social services (e.g., spiritual activities organized by faith-based organizations, arts and crafts) were the main services extended by the correctional institutions to their clients. These were also perceived as the most beneficial among the services provided by the jails.

Except for Quezon City male jail, the correctional institutions do not have a program or project that provides HIV & AIDS information and services to the MWID. Interest to have such a program in these facilities was expressed by the key informants because they have learned about the

rapid rise of HIV cases among men who have sex with infected men in the metropolis from a spate of news items from TV and the newspapers during the survey period. Risky practices that could predispose the detainees to HIV were also cited by some key informants. Furthermore, it was perceived that the measures for admission of outsiders by the correctional institutions could not totally control the detainees' risky sexual practices.

IMPLICATIONS FOR ACTION AND RESEARCH

The MWID-KAP survey findings open a window of opportunity for PNAC and its partners particularly the DOH, DILG, BJMP, the Presidential Drug Enforcement Agency (PDEA), and the Department of Social Welfare and Development (DSWD)—to pilot an HIV and AIDS project in Metro Manila at the male city jails. This intervention could provide reliable information and services to MWID at selected city jails to eliminate persistent erroneous notions about HIV. It could also empower the detainees to care for their health and to avoid risky practices that could predispose them to HIV and HCV. Families and communities could also become part of this pilot project to provide support to detainees to avert recidivism especially when they would be released from the correctional institutions.

Because a majority of the inmates at correctional institutions are detained for drug-related crimes, it would be more beneficial and cost-effective in the long-run to include not only the MWID but also all the detainees in the pilot institutions. It is known that many MWID often began their injecting drug addiction by initially using other illegal drugs. The pilot project that would be designed for city jail detainees could help prevent many ever-users of prohibited drugs from going to the same path as the MWID. Inclusion could also help reduce stigmatization of the MWID especially if they would be tested positive for HIV.

The detention of the MWID in this study is often temporary and many would be released from correctional institutions and would rejoin their families and the general population. Their risky behaviors would likely resume unless strategic interventions are provided to them and the other detainees within the correctional institutions.

The results of the survey and key informant interviews suggested that the HIV and AIDS intervention for correctional detainees should be a

comprehensive information and services project that will draw support not only from the health sector but also from the community of people who inject drugs, the donors, and other pertinent stakeholders from the civil society. This approach will no doubt reach out to this at-risk population and will provide essential information and care that would empower the men to avoid risky practices while in prison and when they would rejoin their families and communities.

Careful groundwork to orient the pilot institutions' personnel particularly the BJMP officials and personnel would ensure that these gate keepers are not only knowledgeable about prevention and care, but will sustain an HIV and AIDS undertaking that is gender-responsive, ethical and respectful of the human rights of city jail detainees.

Needless to say, a systematic study of the pilot study is vital in drawing lessons that could be utilized in the replication of the foregoing strategies in other city jails in the country.

REFERENCES

- Action for STD and AIDS Philippines, Inc. (2007). *IDU Practices and Prevalence of HIV in Drug Rehabilitation Centers in the Philippines* (Unpublished documentation report). (March 1-December 31, 2006). Unpublished report. NASPCP-NCDPC-DOH.
- Dolan, K., Kite, B., Black, E., Aceijas, C., Stimson, G. V. (2007). Reference Group on HIV/AIDS Prevention and Care among Injecting Drug Users in Developing and Transitional Countries. *Lancet Infectious Diseases*, 7(1), 32-41.
- Gloriani-Barzaga, N. and A. E. Alipio. (1996). Hepatitis C Virus Infection and Risk Factors among Inmates in Muntinlupa, Metro Manila: An Emerging Concern in the Community. *Philippine Journal of Microbiology and Infectious Diseases*. 25 (1): 8-12. College of Public Health, University of the Philippines, Manila.
- National Statistics Office [NSO] [Philippines], and ICF Macro. 2009. *National Demographic and Health Survey 2008*. Calverton, Maryland: National Statistics Office and ICF Macro.
- Philippine National AIDS Council [PNAC]. (2005). *4th AIDS Medium Term Plan 2005-2010: The Philippines*. Philippine National AIDS Council: Philippines.
- Philippines HIV cases spike to record in January, Manila* (Online news article). (2010 March 4). Thomson Reuters. Retrieved from <http://www.reuters.com/article/2010/03/04/us-philippines-hiv-idUSTRE62335B20100304>

- Ramos-Jimenez, P., and R. Lee. (2001). *Male Sexual Risk Behavior and HIV/AIDS: A Survey in Three Philippine Cities*. Behavioral Sciences Department, De La Salle University and Family Health International (FHI) IMPACT-USAID: Metro Manila, Philippines.
- Ramos-Jimenez, P., J. Marco, C. Santos-Acuin, P. Sanchez, and E. Factora (1997). *The Social and Cultural Dimension in the Prevention and Control of Reproductive Tract Infections in two Philippine Urban Poor Communities*. The Social Development Research Center, De La Salle University and The Ford Foundation: Metro Manila, Philippines.

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THE EXPERIENCES OF EXTERNAL AND INTERNAL STIGMA OF HIV POSITIVE FILIPINOS

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ABSTRACT

The paper looks at the experiences of stigma of HIV positive Filipinos, focusing both on the experience of external and internal stigma of the respondents. Using the People Living with HIV Stigma and Discrimination Index, 80 participants have been administered the survey question. In this research, it was found out that the respondents have more experiences of internal stigma compared to external stigma. Moreover, their experiences of stigma are influenced by the social categories they belong to and the number of years they have been living with HIV.

KEYWORDS: *stigma, HIV, stigma and discrimination index*

INTRODUCTION

The sociologist Erving Goffman (1963) defines stigma in his landmark book *Stigma* as “an attribute that is deeply discrediting.” However, he says that stigma need not be an actual or real attribute instead, it can be a “language of relationships,” which means that it is enough that society

defines a particular trait or feature as a stigma to be labelled as such. Or it need not reflect reality. Thus, stigma can be as much imagined as it is real. Stigma has real effects on people, especially the object of the stigma because it “creates outsiders and social boundaries between normals (sic) and the stigmatized” (Alonzo and Reynolds, 1995).

The closest Filipino concept that captures the meaning of stigma is *batik sa pagkatao*, or literally, a stain or a mark in one’s personhood, a stain that is so marked that it could lead to negative judgment, even marginalization. The local conceptualization of stigma adheres to the general idea of Goffman (1963) of the three types of stigmas namely: 1) abominations of the body or physical deformities; 2) blemishes of individual character connected to weak will, domineering or unnatural passions, and homosexuality, among others; and lastly, 3) tribal stigma of race, nation, and religion.

Often, stigma leads to discrimination, which entails the formation of unfavourable opinions or unreasonable feelings, opinions, and or attitudes of hostility towards the stigmatized person. Thus, a stigmatized person may experience the *pangmamata* (discrimination or literally making one feel worthless) of others on account of the disgrace and shame associated with the trait or characteristic the stigmatized person is perceived to have. This could leave a person feeling devalued, isolated, or rejected (Alonzo and Reynolds, 1995).

Sick persons are the object of stigma because of fears of passing the contagion to the public. Moreover, it could carry with it fearsome visible marks on the skin or body, more so with HIV/AIDS because at its advance stages it carries fearsome symptoms such as Sarcoma and/or the very visible wasting away of the body (Bollinger, 2002 in Pedroso et al., 2010). There is also a lot of stigma attached to HIV/AIDS because it is unalterable and potentially fatal (Lee, Kochman, & Sikkema, 2008). According to Bauman (1992), in the modern age and the age where the sciences have made a lot of inroads in terms of curing illnesses and extending life, death has become the unspeakable, a pariah, that is set aside or forgotten. Although HIV/AIDS is no longer a death sentence like it used to be, there are still perceptions that it is fatal.

Borrowing Goffman’s (1963) terms, HIV/AIDS also carries with it not only the stigma of “abominations of the body” but also a “blemish of individual character.” The disease has been associated with homosexuals, sexually promiscuous persons, or drug users, who, even without HIV, are already stigmatized groups in many cultures across the globe. Thus, people

living with HIV (PLHIV) suffer from multidimensional levels and complex forms of stigma.

In a survey done in the United States in 1999, one in five persons “feared people with HIV,” while one in six “admitted feelings of disgust” related to persons with AIDS (Hereck, Capitanio & Widaman, 2002 in Valdiserri, 2002). In another survey done the following year among 5,600 American adults, “one in five respondents agreed with the statement “[p]eople who got AIDS through sex or drug use have gotten what they deserve”” (CDC 2000 in Valdiserri, 2002). Contracting HIV via these two means elicit passionate value-laden feelings among people because within religious and judicial contexts responsibility adheres to the sinful and the lawbreaker and both must atone or be punished for their failing” (Alonzo and Reynolds, 1995).

Unfortunately, it has also been found that stigma often leads to negative effects on the stigmatized. For instance, it has been found that homosexual men who experience stigma engage in more risky behaviours; stigma also dissuades people engaging in risky sexual behaviours from having themselves tested; and for those who have already HIV, lowered self-esteem (Valdiserri, 2002). Regardless of the effect, these could lead to disastrous results. For instance, HIV-related stigma and discrimination has been identified as a significant determinant of the spread of HIV (Parker and Aggleton, 2002) as people who may have already contracted the disease continue with their risky sexual behaviours because they are unaware that they are already carriers of the virus. Stigma may also prevent PLHIV from health seeking behaviours (such as seeking prevention information and strategies and going through testing or consultation with health professionals) for the fear knowing their real situation and eventually experiencing stigma.

According to Alonzo and Reynolds (1995), the nature of stigma changes as the individual progresses from one of the following stages to the next: 1) at risk stage (e.g. there is a felt stigma of being either at risk and suspect in the eyes of others known to associate with an at risk individual), 2) latent stage with the latent acute and latent asymptomatic phases, (e.g. concealing the disease becomes a defence against stigma, being gay and HIV positive can devalue the person’s worth in the eyes of the public, hostility of others if they find out the status of the individual has not been disclosed to them, fears on the part of the PLHIV of being abandoned by friends and kinsfolk) and 3) the manifest stage with early manifest and the full blown AIDS phases

(e.g. appearance of stigmatizing signs and symptoms, PLHIV suffer exclusion and reduced interaction from friends or kinsfolk, among others).

Much of the stigma in the preceding discussions can be regarded as external stigma or stigma perpetrated by people against the PLHIV. However, the International Planned Parenthood Federation or IPPF (2008) also talks about internal stigma or felt, imagined, self stigma. Involved in this is the internalization of shame, blame, hopelessness, guilt, and fear of discrimination associated with being HIV-positive. Although two separate categories, internal stigma is intrinsically linked with external stigma, as the fear of judgment or discrimination from others can profoundly influence the way in which people living with HIV view themselves and cope with their HIV status.

However, stigma does not only affect the stigmatized person him or herself. In fact, IPPF, Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS (ICW), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) qualify that people close to the PLHIV such as spouses, children, and other members of their household are also affected by the stigma by virtue of their association with the PLHIV (IPPF, 2008).

Realizing the ill effects of stigma attached to HIV/AIDS, UN Secretary General Ban Ki Moon said:

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

The statement of the UN Secretary General underscores the importance of understanding the experiences of stigma of PLHIV because this has implications on strategies in not only quelling the spread of the disease but also in extending rights to those who already have HIV and may be suffering from stigma associated with the disease.

This paper aims to contribute to the deepening the understanding of the perceptions and experiences of PLHIV/PLAIDS of stigma and discrimination. Specifically, the paper will look at their experiences of external and internal stigma using the “People Living with HIV Stigma and Discrimination Index.”

THE PEOPLE LIVING WITH HIV STIGMA AND DISCRIMINATION INDEX

The People Living with HIV Stigma and Discrimination Index was developed through the joint initiative of the IPPF, GNP+, ICW, and the UNAIDS. The Index was developed to collect information on stigma, discrimination and the rights of people living with HIV that will help in advocacy efforts (IPPF, 2008). Specifically, the Index aims to:

- Document the various experiences of PLHIV in a particular community or country regarding HIV-related stigma and discrimination;
- Compare the situation of PLHIV in one country or across different countries with respect to a particular issue;
- Measure changes over a period of time as regards their experiences; and
- Provide an evidence for policy changes in programmatic intervention.

The Index comes in the form of a survey questionnaire that is administered to PLHIV respondents by fellow PLHIV. The questionnaire is divided into three sections that seek the following clusters of information (IPPF, 2008):

Section 1: General introduction about the interviewee (and his or her household)

Section 2: Indicators focusing on the reported experiences over the last year of PLHIV on HIV related stigma and discrimination; internal stigma, the protection of the rights of PLHIV through law, policy, and/or practice and effecting change.

Section 3: Indicators focusing on instances of HIV-related stigma and or discrimination over the last year specifically related to HIV testing, disclosure, and the provision of health care.

The Index has been translated and used in different countries including the UK, India, and others. In the UK study done in 2009, they found out that a number of PLHIV still experience stigma. For instance, 17 percent of the 867 HIV participants of the study said that they have been denied health service. Moreover, 44 percent said they feel ashamed and 63 percent said they have low self-esteem because of their HIV status (IPPF, 2009).

METHODOLOGY

For this research, 1) we will look at the general characteristics of the 80 PLHIV respondents who participated in the study in terms of their sex, age, number of years they have been living with HIV, self-categorization, and employment status; and 2) extract some relevant variables that have been pre-identified in the Index pertaining to the participants' experiences of stigma and discrimination. The paper will also look at the deprivation to access to work and their experience of internal stigma.

The participants were administered the translated version of the PLHIV Stigma and Discrimination Index in-depth questionnaire prepared by the IPPF and its partners. The research was carried out from October 2009 to January 2010. It used the purposive, non-probability sampling technique given the difficulty of choosing respondents from the whole population of people with HIV and ensuring each of these people have a definable chance of being part of the sample (IPPF, 2008).

Although the sample is not a representative sample, the relatively large number of participants that participated in the study would allow us to glean the experiences of PLHIV in the Philippines. As of March 2011, there have been a total of 6,498 reported cases of HIV infection in the Philippines (Department of Health-National Epidemiology Center, 2011).

The participants are either known by the PLHIV enumerators who assisted in gathering the data or they have been referred by other respondents or organizations. These individuals were reached through peer support groups, testing sites, hospitals, and AIDS service organization. Moreover, the research was done in three areas (Metro Manila, Angeles City, and Cavite) in the island of Luzon, three in the Visayas (Iloilo, Bacolod, and Puerto Princesa City), and one in Mindanao (Davao City).

Because of the sensitivity of the issue and the private nature of the questions that involve questions about sexuality, gender and experiences of discriminations, strict measures were taken to ensure and safeguard the confidentiality of the participants. Moreover, the research team also ensured that informed consent was given by each of the respondent.

DEMOGRAPHIC PROFILE OF THE RESPONDENTS

In this section, we discuss some relevant sociodemographic profile of the respondents who participated in this research. This will be followed by presentation of data on the experience of external and internal stigma and discrimination among the respondents.

A larger number of males participated in the research with 50 male respondents (62.5 percent) compared to 30 females (37.5%). Of the 50 men, 46.3 percent identified themselves as MSM while 6.3 percent said they were gay. The term MSM is a universal term, catch all term that applies to all males who have sex with fellow males. A subset of this is bisexual men who have sex with both sexes; gay men who exclusively have sex with men; and self-identified heterosexual men who happen to have sex with men (AVERT, 2011). According to AVERT, a website dedicated to averting the spread of HIV/AIDS, men who have sex with men do so for a “variety of reasons including for pleasure or experimentation, societal or cultural norms, because of their environment (i.e. prisoners) or for financial reasons.”

On the other hand, some 27.5 percent of the respondents identified themselves as sex workers, 20 percent identified themselves as migrants, and 18.8 percent said they did not belong to any of the pre-given categories. The term migrant¹ has been used to refer to the PLHIV who have worked as migrant workers abroad but have since stopped because of their HIV status.

In terms of age (Figure 1), majority of the respondents (50%) are in the 30-39 year old age bracket. Majority of the participants are employed (68.8%) in various capacities. Majority (76%) have also had the virus for less than three years.

Table 1: Demographic Profile of Respondents

Characteristics	Percent
Age Range	
<25	13.8
25-29	21.2
30-39	50.0
40+	15.0
Sex	
Male	62.5
Female	37.5
Marital Status	
Married/cohabitating; partner living in HH	26.3
Married/cohabitating; partner temporarily away from HH	2.5
In a relationship but not living together	20.0
Single	41.3
Divorced/separated	3.8
Widowed	6.3
Employment Status	
Full-time	27.5
Part-time	27.5
Self-employed	13.8
Unemployed	31.3
Migrant	
Yes	20.0
No	80.0
Years living with HIV	
Less than 3 years	76.3
3 years and above	23.8
N	80

Most of the respondents have already disclosed (Table 1) their HIV status to various. Majority have revealed their status to adult family members (80%), other people living with HIV (87.5%), health care workers (61.3%), and social workers/counsellors (70.0%). However, there is lower disclosure to employers/bosses (28.8%), friends/neighbours (50%), and co-workers (31.3%).

Table 2: Disclosure of HIV status to People (Multiple Answers)

Disclosed to the following:	Percent
Your husband/wife/partner	46.3
Other adult family members	80.0
Children in your family	33.8
Your friends/neighbours	50.0
Other people living with HIV	87.5
People who you work with (your co-workers)	31.3
Your employer(s)/boss(es)	28.8
Your clients	5.0
Religious leaders	1.3
Community leaders	5.0
Health care workers	61.3
Social workers/counsellors	70.0
Teachers	3.8
Government officials	7.5
The media	16.3

EXPERIENCE OF EXTERNAL STIGMA

As was pointed out earlier in the introduction the stigma attached to certain individuals could have real consequences on the lives of stigmatized individuals because these could result to discrimination and exclusion of PLHIV.

Respondents have experienced various forms of discrimination; however, the most common form of discrimination they have experienced is being gossiped about with 48.7 percent reporting this. Although lower in number but still disturbing is that a significant number of them experienced verbal harassment (28.7%) and physical harassment (16.2%) and assault. There is also low reporting of other forms of discrimination such as social exclusion, be it exclusion from social gatherings, religious activities, or family activities.

Table 3: Types of Social Discrimination Experienced by PLHIV Multiple Answers

Types of Social Discrimination Experienced by PLHIV	Percent
Excluded from social gatherings	17.5
Excluded from religious activities	12.2
Excluded from family activities	12.2
Aware of being gossiped about	48.7
Been teased, insulted, verbally harassed	28.7
Been physically harassed	16.2
Been physically assaulted	16.2
Psychologically-pressured	10.0
Sexually rejected	10.0
Forced to change residence	10.0
Discriminated by other household members	22.2
Discriminated by fellow PLHIV	10.0

Another form of discrimination that PLHIV face is related to the denial or deprivation of institutional services related to health, education, and work. The most common form of deprivation or discrimination the PLHIV participants experienced has to do with the loss of jobs (37.5%) or the refusal of employment or work opportunity by employers (37.5%).

Table 4: Deprivation of access to work, health, and education services because of HIV

Types of Deprivation	Percent
Lost their jobs because of HIV status	37.5
Refused for changing of job description or being refused promotion	13.2
Refused of employment or work opportunity	37.5
Dismissed, suspended or prevented from attending an educational institution	1.2
Denied health services, including dental care, because of HIV status	12.5
Denied FP services because of HIV status	6.3
Denied sexual and RH services because of HIV status	3.8

The experience of social stigma between MSM or non-MSM are almost similar, especially with those who reported frequent encounters of being stigmatized (32.5% for MSM and 32.6% for non-MSM). However, there are differences between those who reported that they have experienced some stigma. There is a higher number of MSM (35.1%) who said they experienced some stigma compared to the non-MSM (30.2%). On the other hand, there are more non-MSM (37.2%) than MSM (32.4%) who reported they have not experienced stigma at all.

The table below shows the specific experiences of external stigma, categorized according to sex and further categorized into MSM/non-MSM. A greater number of females (56.7%) report of being aware of being the object of gossip compared to 44 percent of males. Interestingly, a higher number of non-MSM (53.5%) report having experienced being the object of gossip. Males also have more experiences of being teased, insulted or verbally harassed (30%), with more MSM reporting experiencing this (35.1%). On the other hand, there are more females who report being physically harassed (20%) and assaulted (23%).

Table 5: Experience of External Stigma by Category of Stigmatized

External Stigma	SEX		MSM/NONMSM	
	Male (N=50)	Female (N=30)	MSM (N=43)	Non-MSM (N=37)
Excluded from social gatherings	16.0	20.0	18.9	16.3
Excluded from religious activities or place of worship	14.0	6.7	16.2	7.0
Excluded from family	12.0	10.0	13.5	9.3
Aware of being gossiped	44.0	56.7	43.2	53.5
Been teased, insulted, verbally harassed	30.0	26.7	35.1	23.3
Physical Harassment	14.0	20.0	16.2	16.3
Assault	10.0	23.3	13.5	16.3
Psych Pressure	10.0	10.0	8.1	11.6
Sex Reject	14.0	3.3	13.5	7.0
Discriminated by others with HIV	8.0	13.3	8.1	11.6
Discriminated by other household members	16.0	30.0	18.9	23.3

The differences in the report of the experience of stigma are starker between migrants and non-migrants. There are decidedly more migrants who reported experiencing social stigma. For instance, 43.8 percent of migrants both said that they have experienced some or frequent instances of stigma in the past year compared to the 29.7 percent of non-migrants who reported some and frequent experiences of stigma. On the other hand, there are decidedly more non-migrants (40.6%) who had not any experienced any form of stigma compared to migrants (12.5%). There is also very high reporting of the loss of jobs because of their HIV status, with 50 percent of self-identified migrants reporting this.

A large number of the participants (40%) said that they are unsure why people react to them in that way. However, 26.3 percent of the respondents think that people are afraid of getting infected from them; hence, their reaction. Another 23.8 percent said that people are generally unaware how HIV is transmitted and are afraid they can be infected through casual contact.

Cross-tabulating specific experiences of stigma with the number of years the PLHIV has had HIV, we see that the respondents who have had their HIV for less than three years have relatively higher incidences of experiences of discrimination compared to those who have had it for three years and above.

A little over half of those who have had HIV for less than 3 years report of being aware of being the object of gossip compared to 36.8 percent of those who have been living with HIV for three years and above. There is also higher incidence of being teased, insulted, and verbally harassed (32.8%) among those who have been living with HIV for less than 3 years. Interestingly, there is very low incidence of exclusion from family (14.8% for those living with HIV for less than 3 years and zero for those who have had the virus for 3 years and above). There is also low reporting of discrimination by other household members in both groups and there is not much difference in their reporting of the experience of discrimination. And surprisingly, 13.1 percent among those who have had HIV for less than 3 years report experiencing discrimination from fellow PLHIV.

Table 6: Number of Years Living with HIV and Specific Experiences of Discrimination

Experience of Discrimination	<3 years	3 years or more
	(N=61)	(N=19)
Excluded from social gatherings	18.0	15.8
Excluded from religious activities or place of worship	13.1	5.3
Excluded from family	14.8	0
Aware of being gossiped	52.5	36.8
Been teased, insulted, verbally harassed	32.8	15.8
Physical Harassment	16.4	15.8
Assault	14.8	15.8
Psychological Pressure	9.8	10.5
Sex Rejection	11.5	5.3
Discriminated by others with HIV	13.1	0
Discriminated by other household members	16.4	15.8

INTERNAL STIGMA

A higher number of participants report experiencing internal stigma compared to external stigma. In the Table below, we see that more males and females and MSM and Non-MSM report experiencing at least one type of internal stigma compared to those reporting experiencing at least one type of external stigma. The table shows that everyone has experienced at least one type of internal stigma as opposed to the 2/3 who reported experiencing at least one type of external stigma.

Table 7: Experience of External and Internal Stigma by Gender

Type of Stigma	SEX		MSM/NONMSM	
	Male	Female	MSM	Non-MSM
	(N=50)	(N=30)	(N=43)	(N=37)
Experienced at least 1 type of external stigma	64.0	66.7	67.6	62.8
Experienced at least 1 type of internal stigma	100.0	100.0	100.0	100.0

Three quarters of the respondents report feeling ashamed (73.8%) or guilty (76.3%) of their HIV status. There also those who are engaged in self-blame (65%), those who feel they should be punished for their HIV status, those who blame others because their HIV status (31.3%) and those whose self-esteem (55%) have been undermined because of their condition. And understandably, with the changes in their life and condition, there are also those who have contemplated suicide (37.5%).

They also have certain fears about how others would react to them given their status. For instance, one of the greater fears they have is that people will gossip about them (71.3%). There are also those who fear being verbally insulted, harassed, and/or threatened (58.8%), or physically harassed and/or threatened (47.5%), and being physically assaulted (42.5%). There are also those who are afraid that no one would want to be sexually intimate with them anymore (38.8%).

In the last 12 months, respondents report that they decided not to have (any/more) children (58%). Others have stopped attending social gatherings (48.8%). Some have also decided against getting married (37.5%), having sex (37.5%), or working (37.5%). There are also those who have foregone medical treatment with 35 percent avoiding going to local clinic and 25 percent avoiding going to hospital even when they needed to.

Relating experience of internal stigma with the number of years the respondents have lived with HIV, it appears that people who have had HIV for less than 3 years have more experiences of internal stigma compared to those who have had it for more than 3 years. For instance, 54.5 percent of those who reported less than five experiences of internal stigma belong to the category of PLHIV who have had their HIV for less than 3 years, while only 45.5 percent report less than five experiences of internal stigma. Interestingly, of those who reported many experiences (more than 15 types) of internal stigma, 100 percent of them belong to the category of PLHIV who have had HIV for less than 3 years.

Table 8: Number of Years Living with HIV and Experience of Internal Stigma

Internal Stigma	<3 years	3 years and above
	In percent (N=61)	In percent (N=19)
Less than 5 reported experience of internal stigma	54.5	45.5
Some reported experience of internal stigma (5-9 types)	63.0	37.0
Several reported experience of internal stigma (10-14 types)	87.1	12.9
Many reported experience of internal stigma (more than 15 types)	100.0	0.0

The table below shows specific experience of internal stigma based on the category of Sex and MSM/Non-MSM.

Interestingly, more males (82%) and MSM (81.1%) feel ashamed of their HIV status. There is also a greater number of males (84%) and MSM (86.5%) who feel guilty about their HIV status. There is also more self-blame happening among MSM (76%). On the other hand, more females (83.3%) and non-MSM (81.4%) are afraid of being gossiped about. There are also more MSM who feel suicidal with almost half saying this.

DISCUSSION

That there are more male than female participants reflect the fact that there are more HIV positive males compared to HIV positive females in the Philippines. For instance, in the March 2011 report of the National Epidemiologic Center (2011), of the 6,498 cases of HIV infection, 5,142 are males while only 1,345 are females.

Majority of the participants are in the prime of their lives given that they are in the 25-39 age range. It becomes more difficult for these individuals to face their HIV status because they are at an age when the prospect of death is far from their minds. With their HIV status, these individuals are suddenly faced with the prospect of opportunistic infections and the possibility of death. As if this were not enough, HIV positive individuals also have to face stigma, both the external and internal kinds, which affect how they view and live their lives.

Table 9: Experience of Internal Stigma by Category of Stigmatized

Internal Stigma	SEX		MSM/NONMSM	
	Male (N=50)	Female (N=30)	MSM (N=43)	Non-MSM (N=37)
I feel ashamed	82.0	60.0	81.1	67.4
I feel guilty	84.0	63.3	86.5	67.4
I blame myself	70.0	56.7	75.7	55.8
I blame others	24.0	43.3	32.4	30.2
I have low self-esteem	56.0	53.3	51.4	58.1
I feel I should be punished	38.0	23.3	43.2	23.3
I feel suicidal	38.0	36.7	48.6	27.9
I have chosen not to attend social gathering(s)	50.0	46.7	56.8	41.9
I have isolated myself from my family and/or friends	28.0	33.3	35.1	25.6
I took the decision to stop working	40.0	33.3	48.6	27.9
I decided not to apply for a job/work or for a promotion	32.0	26.7	40.5	20.9
I withdrew from education/training or did not take up an opportunity for education/training	16.0	6.7	13.5	11.6
I decided not to get married	40.0	33.3	43.2	32.6
I decided not to have sex	48.0	20.0	48.6	27.9
I decided not to have (more) children	58.0	60.0	62.2	55.8
I avoided going to a local clinic when I needed to	36.0	33.3	37.8	32.6
I avoided going to a hospital when I needed to	26.0	23.3	27.0	23.3
Fearful of being gossiped about	64.0	83.3	59.5	81.4
Fearful of being verbally insulted, harassed and/or threatened	50.0	73.3	54.1	62.8
Fearful of being physically harassed and/or threatened	44.0	53.3	48.6	46.5
Fearful of being physically assaulted	40.0	46.7	43.2	41.9
Afraid that someone else would not want sexually intimacy	42.0	33.3	37.8	39.5
<i>Experienced at least 1 type of internal stigma</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>

There are less reported experiences of external stigma or discrimination among the respondents. A possible reason for this is that most of them have revealed their HIV status to people who are less likely to form negative judgments on them such as adult family members, other PLHIV, health care workers, social workers, and counsellors. In other words, they have chosen to reveal their status to significant others. On the other hand, few have revealed their status to employers and neighbours and even fewer revealed their status to religious leaders, teachers, community leaders, and government officials. A possible reason for this is because the respondents do not share personal relationships with these people and therefore there are chances that these people will be less accepting of their condition.

The most common form of stigma they have experienced is being the object of gossip. About half of the participants report having experienced being gossiped about by peers and associates. Interestingly, the fear of being the object of gossip is also their greatest fear, with majority of the females experiencing this. Pedroso et al (2010) report that people with HIV endure “insults, taunts and name-calling” and “derogatory and demeaning language” to them. In the Philippines for instance, PLHIV are referred to as, “*may AIDA iyan*” (AIDA is gayspeak for AIDS). The illness now becomes a permanent attachment to the identity of the PLHIV, as if this were the most important trait of the person. Gossip possibly becomes a source of fear because of the difficulty of controlling the information being passed around. This could also lead to ruined reputation or changed attitudes towards them. Interestingly, a greater number of people who have been living with HIV for less than 3 years are preoccupied with being the object of gossip compared to those who have been living with HIV for more than 3 years. This may be because they have not come to terms with their illness and therefore they are afraid of what other people may have to say about their condition. There may also be greater fear for gossip because gossip could potentially disclose their status to people they have not intended to disclose their HIV status to.

On the other hand, there is very high disclosure to family members of their HIV status. The low number of discrimination perpetrated within the family, especially among those who have had HIV for three years and above may have to do with the fact that family members learn to accept and deal with the status of PLHIV at some point. The well-developed sense of

responsibility among Filipinos of the need to take care of family members may have to do with this. The difference in the reporting of discrimination in the family possibly indicates that some family members exclude PLHIV when they initially find out the status of their family member with HIV hence 15 percent of those with HIV for less than 3 years have reported being excluded by family members; however, in time, there is acceptance of the illness of the participant. This possibly explains the absence of reported experiences of family exclusion among those who have had HIV for 3 years or more.

A greater percentage of the respondents report experiencing internal stigma. For instance, almost $\frac{3}{4}$ of the total number of respondents report feeling shame and guilt over their HIV status. This is especially true of the respondents who have had their HIV for less than 3 years who have reported more experiences of internal stigma compared to those who have had the virus for three years or more. We turn to Fife and Wright (2000, 53) for a possible explanation, who say that there is shame because HIV is caused by a “behaviour considered to be deviant, is classified as a sexually transmitted disease, is thought to be acquired by way of immoral behaviour, and is perceived as contagious and dangerous to the community.” The difference between those who have had HIV for less than three and three years or more may be due to the fact that those who have had HIV for less than three years have yet to come to terms with their illness, whereas those who have had it for more than three years have already come to accept their situation. There also appears to be more experiences of internal stigma among MSM compared to males, females, and non-MSMs. This may have to do with the fact that they not only have HIV, they are also MSM, thus they experience double stigma over their sexuality and health condition.

Unfortunately, internal stigma has real consequences on how PLHIV view themselves and how they act as well. For some, their status has not only lowered their self-esteem, but it has also pushed them to isolate themselves from others and to evade social contact. This has led some to experience depression, hopelessness, and alienation from others (Lee et al., 2008). And worse, some have even contemplated suicide.

CONCLUSION

This study is important in that it has given us a preliminary view of the experiences of stigma of Filipino HIV positive individuals. Here we have seen that there are possible differences in the experience of external stigma between Westerners and Filipinos. For instance, in the studies conducted in the United States that were cited in the introduction, we have seen that one of the most prominent experiences of PLHIV from Western countries (i.e. the United States) that have been highlighted in research is the double stigma experienced by MSM. However, based on the results of this study, there may be basis in saying that there is really not much difference between the experience of MSM and non-MSM in terms of external stigma and discrimination. Instead, the difference lies more between migrants and non-migrants; wherein migrants experiencing more instances of discrimination compared to non-migrants. A possible reason for this is that migrants, when they found out that they have HIV, are usually barred by foreign employers from working. Hence, there has been a very high reporting of loss of employment among migrants because of their HIV status. There are indications that families of PLHIV are accepting of kinsfolk afflicted with HIV, which indicates that the family is still an important support structure for HIV individuals.

However, internal stigma appears to be the greater problem of the respondents, especially those who have had to deal with their illness for less than three years. There is also higher reporting of internal stigma among the MSM group compared to non-MSM.

Since this is a quantitative study, it has not captured the nuances of experiences of HIV positive individuals as regards external and internal stigma. Thus, one of the recommendations of this research is to conduct a qualitative study of the experiences of internal and external stigmatization of PLHIV (for example, stigmatization experience of migrants, of MSM, and the like). This will heighten the texture of understanding of the experiences of PLHIV as regards external and internal stigma.

Regarding further studies on the experience of PLHIV, it would be good to compare the experiences of stigma of PLHIV of Filipino PLHIV with PLHIV from different countries that have used the PLHIV Stigma and Discrimination Index. A panel study, tracking the experiences of stigma of

PLHIV would also be good to embark on to see the changes in the experience of stigma of people who live with HIV as the years go by and to see improvements or deterioration in their experiences. Moreover, qualitative studies that mine the experiences of PLHIV should also be embarked on to allow for a deeper understanding of the external and internal stigma experiences and constructions of PLHIV. In future studies using the PLHIV Stigma and Discrimination Index, it would be good to increase the number of respondents to get a more comprehensive picture of the situation of HIV positive individuals in the Philippines. Improvements can also be made in the questionnaire in order to ensure that nuances in the experiences of PLHIV are properly captured.

NOTES

¹ The term migrant in the original questionnaire was translated as migranteng manggagawa in the questionnaire administered to Filipino PLHIV.

² The percentage refers to those who have a spouse/partner.

REFERENCES

- Aggleton, P. (Ed.). (1996). *Bisexualities and AIDS*. London, Routledge.
- Aggleton, P. (Ed.). (1998). *Men Who Sell Sex*. London, Routledge.
- Alonzo, A. & Reynolds, N. (1995). Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science & Medicine*. 41 (3): 303-315.
- AVERT. (2011). *HIV, AIDS, and Men who Have Sex with Men*. Retrieved October 16, 2011 from <http://www.avert.org/men-sex-men.htm>
- Ban, K. (6 August 2008). The stigma factor. *The Washington Times*. Retrieved October 16, 2011 from <http://www.washingtontimes.com/news/2008/aug/06/the-stigma-factor/>
- Bauman, Z. (1992). *Mortality, Immortality, and Other Life Strategies*. London: Polity.
- Department of Health-National Epidemiology Center [DOH-NEC]. (2011). *National HIV/AIDS and STI Strategic Information and Surveillance Kit*. NEC and Department of Health: Manila, Philippines.
- Fife, B. & Wright, E. (2000). The Dimensionality of Stigma: A Comparison of Its Impact on the Self of Persons with HIV/AIDS or Cancer. *Journal of Health and Social Behavior*. 41(1): 50-67.
- Goffman, E. (1963). *Stigma*. London: Penguin.
- International Planned Parenthood Federation [IPPF]. (2008). *The People Living with HIV Stigma Index: User Guide*. London: UK.
- International Planned Parenthood Federation [IPPF]. (2009). *Give Stigma the Index*

- Finger: Initial Findings from the PLHIV Stigma Index in the UK 2009*. Retrieved October 16, 2011 from <http://www.ippf.org/NR/rdonlyres/96FA67B8-37E8-465E-9C6A-F666C7B83136/0/InitialFindingsStigmaIndex.pdf>
- Lee, R., Kochman, A. & Sikkema, K. (2008). Internalized Stigma Among People Living with HIV-AIDS. *AIDS and Behavior*. 6(4):309-319.
- Parker, R. & Aggleton, P. (2002). *HIV/AIDS-related stigma and discrimination: a conceptual framework and an agenda for action*. Washington, DC: Population Council/ Horizons. p.28. Retrieved October 16, 2011 from <http://www.popcouncil.org/pdfs/horizons/sdcncptlfrmwrk.pdf>
- Pedroso, L., Quinto, N., Duque, M., Naldoza, R. & Hows, J. (2010). *Stigma and Discrimination Experiences of People Living with HIV and AIDS in the Philippines* (Research Report). Quezon City: Pinoy Plus.
- Valdiserri, R. (2002). HIV/AIDS Stigma: An Impediment to Public Health. *American Journal of Public Health*. 92(3): 341-342.

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UNDERSTANDING THE NEEDS OF PEOPLE LIVING WITH HIV IN THE PHILIPPINES

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ABSTRACT

Recognizing the need to give voice to people living with HIV in the Philippines, the Philippine National AIDS Council (PNAC) initiated a participatory research with members and leaders of organizations for people living with HIV (PLHIV). Seven FGDs were conducted with five gay or men having sex with men (MSM) groups, one heterosexual female group, and one heterosexual male group. Thematic analysis of the expressed needs of PLHIV focused on the self, the family, the community of PLHIV organizations, and society at large. Most salient for the participants were themes of coming to terms with HIV as a person and as a family, followed by basic survival needs. Implications focus on the need for a comprehensive psychosocial support program for PLHIV and their families.

KEYWORDS: *people living with HIV (PLHIV), psychological needs, coming to terms with HIV, psychosocial support, families of PLHIV*

UNDERSTANDING THE NEEDS OF PEOPLE LIVING WITH HIV IN THE PHILIPPINES

Although a low-HIV prevalence country, the Philippines has been experiencing a marked rise in the number of HIV cases in recent years. In April 2011, 171 new cases were reported to the HIV/AIDS registry; an 11 percent increase from the same period in 2010. A 38 percent increase was observed in December 2010 as compared to the same period in 2009. Similar patterns have been noted throughout 2010 and 2011 (Department of Health-National Epidemiology Center [DOH-NEC], 2011).

Both the government and the private sector, including international development agencies, have strengthened their response to the alarming increase in HIV cases in the country. But amidst numerous programs and initiatives directed at addressing HIV in the Philippines, leaders and members of the organized community of people living with HIV (PLHIV) still express their need for their individual and collective stories to be heard. PLHIV, in this study, refer to persons diagnosed as positive for HIV. Most of the PLHIV who participated in the study were HIV-positive only while some also had HIV/AIDS.

In an initial group discussion, leaders of organized PLHIV groups observed that their ability to communicate what is truly relevant for them in their journey as PLHIVs is often lost in the sea of voices of institutions and agencies prescribing the appropriate treatment, care, and support for their group. Often the subjects of research, PLHIVs through leaders of PLHIV organizations shared their experience of being seen as mere carriers of a disease rather than as whole persons with everyday realities. This study is a response to a felt need expressed both by the leaders of the PLHIV community and by the Philippines National AIDS Council (PNAC) secretariat to give voice to people living with HIV.

Through a participatory research process initiated by the PNAC secretariat, PLHIVs together with the researchers conceptualized the questions and methodology of this study. People living with HIV were asked to share their life stories, their journey towards healing, their envisioned programs, and their personal needs and concerns in their own everyday realities. It is hoped that an analysis of their narratives using the lens of psychology would be helpful in developing programs that are responsive to the needs of PLHIVs. In this paper, the authors present the results of one

part of a larger research project, the section that focuses on understanding the needs of people living with HIV.

REVIEW OF RELATED LITERATURE

The human immunodeficiency virus or HIV attacks and weakens the body's immune system. A person with HIV becomes vulnerable to severe opportunistic infections called AIDS-defining illnesses. A person manifesting symptoms of these AIDS-defining illnesses is said to have Acquired Immunodeficiency Syndrome or AIDS. A person living with HIV or PLHIV is infected with the virus but may not yet experience the illnesses characterizing AIDS (Cichocki, 2007). In the present study, the PLHIV participants were those who were HIV positive only and those who had HIV AIDS.

Early research on HIV focused on its biological aspect, in particular, how the virus is transmitted and how it progresses from HIV to AIDS (Pretorius, Goldstein, & Stuart, 2005). The interest was mostly on the medical treatment of the HIV virus. With the advent of antiretroviral (ARV) drugs and antiretroviral therapy (ART) that suppress the HIV virus and stop the progression to AIDS, HIV became regarded as a chronic condition rather than a death sentence from an acute illness (Pretorius et al., 2005). The investigation of psychosocial factors came later when it was recognized that they play an important role in the experience of HIV/AIDS. Studies have examined how personality factors like coping style and the presence of social support influence coping with the condition (Mill, Lambert, Larkin, Ward & Harrowing, 2008; Hall, 2003; Reeves, Merriam, & Courtenay, 1999).

Later studies explored the impact of being HIV positive on the everyday lives of PLHIV. Zulkifli, Soo Lee, Wah Yun, and Lin (2006) who looked into the psychosocial, medical, and economic impact of being HIV-positive in Malaysia focused on the need of PLHIVs to participate in policy-making and program implementation. Majumdar and Mazaleni (2010), in a qualitative study with PLHIV in South Africa, found that the needs of PLHIV include the physical/medical, social, material/financial, and psychological/emotional. Gender issues were also noted. They highlighted the experience of HIV in the context of poverty and limited access to resources and services. Among the findings is how PLHIVs cope with the condition by accepting their status and drawing strength from spirituality and support from family..

Other studies have described the psychological distress brought about by the condition and how coping strategies become extremely important to deal with the emotional stress of living with HIV (Kabbash, El-Gueneidy, Sharaf, Hassan, & Al-Nawawy, 2008).

In the Philippines, studies have similarly focused on prevalence rates, epidemiology, the experience of stigma and discrimination, and the various programs that the Philippine government has created to address the problem of HIV/AIDS (Ditangco, 2006; Ortega, Bicaldo, Sobritchea, & Tan, 2005; Mateo, Sarol, & Poblete, 2004). Little is known about the issues, concerns, and needs of people living with HIV and their lives as persons beyond their being HIV positive. This paper seeks to address this gap by understanding the needs of people living with HIV in the Philippines by listening to their voices.

THEORETICAL FRAMEWORK

In this study, we adapted the ecological framework to guide the study and analysis of the needs of people living with HIV. Conceptualized by Bronfenbrenner (1977) to understand human or child development, Ecological Systems Theory argues that the person is in constant interaction with the environment and that this ecological environment is comprised of nested layers which he originally organized as five sub-systems. The innermost layer is the immediate environment such as the family, which then connects to the external environment like the workplace, and progresses to the larger cultural context such as the economy. The model is often depicted in terms of concentric circles that represent the individual in the context of the microsystem, the mesosystem, the macrosystem, and the chronosystem (i.e. time).

Ecological systems theory further posits that these different layers interact in shaping human development across time. Its main contribution is the conceptualization of the person in context, of human phenomena embedded in increasingly larger units of social organization (Bronfenbrenner & Evans, 2000). It is this main idea that we utilize for our ecological framework when we locate the needs of people living with HIV in the individual self and the social groups they belong to. This adaptation of the nested ecological model has been similarly done in past studies. For instance, Heise (1998) developed an ecological model to explain violence

against women with four spheres depicting the factors related to abuse: (a) individual, (b) situational, (c) structural, and (d) cultural. In another example, Ofreneo and de Vela (2010) used an ecological model to locate the issues of Asian lesbian, gay, bisexual, and transgender activists in four spheres: (a) the self, (b) family and peers, (c) community and social movements, and (d) formal institutions.

In this study, we organized the needs articulated by people living with HIV in a nested ecological model with four spheres: (a) the individual; (b) the family; (c) the organized community of PLHIV; and (d) Philippine society at large.

METHOD

This study utilized qualitative research methods. The participants were people living with HIV who belong to PLHIV organizations. The PLHIV participants were mostly HIV positive individuals but some participants had HIV AIDS. The focus group discussion (FGD) was used to gather data from seven groups of PLHIV participants. Each FGD was audio-recorded, and transcribed with permission from the participants. Data was analyzed following procedures for thematic analysis.

PARTICIPANTS

A total of 56 individuals living with HIV participated in the study. In consultation with leaders of PLHIV organizations, focus groups were formed based on their gender, sexual orientation, and stage of diagnosis as HIV positive. A total of 7 FGDs were conducted: five (5) with men having sex with men (MSM) or gay men, one (1) with heterosexual women, and one (1) with heterosexual men. Each group had six to 10 participants. Three of the five MSM groups were divided in terms of the length of time between initial diagnosis as HIV positive to the time of the present study: (a) early (0-1 year), (b) middle (2-4 years), and (c) late (5 years and up). The other two MSM groups as well as the heterosexual female and heterosexual male groups have varying lengths of time between initial diagnosis and the conduct of the study. Selection and participation in the FGDs were based on informed consent from the PLHIV participants.

Participants were generally from the lower and middle socioeconomic classes, with secondary and tertiary educational background, and from diverse occupations. Some have previously worked overseas. Many were young adults, in their 20s and 30s, while some were middle-aged adults, in their 40s and 50s. Participants were recruited through purposive and snowball sampling by the PNAC secretariat and leaders of PLHIV organizations. Many of the participants were members of PLHIV organizations.

Names of participants and organizations have been withheld to maintain confidentiality.

PROCEDURE

A set of open-ended questions for the FGD was developed in collaboration with leaders of PLHIV organizations and the PNAC secretariat. The final set of guide questions focused on: (1) the journey of PLHIV from the point of diagnosis to the present, (2) the needs of PLHIV, and (3) programs PLHIV expressly need. Social preparation of participants was conducted prior to the actual FGDs. This involved informing the participants of the purpose and nature of the study, introducing the FGD facilitators and research team, clarifying concerns, and assuring confidentiality. Representatives from the PNAC secretariat and leaders of PLHIV organizations were present during the FGDs. The FGDs were facilitated by psychologists and documented by psychology graduate students. Recording and transcription of data from the FGDs were permitted both by the leaders of the PLHIV organizations and by the participants. All seven FGDs were transcribed verbatim. The team of psychologists organized and analyzed the narratives using thematic analysis. The research team conducted a series of separate individual analyses as well as collective analyses in an iterative process of validating the themes with the raw data. Permission to share the results of the study was granted by the PLHIV participants.

RESULTS

As conceptualized by the ecological framework, the person living with HIV views the self as embedded in a family, in an organized community of PLHIV, and in Philippine society (see Figure 1). Their expressed needs as PLHIV revolve primarily on the needs of the self but include the needs of their family, their community, and the public or society at large. These needs are organized into thematic clusters that are visually presented in Figure 1 and listed in Table 1.

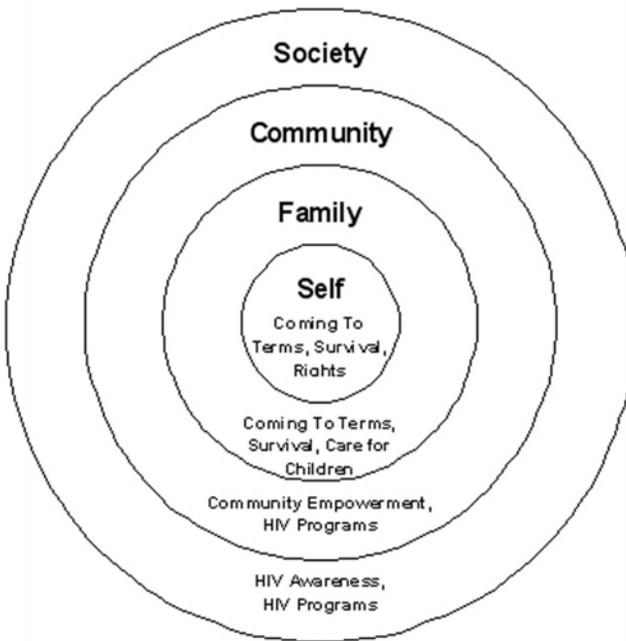


FIGURE 1
Needs of the PLHIV Person in a Nested Ecological Model

Table 1 presents the summary of needs identified by the PLHIV participants per ecological context. The needs are presented as thematic clusters which will be fully discussed in the subsequent sections.

Table 1. Thematic Clusters of Needs of the PLHIV Person in Context

The PLHIV Person in Context	Thematic Clusters of Needs
Self or the Person Living with HIV	<ul style="list-style-type: none"> • Coming to Terms with HIV • Basic Survival of the PLHIV • Rights as PLHIV
Family of the PLHIV	<ul style="list-style-type: none"> • Coming to Terms with HIV • Basic Survival of the Family of the PLHIV • Care for Children with HIV
Community of PLHIV Organizations	<ul style="list-style-type: none"> • Organizational/Community Empowerment • Government Programs for PLHIV Organizations
Society or the Public	<ul style="list-style-type: none"> • HIV Advocacy and Awareness • HIV Government Programs

In the summary table of thematic clusters of needs, the first set of needs resides in the context of the self. The individual needs of PLHIV revolve around coming to terms with HIV, their basic survival as PLHIV, and the exercise of their human rights as PLHIV. The most salient thematic cluster within the context of the self is coming to terms with HIV, which centres on the psychosocial needs of the individual in terms of coping with the condition and functioning fully as a human being. Coming to terms is most important based on the participants' narratives during the FGD as this theme was the most heavily discussed.

The second set of needs of PLHIV falls within the context of the family. The PLHIV participants view the needs of their family as part of their own. These include the families' own need to come to terms with a family member who is HIV positive, their basic survival needs as families living with a family member with HIV and in the case of death, and the unique need to care for children with HIV.

The third set of needs are in the context of the organized community of PLHIV. The PLHIV participants, who are mostly members of PLHIV organizations, also articulated the needs of their organizations which include organizational or community empowerment as well as government programs to service PLHIV organizations.

The fourth and last set of thematic clusters of needs are in the context of Philippine society. The PLHIV participants also perceived the needs of society or the public at large as part of their needs as PLHIV. These focus on HIV advocacy and awareness and HIV government programs that primarily address the stigma and discrimination directed towards PLHIV. These themes will be discussed in detail in the succeeding sections.

NEEDS OF THE SELF OR THE PERSON LIVING WITH HIV

The people living with HIV who participated in the study articulated the need to come to terms with being HIV positive the most; second was survival; and third was the exercise of rights. Coming to terms with HIV symbolized the psychological need to cope with being HIV positive and to adapt to the “new” life of a person living with HIV. For the PLHIV participants, being HIV positive was seen as an illness (*sakit*) even if medical literature distinguishes between having HIV, the virus infection, and AIDS, the disease or illness. In the words of an FGD participant, “*Kung hindi mo tanggap yung sakit mo, di ka pa makakalabas sa isang pintuan na kaya mong harapin ang panibagong buhay. Kung tanggap mo siya as parte na ng buhay mo, handa mo nang harapin yung panibagong buhay...* (If you can’t accept your illness, you can’t open the door to a new life. But if you can accept it as a part of your life, then you’re ready to face a new life...)” It is possible that “*sakit*” is used to refer to being HIV positive as a medical condition, not necessarily as a disease or an illness in medical terms.

Survival needs pertained to their medical or health needs as well as economic or livelihood needs. The PLHIV participants shared their dependence on antiretroviral or ARV drugs that are currently being provided for free by the Global Fund. “*Huwag sana matigil yung suporta ng Global Fund. Kasi paano naman yung ibang tao na hindi afford yung gamot na nasa worth ng P15,000 a month?* (I hope that the support from the Global Fund will not stop. What will happen to those who cannot afford the medicines that cost P15,000 a month?)”

The needs revolving on the PLHIVs’ exercise of rights focus on the right to social services, legal recognition, and political participation. For example, participants stress their right to non-disclosure of their HIV positive status. “*Hindi naman pwedeng i -disclose yan agad agad kasi may right ka sa confidentiality, to have a private life di ba?.. Yung mga policy na kailangan*

mag-disclose... violation of human rights yan. May karapatan ka. (You cannot just disclose because you have a right to confidentiality, to have a private life, right?.. Those policies that require disclosure... those are a violation of human rights. You have rights.)”

The succeeding sections will elaborate on these thematic clusters of needs.

Table 2. Major Themes and Sub-Themes of Needs of the Self or the Person Living with HIV

Major Themes	Sub-Themes
Coming to Terms with HIV	<ul style="list-style-type: none"> • Self-Acceptance • Resilience • Existential Needs • Self-Empowerment • Social Acceptance • Social Support
Basic Survival of the PLHIV	<ul style="list-style-type: none"> • Medical/Health • Economic/Livelihood
Rights as PLHIV	<ul style="list-style-type: none"> • Right to Social Services • Right to Legal Recognition • Right to Political Participation

Coming to Terms with HIV

Coming to terms with HIV is a cluster of needs towards psychological wellness or well-being in the midst of illness. It refers to the psychological needs of the individual trying to accept a life with illness and dealing with the unique demands of being inflicted with HIV. It encompassed cognitive, emotional, spiritual, and existential needs. The need to accept, to “bounce back” and be resilient, to survive and transcend one’s life, and to actively cope with the illness were individual needs shared alongside the need for social acceptance and social support. Six themes fall under this cluster: self-acceptance, resilience, existential needs, self-empowerment, social acceptance, and social support.

Self-Acceptance. Accepting that one has HIV signifies the start of the journey to healing from a psychological perspective. Psychological healing refers to a sense of accepting one's self and one's situation, consequently allowing one to face life as an HIV positive person. The need for self-acceptance is seen as crucial to overcome the negative effects of HIV. Participants shared that if a PLHIV could not accept the illness as part of one's life, one will have difficulties coping with the demands of the disease. For some, accepting that one has HIV is the most important step towards living a bearable even comfortable life as a PLHIV. "*Ang pinaka importante kasi acceptance eh. Dumating talaga sa point na talagang down na down ka, up and down ang buhay mo ngayon, so acceptance ang pinaka maganda diyan para at least lumuwag ang loob mo, maging komportable ka kahit papaano ang buhay mo.* (Acceptance is the most important. One will reach the point of feeling beaten down and acceptance is the best way to experience relief and comfort.)"

Another kind of self-acceptance is accepting one's sexuality, specifically for the homosexual and MSM participants. "*Sa mga MSM diyan na hindi pa tanggap kung sino sila, kailangan nyo tanggapin ang sekswalidad nyo. Hindi nyo dapat ikinahihiya at wag nyong ituring na parusa ang pagkakaroon ng HIV kasi pumatol kayo sa lalake.* (For the homosexuals who still can't accept who they are, you need to accept your sexuality. Don't be ashamed and don't consider HIV as a punishment for having sex with men.)"

A third type of self-acceptance is accepting a "new" life with HIV. This part of self-acceptance reflects the need of PLHIV to start anew and to adjust their goals and plans in life now that they are living with HIV. Such self-acceptance is illustrated in the following passage, "*Siguro acceptance lang talaga ang pinaka the best way to survive. Basta hindi mo tatanggapin kung ano ka, ikaw pa rin mag-sa-suffer. Pero kung tatanggapin mo siya na ganun ka, talagang ma-ma-manage mo ng maganda ang buhay mo.* (Acceptance is the best way to survive. If you can't accept who you are, it is you who will suffer. But if you accept it, you can manage your life well.)" As one participant explained, self-acceptance opens the door to a new life and gives the person courage to face life anew.

Resilience. Resilience is the ability of the PLHIV to cope with the problems and challenges associated with the disease by using cognitive skills such as reframing to cope with the illness. The reframing of the situation enables

them to cope with being HIV positive. Cognitive reframing involves the process of changing negative thought processes into more constructive ones as illustrated in the following quotation, “*Hindi ko tinitingnan na barrier sa buhay ko ang pagiging HIV-positive. Tinitingnan ko siya bilang isang opportunity, blessing in disguise.* (I don’t look at being HIV-positive as a barrier in my life. I look at it as an opportunity, as a blessing in disguise.)” The PLHIV participant further explained that if he were not HIV positive, he would not be a productive human being who is able to help others. “*Kung hindi dumating yung chapter na yon... natutulog lang ako... ngayon nagtatrabaho... tumutulong sa kapwa.* (If that chapter did not happen... I would just be sleeping... but now I’m working... I’m helping others.)” The need for positive thinking was very evident. “*Kung ma-depress ka, magpadala ka sa depression, diyan ka ma, ika nga parang kandila, mauubos ka na, kaya dapat lumakas ang loob mo.* (If you will allow yourself to be depressed, you’re like a candle melting. That’s why you need to be strong.)”

Existential Needs. The PLHIV participants also expressed needs that can be considered existential, which is defined by literature as finding meaning in one’s life and experiences (Pretorius, et al., 2005). Existential needs are expressions of a PLHIV’s desire to make meaning in their lives. They make meaning in being HIV positive by being closer to God and by leaving a legacy in this world through their children. Some of the participants saw their illness as a way of coming back to God after engaging in sinful acts. “*Yung sa akin kasi, kung bakit naging ganito tayo. Kasi siguro, naligaw na tayo. Kaya ang point Niya is inaayos Niya tayo.* (The reason why we have this disease is because we lost our way. So He is trying to make us right.)” Some participants expressed hope of finding someone they can share their life with, someone who will not reject them. “*Gusto ko makahanap ng partner na kaya ba niyang tanggapin na meron ka na.* (I want to find a partner who can accept me as a PLHIV.)” Some of the female participants expressed the need to have a family or children. “*Sana po mag-asawa pa ako, para magka-pamilya, magka-anak. Para kahit mawala ako, ‘yung legacy ko is nandun pa.* (I wish I can still marry, have children, have a family. So even when I’m gone, my legacy continues.)”

Self-Empowerment. Self-empowerment is the need of PLHIV to proactively cope with their condition and move on with their life despite having HIV. It refers to actively taking responsibility or taking charge of

their lives rather than being controlled or being held back by HIV. It involves making decisions towards realizing desired changes, e.g., being more politically involved in HIV/AIDS advocacy, making medical decisions for themselves, striving for economic independence, and actively gaining more knowledge about every aspect of HIV/AIDS. "*Tiningnan ko sa internet kung ano ang HIV, AIDS, parang nag-aaral ka sa sarili mo na alamin mo kung ano ba 'yang, may gamot na ba dito.* (I look it up in the internet, what's HIV, AIDS. It's like learning for yourself, finding out if there's a cure.)". Other participants stated that they need to help themselves first and not depend on government for help. "*Kung gusto natin ng ano, tulong, wala namang higit na makakatulong sa atin kundi ang mga sarili natin.* (If we want help, no one can help us better than ourselves.)"

Social Acceptance. The participants also expressed their need for social acceptance, specifically from their families and intimate relations. They believed that the acceptance they receive from the people around them helps them cope with the illness. "*Pag 'di ka tanggap ng pamilya mo, maaga ka mabubura sa mundong ibabaw. Tanggap ako ng pamilya ko kaya buhay pa.* (You will die early if your family does not accept you. I'm accepted by my family. That's why I'm still alive)". The participants also expressed their need for acceptance from society at large. "*Sana lumawak pa yung mga taong katulad ninyo na nagbibigay ng oras sa mga katulad namin. Kasi malaking bagay na yun sa amin para mapalakas pa yung loob ng mga taong tulad namin na nawawalan ng pag-asa.* (I hope there will be more people like you who will spend time listening to us. Because it gives us hope, especially those among us who are already losing hope)."

Social Support. The last sub-theme under coming to terms with HIV is social support from partners, families, the PLHIV community, and society. Support can come in the form of encouragement or any kind of assistance. "*Atsaka andiyan pa rin ang pamilya. So sila lang ang hinuhugutan ko ng lakas.* (My family is still there. It's from them that I draw my strength.)" The PLHIV community is also an important source of support as participants reported needing to talk to and be with people who share their experience as PLHIV. "*Yung kapwa positive mo din na iintindihin ka at makakausap. Nasa likod mo lang.* (It's the other HIV positive people who will understand you and talk to you. They're just at your back.)"

Basic Survival of the PLHIV

Basic survival is the second thematic cluster of individual needs of PLHIV. The psychological needs as articulated by the PLHIV participants were presented first as these were the most salient in the focus group discussions. Basic survival needs for people living with HIV mean addressing their needs for medical care and financial support. Participants shared their dependence on antiretroviral (ARV) drugs or antiretroviral therapy (ART) for survival. This medical care is dependent on financial support, which is currently provided for by the Global Fund. Without free medical care, the survival of the PLHIV is dependent on one's means to find resources or to provide. And yet many of the PLHIV participants shared their difficulties in finding employment as many lost their jobs because of their HIV positive status. For the PLHIV participants in this study, health needs are intertwined with economic needs.

Medical/Health Needs. The medical needs of PLHIV centred on their need for access to treatment facilities, medicines, and funding for health needs. Many participants see the need for access to treatment facilities in the provinces. They also pointed to the need for more aggressive information dissemination about where Filipinos can get tested, diagnosed, and treated for free. They further noted the need to increase the capacity of the HIV wards of San Lazaro Hospital. A pressing concern is the need for continuous medication as well as monitoring, treatment, and care. All these medical care are dependent on financial support. The participants raised their concern that the free access to medical care through the Global Fund may not be sustained by government. They said that they can not afford the medicines that cost P15,000 a month, as well as their other medical needs including the cost of consultation fees and laboratory tests.

Economic/Livelihood Needs. The other side of survival is their need for employment and/or livelihood training. Some participants need to develop skills while others need opportunities for work. Many of the PLHIV participants shared their stories of being terminated from employment, especially those who worked overseas. Some have found sources of income through informal work like making and selling crafts or through volunteer work with PLHIV organizations. Some have managed to find regular employment. The need to find stable employment or a source of regular

income is most heavily felt by those who have lost work or could not find work because of their HIV positive status. “*Marami kaming natanggal sa trabaho. Walang trabaho. Naghihirap. Sana magkaroon sila ng isang programa na priority yung kagaya samin na magkaroon ng trabaho.* (Many of us lost our jobs. No work. In poverty. I hope that the government can have a program that will prioritize people like us to find work.)” The PLHIV’s economic needs are linked to the need to provide for their families which is later explained in the section on the needs of the family.

Rights of PLHIV

The third major thematic cluster of individual needs of PLHIV revolves around the recognition of their rights as PLHIV. These are rights to social services, to legal recognition, and to political participation.

Right to Social Services. Among the PLHIV’s perceived rights include the right to access social services such as medical and health services, economic or livelihood training and assistance, housing, and cremation assistance. They feel that it is the government’s responsibility to develop a health agenda and a health program for the PLHIV community. This includes sustaining free access to medical treatment. They also think that it is the government’s duty to provide them employment and/or livelihood opportunities. A set of unique needs expressed is the need for a “half-way” house for newly-diagnosed PLHIV, a safe house for PLHIV rejected by their families, and permanent housing for PLHIV and their families. The last social service noted by the participants is the need for cremation assistance upon their death.

Right to Legal Recognition. The participants raised their right to employment and non-discrimination at work and their right to privacy and non-disclosure of their HIV status. Issues in relation to keeping their HIV status confidential were paramount. They viewed it as government’s responsibility to recognize these rights as PLHIV.

Right to Political Participation. The final sub-theme is the PLHIV’s right to political participation. Some of the participants recalled a sense of detachment when the Republic Act of 8504 or the AIDS Protection and Control Act of 1988 was created without active consultation with the PLHIV community. They feel that they have the right to be consulted when policies on HIV/AIDS are being drafted.

NEEDS OF THE FAMILY OF THE PLHIV

The second set of needs expressed by the participants centred on the family. The needs of the families of PLHIV are divided into three major thematic clusters: coming to terms with HIV, basic survival needs of the family, and care for children with HIV.

Coming to Terms with HIV

Coming to terms with HIV deals with the emotional journey of one's immediate family accepting that a family member has HIV. The PLHIV participants believed that their parents and siblings are also undergoing a process of acceptance which can be very similar to their own process. The same is true for the partners or spouses of PLHIV as well as their children. "*It's a process din naman na katulad din natin na dumadaan sa ganung prosesos. Kailangan din nila ng gabay at ng pag-unawa.* (It's also a process that is similar to what we are experiencing. They also need guidance and understanding.)" Similarly, the families of PLHIV also need to empower themselves by being informed about HIV and being able to take an active part in the care and support of the family member with HIV.

Basic Survival of the Family of the PLHIV

The PLHIV participants also expressed the basic survival needs of their families that fall under two sub-themes: financial support for their family, and education for their children. Providing for the family was a primary concern of the heterosexual male participants who were the breadwinners of their families. It is also a concern for gay participants who were providing for parents, siblings, or even relatives, such as nephews and nieces. The concern for the needs of their children was most felt by the heterosexual female participants, some of whom have lost their spouses to AIDS.

A unique concern of PLHIV who have children is the future of their children especially when the PLHIV parent become ill or pass away. They are particularly fearful that their children will suffer in the future, especially if both parents have HIV. "*Pag ang parents na may HIV namatay na, ang nangyayari ganyan, walang choice kundi i-send sa isang agency na nag-cacater sa orphans ang mga bata.* (When the parents with HIV die, there is no choice but to send the children to an orphanage.)" In the midst of unstable

employment and possible death of the PLHIV parent, a participant asked, “*Paano mo mabibigyan ng magandang buhay?* (How can you give your child a good future?)” The economic insecurity facing the families and children of PLHIV is a concern. Thus, the PLHIV participants expressed their families’ need for financial support.

Care for Children with HIV

The last major theme under the needs of the families of PLHIV is caring for children with HIV. Some PLHIV participants fear that no one will take care of their inflicted children when they themselves pass away. In the words of one PLHIV participant, “...*worried pa rin ako sa future niya. Saka, basta ang ano, meron din ako na prayer na, pagkinuha ako ni Lord, gusto ko kasabay ko na iyong anak ko ganon. Parang ayaw ko na maiwan siya.* (...I’m still worried about my child’s future. I have a prayer that when the Lord takes me away, I wish that my child will come with me. I don’t want to leave him behind.)” Some of the participants also requested for special medical assistance for their children with HIV as they raised their unique medical needs as children.

NEEDS OF THE COMMUNITY OF PLHIV ORGANIZATIONS

The third set of needs expressed by the PLHIV participants focused on the needs of their own organized community of PLHIV. It has two sub-themes: organizational or community empowerment, and government programs for PLHIV organizations. Among the concerns raised include the need for unity among the different PLHIV organizations, the need for communication, the need for sincere leadership, and the need for counselling services particularly for newly-diagnosed members. Funding and financial support for their projects as well as the sustainability of government programs targeted to PLHIV organizations were also noted as a cause of concern.

NEEDS OF SOCIETY OR THE PUBLIC

The last set of needs for the PLHIV participants pertain to Philippine society and the public at large. The two major themes under this cluster are the need for HIV advocacy and awareness and the need for HIV government

programs. HIV advocacy and awareness is meant to address the stigma and discrimination experienced by PLHIV as well as to prevent HIV. The participants shared that they experience discrimination even from medical professionals and that some medical personnel are insensitive to their emotional state as PLHIV. Information dissemination about HIV is also needed for the public to be aware of the real nature of the illness and how it can be prevented.

The PLHIV participants also shared the need for HIV government programs that will primarily educate the public about HIV, and consequently help them cope with the stigma and discrimination towards PLHIV. A key government program mentioned is sex education, particularly for the youth.

DISCUSSION AND CONCLUSION

To summarize, understanding the needs of people living with HIV in the Philippines from an ecological perspective is to understand that their needs include the needs of their families, their community of friends or peers, and their wider social environment. As articulated by the PLHIV participants, their needs include the needs of the social groups they belong to. As such, one of the main contributions of this study is highlighting the interaction of the needs of the person living with HIV and the needs of one's family and peers. Unlike past studies (Majumdar & Mazaleni, 2010; Zulkifli, et al., 2006) that have reflected the individual needs of PLHIV, this study shows how the needs of PLHIV go beyond the individual self. Being HIV positive then is not experienced solely by the person with the illness but is felt and lived by the family and group of friends the PLHIV belongs to.

A key recommendation then is for a psychosocial support program that addresses the needs of people living with HIV, their families, and their communities. As the needs of people living with HIV go beyond their personal needs and extend to their families, their friends, and their communities; so do must programs directed towards HIV/AIDS. Psychosocial support programs must also cater to the families of people living with HIV for them to accept and cope with living with HIV in the family. PLHIV organizations likewise need organizational support in order to respond adequately to the diverse needs of their PLHIV members.

The inclusion of the needs of PLHIV organizations and Philippine society at large by the participants of this study could be attributed to sampling. As many of the participants belong to PLHIV organizations, their needs include the needs of their organizations. Their level of political awareness and involvement may explain the articulation of organizational and societal concerns.

Similar to Majumdar and Mazaleni (2010), the needs of people living with HIV in the Philippines include the physical/medical and material/financial, labeled here as “basic survival”; and the psychological/emotional and social, labeled here as “coming to terms”. The need for political participation raised in Zulkifli et al. (2006) was also articulated by the Filipino PLHIV participants and was labeled in this study as “rights”. Of the three clusters of needs – coming to terms, basic survival, and rights – coming to terms was stressed by the Filipino participants the most.

It seems that the most salient and yet seemingly most taken-for-granted need of Filipino PLHIV is their psychological need to come to terms with the illness. This coming to terms is a multifaceted cluster of needs ranging from self-acceptance, resilience, and existential needs, to self-empowerment, social acceptance, and social support. From the emotional to the cognitive, from the social to the spiritual, the psychological experience of living with HIV is made evident in the narratives of the PLHIV participants.

Another recommendation then is for psychosocial support programs to have components that specifically address each of the thematic needs articulated by the PLHIV participants. For instance, counselling may have to focus on facilitating the process of self-acceptance. Cognitive reframing may be a useful tool in developing resilience. A form of spiritual guidance or counselling may be helpful for those with existential issues. Specific behavioral coping strategies may help empower people living with HIV to better cope with the illness. For such a psychosocial support program to be comprehensive or holistic, it has to also be complemented by a medical program that can respond to their health needs as well as an economic program that can address their livelihood concerns.

A dream of the PLHIV participants is for agencies and organizations to help them build a place of sanctuary. Complementing the need for continuous counselling and psychosocial support, a physical structure that can serve as a safe space or refuge can offer them a breathing space from their everyday

lives as people living with HIV; a place to rest from the many demands of families and organizations; a place to be safe from the experience of stigma and discrimination.

To conclude, what was most significant for people living with HIV is their need to come to terms with their life as PLHIV, that is, with HIV/AIDS as part of their everyday reality. They need to cope with the illness alongside continuing to live as human beings with their own unique personal contexts. As one participant shared, they do not stop being persons trying to live a meaningful life just because they have HIV/AIDS. They want to and they need to continue being significant and relevant members of their family, their HIV/AIDS community, and their society. They do not cease to be parents, partners, family members, friends, leaders, and members of society. As such, programs directed towards PLHIV must address their need to not only cope with the illness but to continue making a significant difference in the lives of their loved ones, their community, and the society as a whole.

REFERENCES

- Bronfenbrenner, U., & Evans, G. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development*, 9, 115-125.
- Bronfenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education* (Vol 3., 2nd ed.). Oxford: Elsevier.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-531.
- Cichocki, M. (2007, September 18). *The HIV – AIDS connection: HIV and AIDS are related but they are not the same thing* (online article). Retrieved November 20, 2011 from <http://aids.about.com>
- Department of Health-National Epidemiology Center [DOH-NEC]. (2011). *National HIV/AIDS and STI Strategic Information and Surveillance Kit*. NEC and Department of Health: Manila, Philippines.
- Ditangco, R. (2006). HIV/AIDS in the Philippines. *The Journal of AIDS Research*, 8(1), 12-16.
- Hall, S. (2003). *A phenomenological investigation into the lives of HIV positive South Africans* (Unpublished master's thesis). Retrieved February 23, 2011 from <http://web.ebscohost.com>.
- Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*, 4(3), 262-290.

- Kabbash, I., El-Gueneidy, M., Sharaf, A., Hassan, N., & Al-Nawawy, A. (2008). Needs assessment and coping strategies of persons infected with HIV in Egypt. *Eastern Mediterranean Health Journal*, 14(6), 1308-1320.
- Majumdar, B., & Mazaleni, N. (2010). The experiences of people living with HIV/AIDS and of their direct informal caregivers in a resource-poor setting. *Journal of the International AIDS Society*, 13(20). Retrieved August 10, 2011 from: <http://www.jiasociety.org/content/13/1/20>
- Mateo, R., Sarol, J., & Poblete, R. (2004). HIV/AIDS in the Philippines. *AIDS Education and Prevention*, 16, 43-52.
- Mill, J., Lambert, D., Larkin, K., Ward, K., & Harrowing, J. (2008.). Challenging lifestyles: Aboriginal men and women living with HIV. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 5(2), 151-174.
- Ofreneo, M., & de Vela, T. (2010). Spheres of lesbian, gay, bisexual, and transgender struggles: A comparative feminist analysis. *Gender, Technology, and Development*, 14 (2), 197-216.
- Ortega, N., Bicaldo, B., Sobritchea C., & Tan, M. (2005). Exploring the realities of HIV/AIDS-related discrimination in Manila, Philippines. *AIDS Care*, 17, S153-/S164.
- Philippine HIV and AIDS registry (2011).
- Pretorius, H., Goldstein, N., & Stuart, A. (2005). Meaning-making of a group of South Africans in their experience of living with HIV: A phenomenological study. *Health SA Geseonheid*, 10(1), 41-51.
- Reeves, P., Merriam, S., & Courtenay, B. (1999). Adaptation to HIV infection: The development of coping strategies over time. *Qualitative Health Research*, 9(3), 344-361.
- Zulkifli, S., Soo Lee, M., Wah Yun, L., & Lin, W. (2006). *Study on the impact of HIV on people living with HIV, their families and community in Malaysia* (Project Report). United Nations Country Team on HIV/AIDS Malaysia PAF Project.

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and Practices Related to HIV Infection

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in the Philippines

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