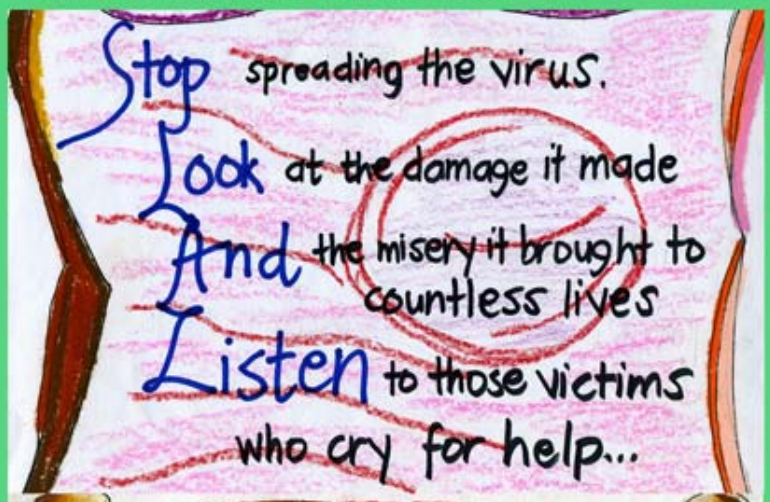
UNESCO
HIV Preventive Education Information Kit for Filipino Teachers

Philippine Pilot Version

"Unite for an AIDS-free nation!!"



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HIV Preventive Education Information Kit for Filipino Teachers

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HIV Preventive Education Information Kit for Filipino Teachers

November 2007

UNESCO Asia and Pacific Regional Bureau for Education
Bangkok

PREFACE

Dear Sir / Madam:

Given the current absence of a cure or vaccine for HIV and AIDS, preventive education and the transfer of relevant skills/attitudes are critical to reducing young people's vulnerability and are an effective response to the pandemic. As an educator, you play a key role in ensuring that young people gain the knowledge, skills and attitudes needed to adopt healthy practices and live healthy lives. You can also help to create understanding and reduce fear, stigma and discrimination towards those living with or affected by HIV and AIDS.

The *HIV Preventive Education Information Kit for School Teachers* contains up-to-date, relevant, school-focused information about HIV prevention and AIDS. We believe it provides you with essential techniques to mobilize action and respond to HIV and AIDS within your school and community, at large.

In 2002, UNESCO Bangkok developed an advocacy toolkit on HIV, AIDS and education targeted at middle and senior level officials of the Ministries of Education in the Asia-Pacific region. The 2002 advocacy toolkit focused on promoting HIV preventive education and increasing awareness of the virus' impact on the education sector. Feedback from the field studies of that toolkit indicated that there was a need to create a similar toolkit geared towards school teachers.

UNESCO Bangkok, thus, developed this information kit to encourage and assist you and your colleagues in increasing awareness about HIV and AIDS' impact and the importance of HIV preventive education. Your close interaction with young people means that you have a direct influence on their minds and behavior. You are, indeed, one of the key forces in preventing HIV infection among young people. You can make a difference by adopting school-based responses to HIV and AIDS.

Please join in efforts to strengthen the education sector's response to HIV and AIDS at the school level. Your valuable support and action is needed. I sincerely believe that this kit can make a difference in our continued efforts to provide high quality HIV preventive education to all young people in the Asia-Pacific region.

Sheldon Shaeffer
Director, UNESCO Bangkok

INTRODUCTION

HIV, being one of the major programs of the United Nations (UN) System, has been the focus of our UNESCO concerns. The UNESCO National Commission of the Philippines has just conducted two Philippine adaptation workshops on the UNESCO HIV Preventive Education manuals recently developed by UNESCO Jakarta and UNESCO Bangkok.

Prior to the Philippine adaptation, the UNESCO HIV Preventive Education Information Kit for School Teachers has already been adapted in the different Asia-Pacific countries, such as Nepal, Uzbekistan, Kazakhstan, Vietnam and Lao PDR.

As an educator for the past 45 years, I would like to share with you my experience in the teaching of HIV Prevention to children from 3 – 16 years old. These topics have been contextualized for our country's condition and culture: *Personal Grooming and Hygiene from Head to Toe*; *The Facts of Life for Primary School*; *From Puberty to Adolescence for Grades 4-6*; *Under the Heart is a Little Room and Puberty of Boys;* and *the High School Consumer Course on Marriage*.

Personal Grooming and Hygiene from Head to Toe is an LLSD (Lifelong Learning for Sustainable Development) course for boys and girls regarding their sexual responsibilities and correct attitude towards physical health, beauty and sacredness of the human body, which should start during the first six years. For preschoolers, this would be an action lesson on personal grooming and hygiene "from head to toe," like taking a bath. The teacher demonstrates to the children the different steps in taking a bath from washing their hair, soaping their body parts to rinsing their whole body from head to toes.

The Facts of Life for Primary School & *From Puberty to Adolescence for Grades 4-6*. Grade schoolers with their enormous reasoning power appreciate the lesson of the powerful Human Body. The lesson has two parts. For Grade I -III students, their imagination can be inflamed with the "Fable of the Great River." The great nation in the story of the Great River symbolizes the Human Body. The President is the Nervous System. The Department of Communication is represented by the five sense organs – eyes, ears, nose, tongue and skin. The Department of Nutrition is the stomach, intestines and glands. The Department of Sanitation is the kidney and the parts used for excretion of waste materials, like the skin and the anus. The Department of Transportation is made up of the Blood Vessels, and the Great River is the Circulatory System. The citizens represent the cells. When the cells combine, they form a tissue. The tissues make up organs and a group of organs make up a system. These different systems work together in perfect harmony to keep the human body healthy and strong. Later, the Grades IV to VI students can be given the advanced lesson on the various body systems, since they are already in the puberty stage.

Under the Heart is a Little Room and Puberty of Boys. Between 9-12 years old, the girls exhibit bodily changes earlier than boys. They increase in height and body size. Hormones are emitted to help them become young ladies or young men. Pimples appear and body perspiration changes, and so with the body smell. When puberty comes, it is time for parents and teachers to agree on the healthy approach to sex education and its corresponding responsibilities. This story of love is different for each sex; thus, boys and girls should be taught differently.

Under the Heart is a Little Room is a lesson for girls covering physical changes, including the menstrual cycle. For boys, Mother Nature gives the message of physical changes through the growth of the Adam's apple with the change in voice, circumcision (ceremony of "becoming a man") and the nocturnal flow or wet dreams, and the emission called semen. In life, males and females are physically and psychologically different from each other. But, it is these differences that attract them to one another. While the boys tend to become assertive, self-centered and dominant, girls are more patient and generous. Parents and teachers must encourage the natural virtue of masculinity of the boys, so with the femininity of the girls.

Young Adulthood. To complete the curriculum, senior students can go through the high school consumer course on marriage. A male student is partnered with a female student with whom he does not have any emotional attachment. They pretend to become steady friends. They get engaged, plan for their wedding, look for a place to live, prepare for the coming of a baby and deal with other plans for starting a home. In the process, the students learn the cost of an engagement ring, wedding license, a condominium unit, the wedding ceremony and reception and even honeymoon packages.

The girls experience how it is to be pregnant and raise a family. The couple places an egg in a basket for nine weeks (1 week being equal to 1 month). Everywhere the girl goes, the basket goes. This is likened to a pregnant woman who carries the baby for nine months. If the egg breaks, they find out that the expense for a miscarriage is similar to giving birth the normal way. They are appalled at the cost of delivery by caesarian section. They also get to know the difference in cost between private and government hospitals, as well as lying-in clinics. At the end of the activity, the young adults realize that the heavy expenses incurred for each event in life signifies the serious responsibility a couple faces before deciding to get married.

We must condition our young to respect and be kind to each other by the right choice of community and school environment. These topics can help the teacher face the challenge of teaching HIV and AIDS to young children and touch on sensitive issues like sex, drugs and other topics considered "taboo" in our society.

This UNESCO Preventive Education Information Kit for Filipino Teachers on HIV and AIDS is specially designed for educators in the Philippines. Let us continue our mission of spreading knowledge on the issues of HIV and AIDS as part of Lifelong Learning for Sustainable Development.

Amb. Preciosa S. Soliven, Ed.D.
Secretary-General
UNESCO National Commission of the Philippines

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Key contributors who played a significant part in the preparation of this Kit:

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Robert Horn, David Clarke, and **Jan Wijngaarden**, freelance consultants;
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Rosanne Wong
HIV Preventive Education and School Health Officer

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Common Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retroviral drugs or medicines
CBO	Community-based Organization
DOH	Department of Health
EFA	Education for All
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MDG	Millennium Development Goals
MSM	Males who have Sex with Males
NGO	Non-governmental Organization
OFW	Overseas Filipino Workers
PLHIV	People living with HIV
PNAC	Philippine National AIDS Council
PTCT	Parent-to-child transmission (of HIV)
PPTCT	Prevention of parent-to-child transmission
STI	Sexually Transmitted Infection
TEI	Teacher Education Institutions
UNAIDS	United Nations Joint Programme on HIV/ AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WSW	Women who have sex with women

Users' Guide

The *HIV Preventive Education Information Kit for Filipino Teachers* is an attempt to provide teachers with the basic information that they should know when teaching young people about HIV and AIDS. With HIV expanding across Asia, there is an urgent need to equip teachers with the knowledge, attitudes, and skills necessary for them to play an effective role in HIV preventive education.

The Kit begins with basic information about the human body, followed by a situationer on HIV and AIDS in the Philippines and in the world, and bio-medical information about HIV and AIDS, to allow readers to understand how infection can be averted. Understanding facts about HIV and AIDS is important in combating related myths and stigmatization of children and other persons living with or affected by HIV and AIDS.

Indeed, the impact of HIV and AIDS on children is beginning to be experienced on a larger scale as parents fall ill and die. The Kit provides the bigger picture of how HIV is spreading in Asia and it is important that national HIV and AIDS strategies address this. The Kit also gives particular attention to describing the impact of HIV on individuals, families, communities, schools and the country.

The second part of the Kit addresses the responses to HIV and AIDS on the international and national levels. It narrows down to the multiple roles of schools in fighting HIV and AIDS, with a focus on preventive education and a life skills-based approach. The importance of linking schools and preventive education to HIV and AIDS-related services is described.

The collection of focus sheets covers a range of issues that are important for teachers to understand when teaching children at both elementary and secondary levels. They aim to raise awareness among teachers of HIV and AIDS-related issues and suggest ways in which these may be addressed at the school level. They can also be used as free-standing resources for open learning or as adjuncts for in-service teacher training. In all cases, it is important that they be tailored to meet the needs of particular local sector responses to HIV and AIDS.

Suggestions are made for further reading in the References, and a Glossary of key terms is also provided.

CHAPTER I

BACKGROUND INFORMATION

Basic Facts about HIV and AIDS

This section introduces the basic facts about HIV and AIDS, such as definition, transmission and prevention. It is important for every teacher to know these to help them in addressing some of the misconceptions that are widespread and which undermine prevention efforts.

What is HIV?

The acronym HIV stands for *Human Immunodeficiency Virus*. It is a virus that attacks and destroys the immune system of human beings. The immune system is the body's natural defense system to fight off infections and disease-causing microorganisms that invade the body.

The HIV was first identified in the United States in the twentieth century, and has spread across the world through the global mobility of people. Today, almost all countries have been affected by the human loss and financial cost of treating and preventing the spread of the HIV.

The HIV belongs to a special class of viruses. Once it enters the body, it lives in the white blood cells, using them as food to grow and reproduce. It kills these cells in the process. In particular, it destroys a type of white blood cell that normally protects us from disease--a CD4 cell.

HIV is generally slow to impact on the health of an infected individual. Some people become sick quickly, but most adults do not develop symptoms for around 10 years. As HIV progressively weakens the immune system, the person infected becomes vulnerable to a range of illnesses, called *opportunistic Infections* (OIs). The most common opportunistic infections in the Philippines are tuberculosis, pneumonia and candidiasis.

Persons diagnosed as HIV-positive are referred to as HIV-positive persons or Persons Living with HIV (PLHIV). Since the progression of the disease is slow, an HIV-positive person may appear perfectly healthy and normal.

When a person begins developing opportunistic infections because HIV has weakened his/her immune system, that person is considered to have AIDS.

What is AIDS?

The acronym AIDS stands for *Acquired Immunodeficiency Syndrome*. It is identified on the basis of certain infections and by the amount of HIV (or viral load) in the body. AIDS applies to the most advanced stages of HIV infection. A person with AIDS typically would have a decreased level of CD4 cells and may die of opportunistic infections that would not normally affect a person with a healthy immune system.

How HIV is Transmitted

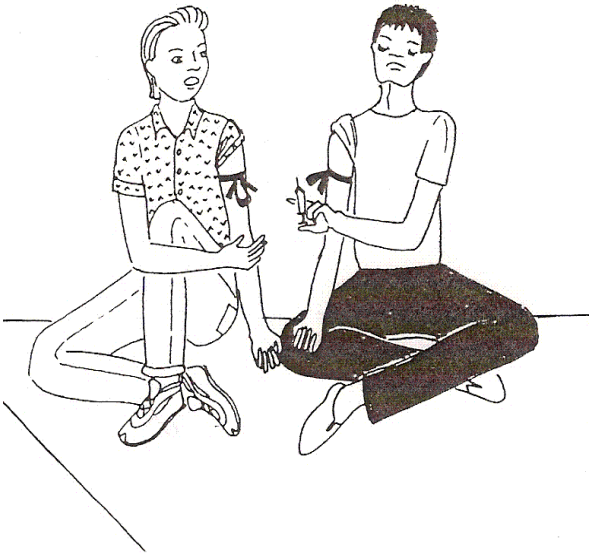
HIV cannot travel by itself or survive long outside the human body. It needs human body fluids to live, reproduce and infect other people. It is transmitted through the blood, semen, vaginal secretions or breast milk of an infected person. There are three main methods through which HIV is spread:

1. ***Unprotected sex***. Sexual intercourse (vaginal, anal or oral) with an infected person is the most common way of transmitting HIV. Women are biologically at greater risk of HIV infection than men through vaginal sex. They are culturally vulnerable, too, because their gender status often undermines their ability to avoid sex with HIV-infected partners or to insist on safer sex using a condom. Anal sex, whether male to male or male to female, is a high risk, especially to the receptive partner because the lining of the anus and rectum is easily damaged during intercourse. Oral sex poses a risk when semen is ejaculated into the mouth, or when either partner has cuts or sores in the mouth caused by sexually transmitted infections (STIs), recent tooth brushing or canker sores. These cuts allow the virus to enter the bloodstream.

2. ***Exchanges of blood, blood products and organs***. There is higher than a 90% risk of acquiring HIV through transfusion of infected blood and blood products. HIV can also be transmitted through organ transplantation.

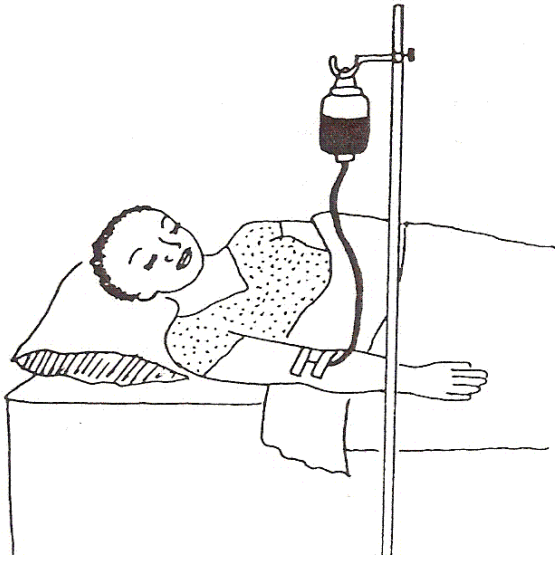
3. ***Re-using or sharing of needles, syringes and other medical equipment***. The exchange of blood happens when people share contaminated needles or syringes with an HIV-positive person, usually to inject drugs. The use of unsterilized equipment in tattooing and body piercing can also spread the virus.

4. ***Parent-to-child transmission***. Generally, there is a 15-30% risk of transmission from mother to child before and during delivery. Breastfeeding increases the risk of transmission by 10-15%. This risk depends on clinical factors and may vary according to the pattern and duration of breastfeeding. If a woman is HIV-positive, she will have a 35% chance of passing on the virus to her child during pregnancy, birth or breastfeeding. With treatment using certain drugs, that can drop to a 7% chance.[3]

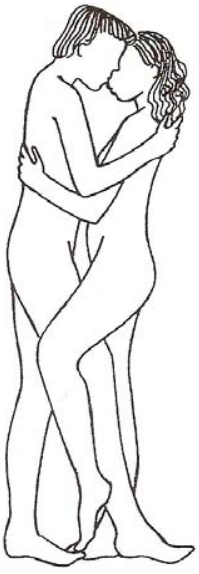


Sharing needles can pass HIV

An HIV positive mother can pass HIV to her unborn or newborn baby



A transfusion with unscreened blood can pass HIV .



Sexual contact can pass HIV

Mothers have usually been infected by their husbands or male partners, and so these men also share the responsibility for infecting the child. That is why this is referred to as parent-to-child-transmission (PTCT) and not mother-to-child-transmission.

Young People--A Especially Vulnerable Group to HIV Infection

Young people are especially vulnerable to STIs and HIV because they are sexually active and might take risks. Young people might take drugs and alcohol, which would raise the likelihood that they would engage in risky sexual behaviors. It is important that they recognize their vulnerability and risk-taking. It is likewise essential that they have the information and skills necessary to protect themselves as well as their current and future sexual partners.

Reducing the Risk of Becoming Infected with HIV

It is vital that people know how to prevent HIV transmission.

1. ***Safer Sex***. The more sexual partners a person has, the greater the risk of infection, especially if sexual intercourse is unprotected by a condom. Three strategies, regarded as integral approaches to HIV prevention, are generally promoted to reduce the risk of HIV infection through sexual contact:

- Abstinence from sexual intercourse
- Sexual fidelity to one partner
- Safer sex by using a male or female condom

Successful prevention efforts require all three to reduce sexual networking and increase safer sex. An approach that promotes only abstinence will not be fully effective because not all sexually active men and women are able to abstain from sex. The promotion of abstinence among young people can, however, help to delay the start of sexual activity for those not yet active. Of course, sexual fidelity can only be effective if both partners observe it. Unfortunately, many faithful wives have been infected with HIV by their unfaithful husbands. Ensuring that STIs are diagnosed and treated is important, too. Studies show that having an STI can increase the risk of both acquiring and transmitting the HIV. This is true for STIs, which produce sores or breaks in the skin (such as syphilis, herpes and cancroids) as well as for those that do not (such as chlamydia and gonorrhea).

Finally, coercive sex (sex without consent) presents a high risk of HIV transmission because vaginal linings can be damaged in the process. Coercive sex can take place in marriage as well as outside of it.

2. Blood Safety. Ensure that blood products and organs are tested for HIV and that blood safety standards are implemented.

3. Use of sterile needles and medical equipment. These must be observed at all times, as it is a relatively efficient means of preventing HIV transmission. Previously used needles and syringes should be disinfected with bleach to reduce the risk. Tattooing and body-piercing equipment should be sterile. Drug users should never share used syringes with anyone else. Ensure that blood has been screened for HIV before transfusion.

4. Preventing parent-to-child transmission. Infection from mother to child can be prevented by drugs that stop HIV transmission to the fetus. Infected mothers should be counselled not to breastfeed, which is a route of transmission. It is important for women who are pregnant or considering becoming pregnant and who might have been exposed to the HIV virus to seek an HIV test and counselling.

In conclusion, the basic prevention for HIV can be summarized in five letters:

A – Abstinence from sexual contact
B – Be Faithful
C – Correct and consistent use of Condom
D – Don't share needles, alcohol and drugs
E – Education, early detection and treatment of STIs

What to Do if One is Suspected to Be Infected With HIV

Commonly-used HIV tests detect HIV antibodies (which are produced by the immune system in response to an infection) because they are cheaper and easier to detect than the virus itself. For most people, it takes three months for these antibodies to develop. In rare cases, it can take up to six months. In general, a person should wait for three months to be tested after suspecting that s/he has been exposed to HIV. This is because the virus cannot be detected in the very early period of infection.

If a person has been infected, s/he can transmit HIV even before testing can reveal the presence of the virus. Thus, s/he can pass on the virus to others without knowing that s/he is likewise infected.

The HIV test should be given with confidentiality, counselling and informed consent. If the test has a positive result, a confirmatory test should be done, as sometimes there are false positive results. If the confirmatory test is positive, the person should immediately seek counselling (if it is not already being provided) and medical help to understand his/her condition and the best ways to cope with it.

Can HIV and AIDS be Cured?

There is no cure as yet for HIV and AIDS. Doctors and scientists are still working to develop an HIV vaccine – a drug that will prevent people from becoming infected with HIV.

Treatment using antiretroviral drugs (ARV) is available in selected hospital facilities in the Philippines. An anti-retroviral drug is not a cure, but a treatment to reduce the level of HIV to an almost undetectable level. Once the level of HIV in the body is reduced, there is an increase in the number of CD4 cells to improve the body's immune system. If an HIV- positive person takes anti-retroviral drugs, his/her life can be prolonged for many years and s/he can have a better quality of life.

The earlier the treatment is begun, the better the chance that treatment will be effective. It is, therefore, important that persons who may have been exposed to the virus take an HIV test to know whether or not they have HIV.

Taking ARV drugs also have some drawbacks. The drugs --

- are taken for life;
- have to be taken strictly at the scheduled time;
- may have some side effects;
- are expensive.

The absence of a vaccine or cure and the limited availability of antiretrovirals mean that prevention is the best response to HIV and AIDS.

Misconceptions about HIV and AIDS

Some misconceptions surround HIV and AIDS. The following are NOT true:

1. *Only foreigners have HIV and AIDS.*
   As of July 2007, there were 2,916 Filipinos diagnosed as HIV-positive.

2. *Only bad people get HIV and AIDS.*
   The virus does not recognize people's behavior.

3. *If someone has HIV, s/he probably did something to deserve it.*
   Infants who acquire HIV certainly did not do anything to deserve it.

4. *HIV-positive persons want to infect others.*
   Attitudinal judgment does not apply to everybody.

5. *HIV can be transmitted by an HIV-positive person through:*
   - *coughing and sneezing*
   - *sharing of food, utensils, clothes, pens, textbooks, etc.*
   - *touching, hugging or kissing*
   - *shaking hands*
   - *sharing toilets and bathrooms*
   - *using public phones*
   - *bites of mosquitoes and other insects*
   - *contact with feces, urine, saliva, sweat and tears*
   - *manicure and pedicure*

The HIV cannot survive outside of the body for long. It dies on exposure to the elements: water, air, and sunlight.

Misconceptions About Males who Have Sex With Males(MSM)

6. *Most MSM are effeminate, so it's easy to know who they are*.
   While some MSM have effeminate mannerisms, many do not. Some, in fact, are extremely macho or masculine. Those who have effeminate mannerisms are not necessarily transgender – they do not wish to be women.

7. *MSM are usually hairdressers, designers, workers or professionals who are creative or feminine*.
   Some are, but many aren't. MSM may be world boxing champions. soldiers, – even officials – policemen, doctors or professors.

8. *All MSM have HIV and AIDS*.
   Even though the prevalence rate of HIV is alarmingly high among MSM, the vast majority do not have HIV and AIDS.

9. *Male-male sex is safer than male-female sex*.
   Most MSM engage in anal sex. The anus is not naturally lubricated, and so during sex, small cuts and tears can occur, allowing the HIV – if it is present in one partner – to enter the blood stream of the other partner. Unprotected anal sex is the riskiest form of sex.

10. *Most clients of male / female sex workers are foreigners*.
    In all countries surveyed, most clients of male sex workers are local people.

11. *Sexual predators and pedophiles are usually MSM*.
    This is simply not true. While some MSM fall into this category, police records show that most sexual predators and pedophiles are heterosexual, and most victims are female.

12. *HIV and AIDS is a gay disease*.
    Anyone can get HIV and AIDS. No one is immune, and it does not affect just one group of people. It is not who you are but how you behave that puts you in a risky situation.

HIV is *not* spread by:

Insects

Caring for someone with AIDS

Shaking hands

Toilet seats

Sharing belongings

Touching and hugging

HIV and AIDS: A Situationer

This section contains facts and figures that give a brief overview of the magnitude of the AIDS epidemic in the world, the Asia-Pacific region and the Philippines.

Some 39 million people were estimated by UNAIDS to be living with the virus in 2005. More than 25 million people have already died from HIV and AIDS.[1] Most do not know that they are already infected.

In 1981, doctors in the United States identified the first cases of AIDS in San Francisco and New York. Studies showed that the disease was uncommon until the late 1970's and early 1980's, when more similar cases began to appear in both Central Africa and the United States. At present, there are an estimated 42 million HIV-positive people worldwide, and more than 3 million die every year from AIDS-related illnesses.

The Global Situation

Statistics indicates that there is no country in the world that is immune to the HIV and AIDS pandemic. In spite of expensive and extensive awareness campaigns, numbers continue to rise.

Consider the following facts and figures:

Over 8,000 AIDS deaths per day

Almost 11,000 new infections per day

38.6 million people HIV-positive in 2005

4.1 million people infected in 2005

More than 3 million HIV-positive children (0-14 years)

25 million dead from AIDS

2.8 million dead in 2005

15.2 million children (0-17 years) lost either their mother or both parents due to AIDS

Women account for more than half of all new infections

Children under 15 years of age account for one of six AIDS-related deaths worldwide.

The economic loss is estimated to account for more than 20 per cent of GDP in the worst affected countries by 2020.

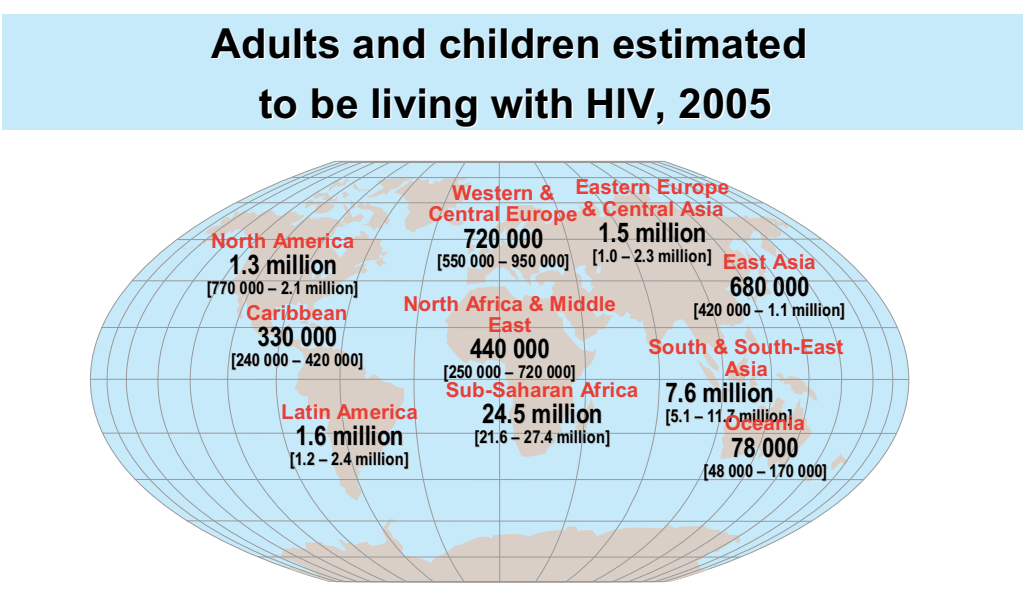


*Figure 1.*Adults and children estimated to be HIV-positive in the world, as of the end of 2005

The Situation in the Asia-Pacific Region

HIV does not respect borders!

The Asia Pacific Region has the second largest number of HIV-positive people in the world; Africa has the most. No country in Asia or the Pacific is free of HIV and AIDS. At the end of 2006, an estimated 8.8 million people in the Asia-Pacific Region were HIV-positive. Approximately 1.1 million of them were infected during 2005 alone.[2] About 10% of young people in the Asia-Pacific Region are directly engaged in risk-taking behaviors, such as injecting drugs, sex work, or having unprotected male-male sex.[3]

World leaders and health professionals say that it is important to take action now. If nothing is done, UNAIDS predicts that there will be 12 million more people infected with HIV in Asia and the Pacific in the next five years. With proper prevention programs, UNAIDS believes that the number can be cut in half[4]

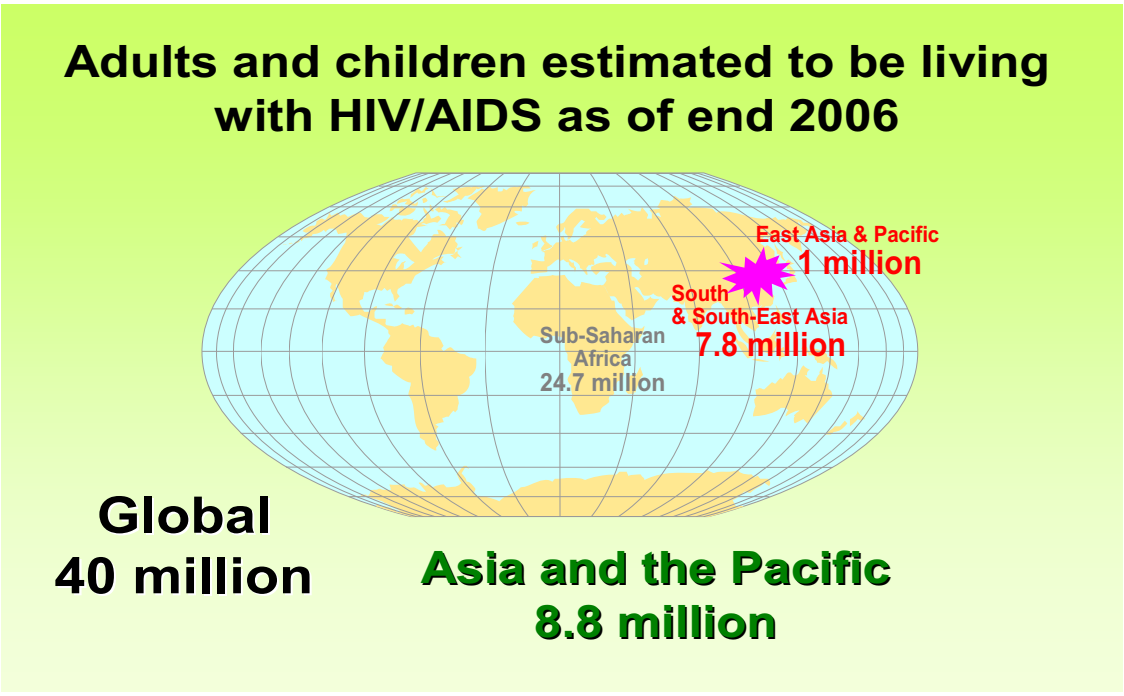


Figure 2. Adults and children estimated to be living with HIV and AIDS in the Asia-Pacific Region as of the end of 2006.

There is still time to prevent a worse epidemic. The Asia-Pacific Region has been described as a *low prevalence* region. This means that the percentage of people living with HIV is less than 1% of the population in most countries.[5] Concerted action needs to be taken to prevent the virus from spreading into the population at large, and from further increasing its chances of transmission. Countries in the world that are experiencing high prevalence epidemics are encountering significant negative impact on their development, including their educational systems. Asia can still avoid the major socio-economic impacts of HIV and AIDS.

Low prevalence still means huge numbers of people are infected. The Asia-Pacific Region is home to more people than any other part of the world. Even if a small percentage of people in some countries are infected, it often translates into a substantial number of people who are HIV-positive. As an example, let's compare two countries. The prevalence rate in India is estimated to be about 0.9% of the population. The rate in South Africa is higher at about 20%. Nonetheless, because India's population is so much bigger than South Africa's, it actually has more people living with the virus. There are approximately 5.7 million people living with HIV and AIDS in India, while South Africa has 5.5 million.[6]

The Asia-Pacific Region in Numbers[7]

Projected new infections in South and Southeast Asia by 2010, if prevention is not scaled up: 10 million, according to Dr. Swarup Sarkar of UNAIDS[8]

- There were about 8.3 million HIV-positive people in Asia and the Pacific in 2005.
- Approximately half a million people died from AIDS-related illnesses in 2005.
- There are about half a million children who have been orphaned because of AIDS.
- Fifty percent of new infections are among young people (15-25 years).
- There are 2.2 million HIV-positive young people in Asia.
- There are close to 1,400 new infections of people under 24 years in Asia every day.
- The majority of new infections are clients of sex workers.
- The male to female ratio of new infections is 3:1.
- More than 11,000 children under the age of 15 were newly infected in 2005.
- There were 8,500 children under the age of 15 immediately needing anti-retroviral treatment in 2005.
- There are 7,500 mothers in need of prevention of Parent-to-Child Transmission (PPTCT).

Low prevalence can still mean high risk. Although most countries in Asia and the Pacific have a relatively small percentage of people infected, there are geographical areas within countries where prevalence is high. Myanmar provides an example. The national infection rate is 1.2 %, but in some areas, it is as high as 7% or 5%. In these areas, communities might be facing significant impacts from HIV and AIDS, including leaving children orphans. Furthermore, infection rates are extremely high among groups who engage in behaviors that put them at risk of acquiring HIV, such as injecting drugs users, female sex workers, their male clients/partners and males who have sex with males.

Some countries have been hit hard. Thailand, Myanmar, Cambodia and Papua New Guinea have the highest HIV prevalence rates in the Asia-Pacific Region. The impact on development has been significant. According to UNAIDS, the Asia-Pacific Region is losing $29 billion a year because of the HIV and AIDS epidemic. In comparison, the economic impact of the 2004 tsunami was about $8 billion.

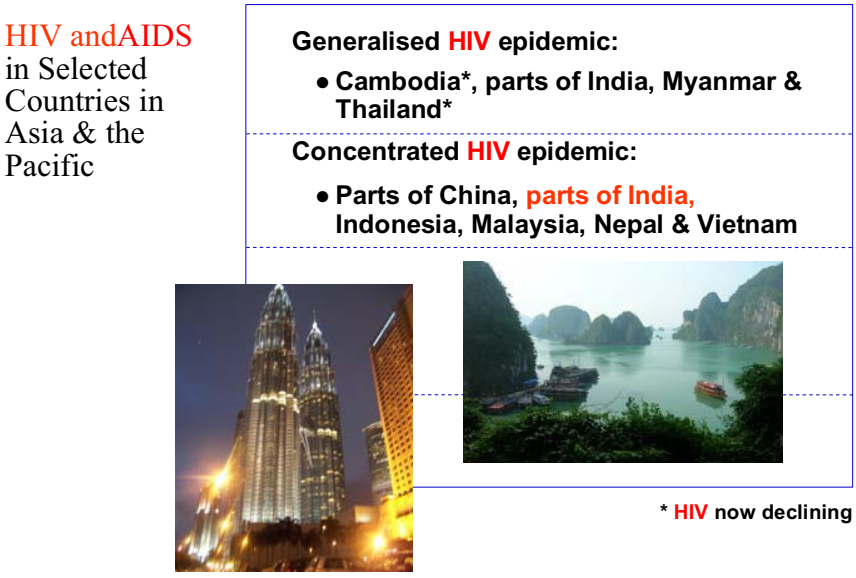


Figure 3. HIV and AIDS in selected countries in the Asia-Pacific Region.

The Situation in the Philippines

The first case of AIDS in the Philippines who was identified in 1984 raised an alarm, causing immediate response not only from the government but from civil society as a whole. Although our country is one of the few remaining low prevalence countries in the region, there is also cause for concern because there is an increase in the number of cases reported every year. From 1993 to 2003, a period of 10 years, there were 100 HIV cases reported per year; from 2004-2005, 200 cases were reported per year; and in 2006, there were 306 cases reported.

Total cases from January 1984 to July 2007

HIV +	2,916
Asymptomatic	2,146 (74%)
AIDS	770 (26%)
Deaths	304 (40%)

Estimate (WHO): 2005
10-13,000 cases

- More than half (58%) of the cases were in the 25-39 years age group.
- 66% (1,908) were males.
- Sexual intercourse (87%) was still the leading mode of transmission.

Red flags. Red flags are factors or situations that indicate the potential and significant increase of the number of HIV cases.

The HIV and AIDS situation in the Philippines is like a thief in the night—slowly and silently creeping in. When it finally becomes full-blown, we might be caught unaware. Hence, this is an opportune time to raise warning flags, because of the following reasons:

- All known modes of transmission are present in our country:
  - Unprotected sex
  - Exchanges of blood
  - Parent-to-child

- Our sex industry is still growing.

- The Most At Risk Populations (MARPs) have low condom use (An average of 40% of MARPs use condom).

- There is a high rate of sexually-transmitted infections (Chlamydia infection among ante-natal women is almost 12% prevalent).

- There is an increased sexual risk behavior among young people ages 15-24. (Young Adult Fertility Study [YAFS] done in 2002 revealed that the sexual debut is around 18 to 20 years old).

- The level of knowledge on HIV and AIDS is low (NDHS, [2003] revealed that although HIV awareness is high, knowledge on the basic HIV is low).

- Young people have a low perception of risk (They think that only the adults are vulnerable to HIV infection).

- The problem of HIV among Injecting Drug Users is emerging. (DOH Integrated HIV Behavioral and Serological Surveillance done in 2005 revealed two IDU-positive for HIV).

- There is an increasing number of OFWs with HIV (Currently, of the total number of registered HIV positive, 35% were OFW).

Table 1 shows that most of the HIV-positive adults are males having sex with males (MSM), followed by female sex workers (FSW). The latter have a mean age of 20 and have a high rate of sexually-transmitted diseases.

Table 1

Estimated Total Number of HIV-Positive Persons (NEC-DOH, 2005)

Estimated Total Number of HIV Infected Persons, NEC – DOH, December 2005

Risk Group	Population Estimate	Prevalence	Number of Adults Living w/ HIV/AIDS
Total			**11,168**
• IDU (Injecting Drug User)	16,000-30,500	0.89-1.00%	349
• MSM (Male having sex with male)	92,269-338,468	0.00-0.39%	1,171
• FSW (Female Sex Workers)	112,354-175,553	0.06-0.34%	1,136
• Clients of SW	280,604-438,400	0.00-0.63%	286
• **General Population**	22,029,660-22,098,584	**0.01-0.03%**	**8,226**

The Impact of HIV on Families, Communities, Schools and the Country

This section deals with the impact of HIV on families, communities and schools in the Philippines. These institutions should be aware of HIV and AIDS in order to protect, secure and guide young people, so that they may be free from discrimination and stigma.

While HIV prevention must be the first priority for any national response to HIV and AIDS, the complex impact of the epidemic on society must also be understood and addressed. Children are often disproportionately affected by the consequences of HIV infection in the community, especially if their parents carry the virus. They certainly require additional protection, care and support. (See Focus Sheet on Orphans and Vulnerable Children)

The most devastating impact of HIV and AIDS is at the grassroots level – on individuals, families, schools and communities. HIV and AIDS push families deeper into poverty, and create a growing number of orphans, homeless and street children. It strains community resources to provide care and support for those living with or affected by HIV and AIDS.

The stigma caused by HIV and AIDS also often elicits two responses at the grassroots level: people either turn against each other because of fear, resulting from myths and misconceptions, or they rally around each other and strengthen bonds of care and support. Both reactions can sometimes be seen within the same community.

Two of the worst consequences of HIV and AIDS are the stigma and discrimination faced by those found to be living with the virus or perceived to be so. Stigma and discrimination not only harm HIV-positive persons; they also help fuel the epidemic. People generally fear the reactions of others if they are known to have HIV; hence, they do not submit to testing and are ignorant about their HIV status. They may already be infected and are unknowingly passing it on to others.

As a result of HIV and AIDS-related discrimination, HIV-positive people who are aware of their status, hide their secret and become withdrawn and isolated. They suffer from low self-esteem that adversely affects their health. Self-stigmatization or the feeling of shame has led people who have tested positive to become depressed and contemplate or commit suicide.

People tend to fear the unknown. Stigma also results from irrational fears of contracting HIV. Education about HIV and AIDS can help reduce this, and teachers have a significant role to play in this.

Much of the stigma surrounding HIV and AIDS come from the fact that the virus is often transmitted by people engaged in behaviors the community often frowns upon, such as injecting drugs, sexual promiscuity, or men having sex with men.

Women found to be HIV-positive might also suffer stigma because some people might think that they must have engaged in sex with multiple partners to have become infected. However, many women who have been infected have been monogamous and faithful to their husbands or the male partners who have infected them. It had been, in fact, the risky behavior of the husband or male partner which had led to the infection of the woman.

Research on HIV and AIDS-related discrimination in Asia carried out by the Asia Pacific Network of People Living with HIV and AIDS (APN+) found that the major area of discrimination was in the health sector, where treatment could be refused, confidentiality breached, and delays in provision of health services could occur. Within the family and the community, it was found that HIV-positive women were significantly more likely to suffer discrimination than men. They were often subjected to ridicule, harassment, physical assault and even forced to change their residence.

The education sector is another site for HIV and AIDS-related discrimination. HIV-positive children may be refused admission at school. Children affected by HIV and AIDS may be bullied and ridiculed by other children. Teachers living with HIV may have to resign from their teaching job.

Impact on the Individual

The HIV-positive person may suffer physical, social, emotional, and mental pain and anguish over his/her condition.

Physically, the person may suffer secondary infections (such as diarrhea, skin cancer, and pneumonia). Fifty percent of adults diagnosed with AIDS die within 18 months of diagnosis. The fear of pain and the thought of impending death may bring about emotional problems.

Socially, the HIV-positive person may be rejected by friends and loved ones, resulting in isolation from social or community activities. S/he may experience further acts of discrimination felt by members of certain groups, such as gay men, intravenous drug users, and prostitutes. S/he may even be denied entry into certain countries.

The HIV-positive individual also faces economic problems due to the high cost of drugs, and hospitalization frequently combines with the inability to continue working.

The HIV-positive person may also grapple with psychological and emotional issues that go hand in hand with the physical and social issues, which include the following:

- Feelings of loss related to his/her ambitions, confidence, physical attractiveness, potency, sexual relationships, status in the community, financial stability, future plans, and independence;

- Feeling of anger and a resultant blaming of him/herself for acquiring HIV, or others for perceived abuse of his/her body or privacy;

- Suicidal tendency, which may be seen as a way of avoiding pain and discomfort or to lessen the shame and grief of loved ones;

- Loss of self-esteem and feelings of self-worth caused by rejection by colleagues or loved ones, combined with the physical impact of HIV, such as disfigurement, physical wasting, and loss of strength;

- Hypochondria – an obsessive state due to preoccupation with health and avoiding infections;

- Grief about the losses s/he has experienced or is anticipating;

- Guilt over the possibility of having infected others, over the behavior that may have resulted in infection, and over the hardship his/her illness will cause loved ones, especially children;

- Depression due to the absence of cure, and the resulting feelings of helplessness and loss of personal control;

- Anxiety over the—
  - loss of privacy;
  - risk of infecting others;
  - ability of loved ones to cope;
  - short-term or long-term prognosis;
  - fear of dying in pain without dignity;
  - risk of infection from other diseases;
  - declining ability to function efficiently;
  - future social and sexual unacceptability;
  - possibility of abandonment and isolation;
  - loss of physical and financial independence;
  - availability of appropriate medical/dental treatment
  - dismissal from employment or denial of employment for no other apparent cause;

On the other hand, uninfected people close to HIV-positive individuals likewise suffer socially and emotionally. They may have feelings of fear, anxiety and paranoia, among others.

An HIV-positive child suffers on many levels. Without access to treatment, HIV progresses more rapidly in young children than among adults.[2] Aside from physical illnesses that come with the onset of AIDS, the HIV-positive child is often target of stigma and discrimination. Feelings of rejection, along with physical illness, can often

lead to depression and other behavioral problems, if care, treatment and support are not available.

Impact on Families

The family is the smallest unit of society. Among Christians, Muslims and many other sects in the Philippines, the family is considered as a small church or mosque where the priest, pastor or the imam is the head. This shows the importance of the family in the Filipino culture.

Families can either be torn apart or pulled together in the face of HIV and AIDS. Family members may suffer from psychological stress caused by anger, sorrow, frustration, and the inability to cope with the needs of the HIV-positive individual. Discrimination and rejection may also be faced by family members involved with their care.

Children affected by HIV and AIDS may experience emotional distress at watching their parents suffer and ultimately die. When this happens, they lose their most valuable source of love, protection and care. Many of these children will either be absorbed by their extended families (such as grandparents) or sent to government or religious institutions or end up in the street. It is probable that not one is equipped to provide children with the individualized attention they need as they are growing up. Grandparents and other relatives have to shoulder the financial responsibilities of raising children orphaned by AIDS, which may push them into poverty. They must also deal with the difficult psycho-social problems these children may be experiencing because of the loss of their parents. However, children almost always prefer to stay with their extended families and within their community. Institutionalizing them in orphanages should be considered as a last resort.

HIV and AIDS often have a devastating impact on household income. HIV-positive parents may be too sick to make a living, and any remaining income is consumed by health care and related costs. As a result, children especially girls from families affected by HIV and AIDS are often forced to leave school to help with household duties or to earn money. Studies in Cambodia show that as many as two in five children affected by HIV and AIDS leave school and start working.[1] Many children also end up living without basic necessities, such as food, leading to malnutrition. Malnourished children have many health problems and their weakened physical condition makes learning difficult.

Among migrant workers in the Philippines the loss of income is an effect of being afflicted with the disease, as some lose their jobs, although others opt to go back to the country where they used to work and resume working, probably further spreading the disease.

Tragically, some families might also reject their own HIV-positive members. At a Buddhist temple in Lopburi, Thailand, there is a room containing the cremated

remains of thousands of people who have died from AIDS. The small boxes of dust and bones have been collected by relatives to be kept there, buried or scattered to the winds in a final religious or spiritual ceremony. The stigma of AIDS is so strong, that even in death they continue to reject their own.

Impact on Communities

HIV and AIDS can either divide or unite communities. A common reaction to HIV and AIDS is the discrimination against and stigmatization of HIV-positive persons. Attempts to "cast out" those affected by the disease – from barangays, villages, hospitals, schools and houses of worship – have been experienced in virtually all parts of the world and among all ethnic groups, as well as in all social and economic classes.

On the other hand, some religious and spiritual groups have taken a strong pro-active role in dispelling fear, ignorance, stigma and discrimination. Churches, temples and mosques have taken in and offered care, education and support to HIV-positive adults and children orphaned by AIDS or living with HIV. Sadly, there are also some spiritual leaders who have refused care and religious burials to HIV-positive persons.

In some communities in sub-Saharan Africa, AIDS has taken the lives of so many young and middle-aged adults that the social structure of these communities have been affected. With many young, productive adults no longer present, more burdens have been placed on the elderly and the very young. Children have been forced to leave school and begin working to support their families, and the elderly have been forced to return to work, for the same reasons. These burdens have caused financial and emotional stress within families and the communities. While this is not a common situation in Asian communities at present, it could become so if response to the epidemic is not scaled up. Some island communities might be especially vulnerable to this scenario because they are small, hence the number of adults dying would have a greater impact on the community.

Small communities depend upon small businesses. As people die of AIDS-related illnesses, businesses lose valued employees and people with specialized skills. Some businesses shut down completely. In places such as in sub-Saharan Africa, so many people have been infected in some areas that the labor force has been decreasing. A shortage of workers will naturally have a negative impact on the economic growth and development of the country.

Impact on Schools

HIV and AIDS affect the demand for and supply of education, as well as its quality. The impact can be significant in high HIV-prevalent communities. Children affected by HIV and AIDS often drop out of school. Unless they have access to treatment, HIV-positive children will eventually die. Moreover, the parents of other children or school officials might block children living with or affected by HIV and AIDS from coming to

school because of the irrational fear of infection. The children themselves might decide they could no longer endure the teasing and bullying they suffer.

If a parent or sibling can no longer work, the child may be required to find work to make up for the difference to support the family. If the child is a girl, she may also be required to take care of the home. Children must sometimes assume the role of caring for a parent or sibling ill with AIDS. The loss of income suffered by a sick parent may mean the family can no longer afford to pay for school fees, and so the children drop out. More often than not, girls leave or are taken out of school in greater numbers than boys.

Children from families with an ill parent may suffer from malnutrition because of poverty. Weakened physically, they may not be able to perform well academically. They may also have psycho-social problems because of their situation at home or due to the stigma they experience in the school or community. Teachers need to be trained to recognize the causes of these behaviors and how to deal with them.

On the other hand, teachers and other school staff may also be HIV-positive. This can affect their performance and the quality of education children receive. HIV-positive teachers need treatment, care and support. They need anti-retroviral therapy, and they need to be encouraged and supported to continue teaching and serving the community. Their knowledge, experience and contributions are invaluable and must not be needlessly lost.

HIV and AIDS also impact on the educational system as a whole. The worst scenario is that as children and young people become ill, leave school and perhaps die, there will be fewer students left and that decreases demand for schooling. With HIV and AIDS infecting members of communities, teachers are bound to be among those infected. As teachers become ill and possibly die, their numbers diminish. Shortage of teachers can negatively affect the quality of education, as classrooms become overcrowded and school systems are forced to recruit less experienced or even unqualified teachers.

Impact on the Country

HIV and AIDS have been called a developmental issue. It can impede a country's development and wipe out hard-won economic and developmental gains. This can happen as funds from other areas of public need are drained by costs associated with AIDS prevention, diagnosis, treatment, and care. Strain is also felt on the health-care system and by insurance companies. There is likewise loss of economic output and productivity due to illness during the prime working years of individuals. While this situation is not yet prevalent in most countries of the Asia-Pacific Region, it could become so unless prevention programs become more effective.

Economic Impact of HIV and AIDS

The succeeding tables show the economic impact of HIV and AIDS at different levels and stages of the disease.

Table 2

Economic Impact of HIV and AIDS on the Individual, the Community, and the Nation

Sector	Individual	Community	Nation
Health	Increased expenditure	Increased expenditure	Need to expand health infrastructure
Education	Absenteeism	Decreased value of future human resources	Loss of trained people
Trade & Industry	Loss of productivity	Increased emigration	Effects on tourism
Agriculture	Loss of productivity	Reduction in cultivated land	Threat to food security

In many third-world countries, women lack access to wage employment, and the responsibility for child and family upkeep forces dependence upon male partners for economic stability. Such circumstances obstruct any effective HIV prevention campaign. Some women may even be compelled to turn to commercial sex work as an economic strategy, exposing themselves to high risk of HIV infection

The common perception of AIDS in the 1980s was as a disease of promiscuity and drugs in the industrial countries. But, there is no doubt now that AIDS is closely linked to poverty, particularly of women.

Poverty offers a fertile breeding ground for the epidemic's spread, and infection sets off a cascade of economic and social disintegration and impoverishment.

This is how an HIV-positive housewife and mother put it:

> "*The problem I had initially was as a nurturer-- taking care of my husband who had HIV-related illness, the household, and raising a child, doing all the ordinary tasks every day – and having someone sick, trying to meet my husband's needs and look after my child and myself – but feeling overwhelmed. AIDS has made me sick but if I don't work, my family would not eat.*"

Table 3

Costs at Different Stages of HIV Infection (UNAIDS)

Cost	Before Infection	Infection	Illness	Death
Direct	Control & preventive measures	Testing & outpatient care	Inpatient care	Funeral & associated expenses
Indirect	Precautionary saving	Lower productivity of ill members	Lower productivity & loss of income	Income foregone
	Insurance	Reduction in consumption & investment	Reduction in consumption & investment	Drop in family income
	Acceptance of less risky, but less well-paid jobs	Opportunity cost of looking after ill member	Opportunity cost of looking after ill member	Poor health of surviving members
		Psychological cost to the ill person & to other family members		
		Cost to others unwittingly affected by ill member		

"Research in Africa and Asia has provided information on the impact of HIV/AIDS, both at the societal level and at the level of specific populations. We know now that affected households have substantially reduced incomes; that school-age children are taken away from school to restore income; that death due to AIDS produces a large number of orphans; that children often become heads of households; and that elderly people may be left to take care of themselves. The coping strategies for these households are reduction of consumption, exhaustion of savings, selling of assets (land, vehicles and livestock) and borrowing of money. It is against this background that UNAIDS and its co-sponsors have undertaken a number of projects, including support for key studies and publications aimed at sharing experience among regions, countries and districts in an attempt to alleviate the impact of AIDS." (UNAIDS Progress Report 1996-1997, p. 67)

CHAPTER II

RESPONSES TO HIV AND AIDS

International and National Commitments

This section discusses the international as well as the regional and national initiatives to contain the HIV and AIDS epidemic.

International Commitments

A rights-based approach. International commitments are one of the cornerstones of a rights-based approach to HIV and AIDS. They are a public pledge by governments to respond to the HIV and AIDS epidemic with appropriate, fair and substantial measures. They are a recognition by governments that they have obligations to address issues, such as discrimination, gender inequality, and unequal access to basic services. Most governments in the Asia-Pacific Region have signed major international agreements on HIV and AIDS. These agreements provide an important bases for action.

Countries that have signed international agreements are duty-bound to uphold and fulfil these legally-binding obligations. These agreements, including human rights conventions, mandate government accountability. They endorse the principles of participation and empowerment, particularly for Most At-Risk Populations (MARP) and the vulnerable populations. As such, it is incumbent upon countries to allow and assist MARP and other claimholders to strengthen their capabilities in all areas that will lead to their empowerment.

The Declaration of Commitment on HIV and AIDS. In June 2001, heads of state and government representatives met at the United Nations General Assembly Special Session on HIV and AIDS. The Declaration of Commitment on HIV and AIDS is a clear statement of their commitment in response to the worsening situation. It demands that--

- Prevention be the mainstay of their response;
- Respect for the rights of people who are HIV-positive must remain paramount in the response to HIV;
- Empowering women is essential; and
- Children orphaned by HIV and AIDS need special assistance.

The Millennium Development Goals. The Millennium Development Goals (MDG) was adopted by member countries of the United Nations, with the aim of creating better conditions for the people of the world. A global partnership based on commitments and targets established at world summits during the 1990s, they are intended to respond to the world's main development challenges and to the calls of civil society. The MDG promotes poverty reduction, education, maternal health, and gender equality. It also sets targets to combat child mortality, AIDS and other diseases.

Three of the targets set by the MDGs deal directly with education and HIV and AIDS:

- Target 2 - Ensure that all boys and girls complete primary school;
- Target 3 - Eliminate gender disparities in primary and secondary education, preferably by 2005, and at all levels by 2015;
- Target 6 - Halt and begin to reverse the spread of HIV and AIDS.

The Convention on the Rights of the Child. The Convention on the Rights of the Child, or CRC, was adopted by the UN General Assembly in 1989 with 192 signatory nations. It is a legally-binding instrument derived from legal codes and cultural traditions. It states that--

> "…the Convention is a universally agreed set of non-negotiable standards and obligations. These basic standards—also called human rights—set minimum entitlements and freedoms that should be respected by governments. They are founded on respect for the dignity and worth of each individual, regardless of race, color, gender, language, religion, opinions, origins, wealth, birth status, or ability and therefore apply to every human being everywhere. With these rights come the obligation of both governments and individuals not to infringe on the parallel rights of others. These standards are both interdependent and indivisible; we cannot ensure some rights without—or at the expense of—other rights." [1]

The Convention guarantees children's rights to education, health, and information. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the Convention stipulates that the best interest of the child shall be a primary consideration. HIV prevention efforts for children and young people are part and parcel of education, health, and acting in the best interest of the child.

EDUCAIDS: The global initiative on education and HIV and AIDS. With UNESCO as the lead agency, EDUCAIDS is a joint initiative carried out in partnership with 10 United Nations agencies. Its purpose is to help governments and other key stakeholders put together a comprehensive response in the area of HIV and AIDS education.

EDUCAIDS provides a response to HIV preventive education that is simple and standardized, yet comprehensive and sensitive to different cultures and societies. The purposes of the initiative are:

- Increasing awareness and commitment to HIV and AIDS issues among opinion leaders and policy makers who influence education;

- Supporting governments and other key stakeholders as they prepare a comprehensive educational response to HIV preventive education and mitigate the impact of HIV and AIDS on the education sector;

- Assisting in the development of comprehensive policies and programs that reduce vulnerability and risk by combining effective elements of a comprehensive response that include curricula, teacher training, school health programs, workplace policies, and school feeding programs;

- Reaching out to out-of-school young people, orphans and other vulnerable population through non-formal education;

- Working to develop improved tools for planning, management and monitoring at the country level.

The ultimate goal of EDUCAIDS is to make a significant impact against the HIV and AIDS epidemic at the national level.

Education for All (EFA) – UNESCO's initiatives. In 1990, delegates from 155 countries, as well as representatives from some 150 organizations, agreed at the World Conference on Education for All to universalize primary education and massively reduce illiteracy before the end of the decade. UNESCO was chosen as the lead agency to spearhead this effort.

UNESCO's mission is to promote education as a fundamental right; to improve the quality of education; and to stimulate experimentation, innovation, and policy dialogue. As the lead agency in EFA, UNESCO coordinates, mobilizes, and harmonizes the efforts of governments, development agencies, civil society, and non-governmental organizations.

To implement EFA, UNESCO helped establish two important bodies – the High-Level Group and the Working Group on Education for All. The first meets annually with the goal of strengthening the political commitment and mobilizing resources. It consists of 30 Ministries of Education, along with representatives of development agencies and civil society. The Working Group provides technical assistance, support and information exchange between partners and stakeholders.

UNESCO has also drafted the Global Action Plan for EFA and publishes an annual *EFA Global Monitoring Report*. The first outlines roles and strategies for partners and stakeholders. The Monitoring Report measures progress countries make towards meeting EFA goals in the areas of primary education, adult literacy, gender parity, and quality.

The Dakar Framework for Action. This framework was adopted by 164 nations at the World Education Forum, which was held in Dakar, Senegal in 2000. The framework notes that HIV and AIDS are impeding attempts to achieve Education for All, with Article 64, in particular, urging action on the part of the education sector:

> "Education institutions and structures should create a safe and supportive environment for children and young people in a world with HIV and AIDS, and strengthen their protection from sexual abuse and other forms of exploitation. Flexible non-formal approaches should be adopted to reach children and adults affected by HIV and AIDS, with particular attention to AIDS orphans. Curricula based on life skills approaches should include all aspects of HIV and AIDS care and prevention. Parents and communities should benefit from HIV and AIDS-related programs. Teachers must be adequately trained both in service and pre-service to provide HIV and AIDS education, and teachers affected by the pandemic should be supported at all levels."

National Commitment

HIV and AIDS have reached the Philippine shore and continue to spread, as statistics reveals. There are social realities, with highly vulnerable persons in the scene that may blow up the present numbers out of control. The Philippine government has recognized the seriousness of the problem and has given priority to establishing preventive and control measures.

The Philippine response to the HIV and AIDS problem consists of the following:

- Formulation of the National AIDS and STI Prevention and Control Program In 1987 by the DOH;

- Enactment of Republic Act 8504, otherwise known as AIDS Law, signed in February 1998 (Appendix A): An Act promulgating policies and prescribing measures for the prevention and control of HIV and AIDS in the Philippines, instituting a nationwide HIV and AIDS information and education program, establishing a comprehensive HIV and AIDS monitoring system, strengthening the Philippine National AIDS Council, and for other purposes;

  The Philippines serves as a model country in the Asia-Pacific for being the first country to pass the AIDS Law.

- Creation of the Philippine National AIDS Council or PNAC, the central advisory, planning and policy-making body for the comprehensive and integrated HIV and AIDS prevention and control program in the Philippines;

- Establishment of the HIV Surveillance System by the DOH through the National Epidemiology Center, which monitors the progression of HIV infection in the Philippines, for the purpose of evaluating the adequacy and efficacy of the countermeasures being employed;

- Development of the AIDS Medium-Term Development Plan for 2005-2010

- Development of AIDS policies in the Workplace;

- Development of AIDS modules for schools;

- Development of guidelines, standards and protocols;

- Implementation of community-based interventions;

- Capacity building of health care providers;

- Creation of local AIDS Councils;

- Integration of AIDS and Migration in the program of the Department of Foreign Affairs;

- Establishment of a National Monitoring and Evaluation system for AIDS;

- Provision of free anti-retroviral drugs to HIV-positive individuals.

The following relates the milestones in the Philippines' attempt to combat the disease:

Milestones in Combating HIV and AIDS

1985-1995

- HIV and AIDS declared as a Modifiable Disease
- Establishment of the National AIDS/STD Prevention and Control Program and AIDS Registry
- Creation of Philippine National AIDS Council
- Formulation of 1st- 4th AIDS Medium-Term Plan
- DOH-initiated HIV biological surveillance

1995 to 2000

- First Filipino movie with AIDS theme:" The Dolzura Cortez Story"; inauguration of *Bahay Lingap*
- Creation of HIV and AIDS Core Teams in all government hospitals
- Hosting of the 4th International Congress on AIDS in Asia and the Pacific
- Establishment of the STD/AIDS Cooperative Central Laboratory (SACCL) and Behavioral Surveillance
- Enactment of Republic Act 8504 (AIDS Law)

2000-2005

- UNGASS Declaration of Commitment on HIV and AIDS
- UNAIDS adoption of " Three Ones"
- Formulation of 4th AIDS Medium Term Plan 2005-2010
- Development Monitoring and Evaluation Systems

Department Issuances. Various Departments of the government have issued memoranda related to HIV and AIDS:

- Department of Education Memo Circular No. 445 s. 1996 (Appendix B)
- Commission on Higher Education (CHED) Memo Circular No.16 s. 2000 Integration of HIV and AIDS in the following subjects, to wit: Natural/Biological Sciences, General Psychology, and General Sociology, effective school year 2000-2001
- CHED Memo Circular No. 37 s. 2001
    - Sec 5. HIV and AIDS Information as a Health Service

All efforts shall be exerted to provide inpatients and outpatients with HIV and AIDS education, individually or in groups, during consultation, confinement in a clinic, hospital or medical center, both government and private.

- Sec 6. HIV and AIDS Education in the Workplace
  HIV and AIDS education shall be integrated in the orientation, training, continuing education and other human resource development programs of employees and employers in all government and private offices.

  The Department of Labor and Employment (DOLE), Department of Health (DOH), Armed Forces of the Philippines (AFP) and the Philippine National Police (PNP) shall oversee the implementation of this section.

  1997 Workplace Declaration of Policy on HIV and AIDS

    DOLE Dept Order, 38-03, s. 2002;
      Inter-Agency Committee on HIV and AIDS in the Workplace
      Corporate Sector Advocacy/Menu of Partnerships
      Labor/CBA Integration of RH/HIV and AIDS
      Workplace Program of HIV and AIDS

    PNP/AFP manual on HIV and AIDS

    DOLE - Pre-Employment Orientation Seminar (PEOS) on HIV and AIDS

    DOT Training of Hotel Workers on HIV and AIDS

- Sec 7. HIV and AIDS Education for Filipinos Going Abroad
  Filipinos going abroad, consisting of all overseas Filipino workers (OFWs), as well as diplomatic, military, trade and labor officials and staff who will be assigned overseas, shall attend an HIV and AIDS education seminar prior to departure.

  DOLE, DFA, Department of Tourism (DOT) and the Department of Justice (DOJ) shall oversee the implementation of this section.

  Pre Departure Orientation Seminar (PDOS) on HIV and AIDS

    POEA Memorandum Circular No. 1 s. 2002

    Manual on Repatriated Filipinos on HIV and AIDS

  Training of Foreign Service Personnel on HIV and AIDS (DFA-Foreign Service Institute)

- Sec 8. Information Campaigns for Tourists/Transients
  HIV/AIDS information materials, such as brochures, flyers, posters, audio and video tapes shall be prominently displayed or played, easily accessible and available at places where there are tourists and transients.

  DOT, DFA and DOJ, in collaboration with DOH, shall oversee the implementation of this Act.

- Sec 9. HIV/AIDS Education in Communities
  Local Government Units (LGUs), through their health, social welfare and population officers, shall undertake an HIV and AIDS education and information program in the community. LGUs, in collaboration with the DOH, shall conduct educational and information campaign on HIV and AIDS.

Preventive Education

This section makes teachers aware of the characteristics of young people and uses this awareness in empowering them to protect themselves from HIV infection. An approach that teachers can use is life skills-based education, which produces behavior change or behavior development.

Providing young people with good quality HIV preventive education should be a priority for education reform processes everywhere. At present, countries are at different stages in developing school-based programs. Some are just starting to develop the curriculum and train teachers; others are farther ahead and reaching widespread coverage. All have to find ways to address socially-sensitive topics related to sexuality and sexual health at school. This represents one of the more difficult challenges faced by the Department of Education in developing preventive education, and by teachers in implementing it in the classroom.

Face the Facts about Young People

At any time anywhere some young people may be having sex. Whether or not adults approve or warn them of the dangers of pre-marital sex or threaten punishment, some young people will have sex anyway. It is a misconception that young people who have sex are rebellious, disruptive and academically disinclined; likewise, just because some young people are good students does not mean that they abstain from having sex.

Youth is a time of discovery and experimentation. Young people tend to think that they are immortal and invincible, and that bad things only happen to others. They take risks some more than others. It is not only boys or young people over the age of 16 who are having sexual experiences; some girls below the age of 15 are also having sex.[1] Some are also experimenting with drugs and alcohol.

The Young Adult Fertility Study (YAFS) conducted by Raymundo shows the levels, trends and gender differences in risk behaviors manifested by Filipino adolescents in 2002. The findings of the study have implications on HIV and AIDS:

- On drug use: 11% of adolescents have used drugs; more males than females have used drugs; drug use increases with age;

- On premarital sex: 23% of the adolescents have engaged in premarital sex (PMS); more males than females have had PMS; PMS increases with age;

- The age of initiation to risk behaviors are in a pattern of sequence: smoking—drinking--drug use—premarital sex;

In general, the study shows that--

- There is substantial and increasing levels of problem behaviors among Filipino adolescents that can imperil their health and well-being;

- Both male and female adolescents are engaging in substance abuse and premarital sex with clear gender differences;

- Risk behaviors examined are clearly interconnected:

    - There is a pattern in the timing of initiation of risk behaviors;

    - Engagement in premarital sex is highly probable among those who are smoking, drinking or using drugs;

- There are protective as well as risk factors in the environment of the adolescents represented by type of family, education, and location of residence that encourage or discourage the engagement in risk behavior (premarital sex);

- The occurrence, sources of influence and the linkages of risk behaviors are part of the complex human behavior.

Teachers and parents need to recognize this reality if they are going to make a difference in the lives of their students. They must provide their students with the right information to help them make good choices about their behavior.

Parents may resist the teaching of HIV preventive education in school even if teachers think it's a good idea. They may need to be persuaded to support preventive education. However, in many contexts, parents will prefer teachers to educate their children about HIV and AIDS than to do it themselves.

Young People Can't Protect Themselves if They Don't Know How

More than 20 years after HIV and AIDS first appeared in the Asia-Pacific Region, some young people still have never heard of it. Many others have misconceptions or believe the myths about HIV. In many countries, young women are less knowledgeable about HIV than young men. These young women and men are vulnerable or at risk of being infected. For young people to be able to protect themselves, they need honest and accurate information.

Teaching sex education through a life skills-based approach is the first important step in protecting young people. Sexuality and relationship education must address HIV prevention, reproductive health and gender stereotypes. Young people have the right to know and understand these issues as they directly affect them. Young people also have the right to know their HIV status. They need to know where they can get

voluntary and confidential counselling and testing, and other reproductive health and support services.

Sex Education Does Not Promote or Increase Sexual Activity

Many parents express concern that teaching sex education will promote or cause an increase in sexual activity among young people. Researches from around the world show that this is not true. In fact, studies from 113 countries in five continents found that teaching about HIV, AIDS and sexuality helps reduce early sexual activity and other risk behaviors.[2]

Guidelines for Preventive Education

1 Start early, before children and young people become sexually active.

2 Address *all* the factors that contribute to HIV vulnerability, including gender inequality, poverty, discrimination, cultural norms and beliefs, drug use and the position of indigenous peoples.

3 Present the full range of options for HIV prevention, including delaying sexual activity, reducing the number of sexual partners, and correct and consistent condom use.

4 Develop skills in teaching sensitive topics.

5 Equip school staff with the skills to listen to students and handle sensitive issues in a non-judgmental manner.

6 Use various informal channels, such as the media and community network, to reinforce the messages of school-based preventive education.

7 Integrate HIV and AIDS education in both curricular and co-curricular activities, such as sports and Scouting.

8 Actively involve teachers and young people in the design and delivery of the curricula.

Life Skills-Based Education for Healthy Behavior[3]

Experience in preventing the spread of HIV has shown that knowledge is necessary, but not sufficient in itself, to reduce risky behavior. Research suggests that it needs to be holistically integrated across the school in all subjects. Active learning is also required. Life skills-based education is a participatory, interactive approach to learning aimed at producing behavior change or behavior development. It is designed to address a balance of three areas: knowledge, attitudes, and skills.

The goals of the life skills-based approach are to--

1 Address the social and psychological forces that promote risky behavior by developing young people's ability to resist social pressures from peers and the media that encourage the behavior;

2 Promote the ability to be less vulnerable to the internal psychological forces that promote risky behavior;

3 Increase resilience in the face of stress; and

4 Enhance self-sufficiency in making informed decisions about one's behavior.

What does this mean for the teacher and HIV preventive education?

1 Communication skills can be applied so that young people can influence others to abstain from sex, and support them in that decision.

2 Refusal or negotiation skills can be taught so young people can learn and practice ways of refusing sexual intercourse.

3 Decision-making skills can be applied so that young people can consider if, when, and how to express sexuality with someone they care about, what safer behaviors they are comfortable with, and weigh the consequences of each course of action.

4 Critical thinking skills can be applied so that young people can identify media messages regarding HIV and AIDS, gender roles, and contraception, and analyze their accuracy and assumptions. If they have further questions, they can effectively seek out reliable sources of information about these topics.

Combined with an open, honest, and caring atmosphere, interactive methods will promote an open classroom and safe spaces for discussions of controversial issues. Ideally, open discussion in a supportive environment should begin to help address the shame, silence, and stigma associated with HIV and AIDS. It could help address the denial, blame, and discrimination that delay positive steps and prevention.

Interactive teaching methods include—

- Facilitated group discussion
- Classroom demonstrations
- Small group activities
- Debate
- Demonstration
- Behavioral rehearsal or role play

It is important to teach young people how to recognize and resist pressures to engage in unhealthy behaviors (e.g.,peer refusal skills and analyzing media messages). Adolescents often overestimate the prevalence of behavior problems ("everybody is doing it"). It is important to provide accurate information regarding rules of behavior in order to reduce the perception that a particular behavior is common behavior.

School-based HIV preventive education programs should ideally be delivered in many sessions across multiple years. Preventive messages should be used to reinforce and update what is learned.

Teachers may feel threatened and uncomfortable as HIV preventive education providers because of cultural prohibitions regarding drug use and sexuality, or because effective prevention involves interactive and innovative teaching techniques. It is important to provide them with regular in-service training and support to help them master new teaching techniques, overcome discomfort and prejudice, and generate teacher enthusiasm and support. Studies show that teachers who are initially reluctant to teach HIV prevention in a way that encourages student participation can overcome this hurdle during training sessions.

Skills Training for HIV Prevention

To instruct students about resisting the pressure to begin having sex, teachers can start off with instruction and demonstration. Explain to students that when their boyfriend or girlfriend pressures them to begin having sex, they can respond in a variety of ways, including saying NO firmly and confidently. Demonstrate what can be said or give some examples of appropriate responses.

Next, apply behavioral rehearsal. Ask students to break up into small groups. Pairs of students should take turns in a role-play scenario in which one person is pressuring the other to begin having sex. The teacher goes from group to group and observes how individual students respond to the situation.

Then, use feedback and social reinforcement. Review what the students in each group did well and what they could do better. For example, if a student was not convincing in assertively saying NO, tell him/her in a constructive and supportive way that s/he could have been more assertive or used another negotiation technique.

Use extended practice. Ask students which responses they think would work best in different real-life situations. Ask them to practice one of the techniques over the next week in a situation where they are being pressured. Have students report back to class what happened.

The Role of Schools in Responding to HIV and AIDS

The education sector is a critical partner in the national multi-sectoral response to HIV and AIDS. It is through education that young people can be provided with the knowledge and skills to enable them to protect themselves and their peers from HIV infection. Schools and teachers have important roles to play in developing healthy citizens of tomorrow.

Schools Shape Attitudes and Behaviors

Schools play an important role in shaping the attitudes, views and behaviors of young people. Since young people lack knowledge and tend to experiment with new behaviors that may be risky, they are more likely to be affected by HIV and AIDS than any other age groups. Schools can help shape their responses to this reality. Peer groups at school can be motivated to provide support and a positive attitude towards HIV-positive people. Schools can provide an environment in which young people can be educated about HIV and AIDS.

Studies from around the world show that young people who stay in school are less likely to get HIV and AIDS than those who drop out.[1] Schooling increases earning power, self-confidence and social status, allowing young people to take greater control over their choices relating to personal relationships.

Schools Can Be the Center of Community Response

Schools are pillars of their communities. They are trusted by students and parents alike. As a place where friendships are formed and bonds are established among teachers, pupils and parents, schools are more than just places where education takes place. They are often the center of community activities, especially in small barangays and in rural areas. This gives them the potential – provided they have the leadership, the resources and the staff training – to be the cornerstone of a community response to the HIV and AIDS epidemic. They can act as a vehicle for community discussion and for the mobilization of activities, and help break down stigma and discrimination. They can assist in monitoring the impact of the epidemic. Since schools reach very large numbers of young people with information that can save their lives, their role in HIV prevention can be powerful.

Schools Can Be a Sanctuary for Affected Students

Schools can be a sanctuary of stability and normalcy for young people living with or affected by HIV and AIDS. Students may be living with HIV, or their home lives may be troubled or in disarray because a relative is infected or ill. While at school, they are with friends and teachers. The atmosphere and routine are known and predictable. Such an environment provides an important degree of stability and comfort. For a

school to be a sanctuary, however, it must address the problems of stigma and discrimination, which cannot be tolerated in a school setting.

Educators are in an important position to provide psycho-social support for children who are living with or affected by HIV and AIDS, or vulnerable to HIV. Teachers are often the first to notice when a student is having psycho-social problems. Teachers, counsellors and other school officials need to be trained to recognize, provide support and deal with these situations. Simply put, schools are part of the social safety net.

What Schools Can Do

Integrate HIV preventive education in the school curricula. The law mandates the Integration of HIV prevention in the school curriculum. HIV and AIDS education shall be integrated into but not limited to Science and Health, *Edukasyong Pantahanan at Pangkabuhayan (EPP), Sibika at Kultura*, Good Manners and Right Conduct (GMRC) and Filipino at the elementary level; in Science and Technology, Social Studies, Physical Education, Health, Music and Arts (PHEMA) and Values Education at the secondary and tertiary levels. HIV and AIDS education shall also be integrated by DepEd in its alternative learning system program and in the indigenous learning systems. Instructional materials shall be provided for such purposes. Integration of HIV preventive education in the school curricula is an effective way of providing students with the information to protect themselves. Appendices C to G present varied approaches in integrating the study of HIV and AIDS in the curriculum.

Schools should use a life skills-based education approach across the curriculum. Aside from being useful in the prevention of HIV, it teaches young people the skills they need to resist peer pressure and make good choices regarding a range of health and behavioral issues, such as drug use. To accomplish this, teachers need to be trained on how to teach HIV and AIDS education through a life skills-based approach. It will be necessary to develop teaching and learning materials that are both relevant and culturally appropriate to the community.

School principals, teachers and communities might also have to be convinced of the need to allow these topics to be taught. Many have concerns that teaching about human sexuality, reproductive health and HIV prevention will encourage young people to become sexually active. According to UNAIDS, studies from 113 countries show that this is not true. In fact, young people are more likely to delay the start of sexual activity if they have received education in these subjects.

Ensure that children and teachers living with or affected by HIV and AIDS stay in school. Students and teachers living with or affected by HIV and AIDS face personal challenges that may force them to leave school or their jobs. These include illness, family responsibilities and poverty. Yet they have the same rights to education and employment as everyone else.

It is imperative to work with community-based organizations (CBOs), NGOs, provincial authorities and community groups to keep teachers and students at school. This can be done through material assistance, provision of psycho-social support, and activities to combat stigma and discrimination. Schools can also make special provisions for affected students and teachers to enable those with illnesses or extra familial responsibilities to make up for lost time. This requires flexible teaching and learning schedules.

Provide for HIV-positive persons. People living with or affected by HIV and AIDS have particular medical and psycho-social needs. There are several ways in which schools can help meet those needs.

Special support is required for HIV-positive children. Teachers and peers can play a role in counselling and supporting affected students. Specific teacher training and training in peer education may be necessary. Schools can develop referral systems to health and welfare services and inform teachers about these services

Reduce stigma and discrimination. HIV and AIDS-related stigma derives from the virus' association with illegal or taboo behaviors, and with the irrational fear many people have of infection.

Schools reach children and young people in their formative years; hence, they are well-placed to counter misconceptions about HIV and AIDS, and also to promote the rights of people living with HIV. This will help reduce negative attitude towards people living with HIV.

Schools can organize discussions--not just among students, but also among members of the community – about HIV and AIDS. They can invite people who are living with HIV and AIDS, or organizations of people living with HIV and AIDS, to speak about their experiences. This takes HIV from the abstract to the real. It gives the epidemic a human face, and can help dispel fears and increase both understanding and compassion.

Some approaches to reduce stigma and discrimination[2] are--

- Continuing advocacy for social change in response to HIV and AIDS-related stigma and discrimination involving HIV-positive persons and religious/political leaders;

- Empowerment of people living with or affected by HIV and AIDS;

- Action to tackle gender, sexual and racial inequalities and stereotypes, which feed stigma and discrimination;

- Life-skills education and counselling to help children living with or affected by HIV and AIDS cope with stigma;

- Legal protection for HIV-positive people;

- Workplace policies based on the ILO Code of Practice on HIV and AIDS and the world of work;

- Ensuring that codes of ethics and professional conduct are enforced in health settings.

What Teachers Can Do

- Involve community leaders. They have a strong influence on the community and can reduce stigma and discrimination by setting an example. They can encourage the local government unit to put HIV and AIDS on its agenda.

- Be knowledgeable about how HIV and AIDS impact on children and reach out to the community.

- Be sensitive to the psycho-social needs of all your students, including those who are living with or are affected by HIV and AIDS.

- Actively support the teaching of HIV preventive education in school.

- Be a positive role model in raising awareness to reduce stigma and discrimination in the school and community. Practice what they preach.

- Create a supportive environment in class to address gender inequalities.

- Ensure that the classroom is a safe place- free from bullying, violence and harassment.

- Involve HIV-positive people in the school's response. Invite organizations of HIV-positive people to help organize a response in school.

- Support the implementation of the workplace policy on HIV and AIDS in the school setting.

- Encourage teachers' organizations to take an active role in advocacy and in addressing the impact of AIDS on teachers

Young People Who are Out-of-School

The young people most vulnerable to HIV are often those who are out of school. Young people can be out of school for a variety of reasons. They may be too poor to pay school fees, or even lack money for transportation to school. They may have to work to support their families. They may be street children without families. They

may be the children of sex workers or other groups who are stigmatized by the community. Out-of-school young people often don't have access to knowledge, information and services that will help protect them from HIV.

The Bureau of Alternative Learning System (BALS) of the Department of Education can play a role in providing these young people with opportunities for non-formal education, HIV preventive education and other services.

The Dakopha Group in Thailand and the SHAPE program in Myanmar are two examples of this approach. The Dakopha Group is attached to the Bakham Phittayaknom School in the Nakorn Ratchasima province of Thailand. After the Asian economic crisis of 1997, the group was started to build relationships between in- and out-of-school young people, because with the economy in bad shape, those in school one day would likely find themselves out of school the next day. The group of young people underwent a series of capacity-building training--in leadership, life skills, participatory community research and community theatre. In the end, they formed their own CBO, the Dakopha Group. The group conducts preventive education activities both in and out of school in the form of assemblies, camps, and community performances, as well as by using general outreach strategies. The schools' relationship with the community has helped to mobilize support for Dakopha and HIV preventive education within the community.[3]

Many young people in Myanmar leave school after finishing primary education. Most HIV preventive education initiatives for young people start at the secondary level, from age 15 and above. Thus, children who frequently drop out before this level are left without adequate knowledge or skills for HIV prevention. Following the successful national implementation of the formal "School-based Healthy Living and HIV and AIDS Prevention Education" (SHAPE) project for primary school students, which started in 1998, the approach was adapted for application in a non-formal setting to reach out-of-school children and young people in 2002. The strong emphasis on HIV and AIDS, STIs and drug abuse prevention in the school-based life skills initiative was adapted for out-of-school young people with the objective of preventing the spread of HIV among young people, at the same time providing extended learning opportunities.[4] In most cases, these out-of-school young people need to work to help support their families or to help their families at home or in the family business. The schools that have been participating in SHAPE use their network for social mobilization – parent-teacher associations, community leaders, parents, and religious leaders – to mobilize support for out-of-school young people to participate in non-formal education. The project has also helped a number of young people return to school.

The Education Sector's Response to HIV and AIDS

The key elements of the education response are--

1. An education sector policy on HIV and AIDS that addresses both HIV prevention and issues arising from the impact of AIDS on the school;

2. HIV and AIDS training for the Department of Education staff at all levels;

3. HIV preventive education curriculum development and the preparation of age-specific teaching and learning materials;

4. Pre-service and in-service teacher training to implement the HIV preventive education curriculum;

5. Co-curricular activities, such as peer education;

6. Monitoring arrangements to ensure program effectiveness.

The education sector's response to HIV and AIDS is a critically important component of any national multi-sectoral HIV plan and program and should therefore be accorded emphasis in the overall initiative towards HIV and AIDS prevention.

Linking Schools to HIV and AIDS-Related Services

Preventive education needs to be linked to the provision of HIV and AIDS-related services for young people. Students can be informed about the importance of such services and where they can be accessed. Thus, schools can be instrumental in raising both demand for services and their uptake.

Partnerships are Crucial

Schools play an important role in the response to the HIV and AIDS epidemic, but they cannot do everything. Partnerships between schools and outside services are crucial for young people to receive the utmost protection and care.

Most communities have a range of health, welfare and other services that can provide people with information and tools for HIV and AIDS prevention, treatment, care and support. Some are government agencies, while others are private organizations (Appendix H). Most young people have no idea that these services exist. They may also have fears about accessing them.

For the benefit of young people, it is important that schools are aware of these agencies and organizations, and establish relationships with them. Schools and teachers need to understand the services such organizations provide. When a student needs help that is beyond the capacity of schools, a simple referral to an outside service can be a life-saver.

Table 2 lists down treatment centers that schools can partner with for referral.

Young-People Friendly Services

Services that are young-people friendly understand the psychological and social issues related to young people, along with the practical concerns of the services they provide. This means that they respect young people's needs, especially for confidentiality, and deal with them in a non-judgmental way. If services are not young-people friendly, then schools can advocate for them to adopt young people-friendly approaches and practices. Services aren't much good if young people don't know about them or are afraid to access them.

Types of HIV and AIDS-Related Services [1]

Voluntary confidential counselling and testing (VCCT). No response to the HIV and AIDS epidemic can be successful if people don't know their HIV status. Individuals who are HIV-positive need treatment and can't get it if they don't know they have been infected. They may also infect others if they don't know they are HIV-

positive. Services that offer VCCT are essential in meeting the needs of the individual and in addressing the epidemic.

Table 2

Treatment Centers for the Clinical Management of HIV and AIDS and HIV Counseling and Testing Services

TREATMENT CENTERS: CLINICAL MANAGEMENT OF HIV AIDS & HIV COUNSELLING & TESTING SERVICES

Ilocos Training and Regional Medical Center (ITRMC)
San Fernando, La Union
Jeisela B. Gaerlan, MD, FPPS, DTM&H
Medical Specialist II/HACT Leader
Clinic: (072) 700-3808

Baguio General Hospital and Medical Center (BGHMC)
Baguio City
Dr. Maria Lorena L. Santos
HACT Leader / Medical Officer II

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

Research Institute for Tropical Medicine (RITM)
Philinvest Corporate City, Alabang, Muntinlupa City
Dr. Rossana A. Ditangco, Research Chief
Tel: 5261705; 8072628/38 local 801/208;

Philippine General Hospital (PGH)
Taft Avenue, Ermita, Manila
Ms. Dominga C. Gomez
SAGIP, PGH
Telefax: 5261705

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

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

Corazon Locsin Montelibano Memorial Regional Hosp
Lacson St., Bacolod City, Negros Occidental
Candido Alam, MD
HACT Leader/Medical Specialist
Tel: (034) 435-1591; (034) 433-2697

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

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

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

Or Contact:
Dr. Jose Gerard Belimac
Program Manager
National AIDS STI Prevention and Control Program
Department of Health
DOH Compound, Rizal Ave., Sta. Cruz, Manila
Telephone: (02) 7116808, or 743-8301 locals 2350-52

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

Generally, people should get tested for HIV regularly so that they will know their HIV status and can make informed decisions. There are various types of tests that can determine whether or not someone is living with HIV. Most involve taking a blood sample, but there are other tests available in some locations.

From the time a person contracts HIV, there is a “window period” of 3 to 12 weeks. The window period is the period between infection with HIV and the appearance of detectable antibodies to the virus. During the window period, an HIV-positive person has no antibodies in his/her blood that can be detected by an HIV test. HIV can be passed on to another person during the window period, even though an HIV test may not show that s/he is infected with HIV. However, the person may already have high levels of HIV in his/her body fluids, such as in blood, semen, vaginal fluids and breast milk, which is why a person should use condom when having sex. It is necessary to

repeat an HIV test after the window period, since it can take up to three months for the immune system to ensure an accurate result from the test.

The keywords here are consent, confidentiality and counselling. The problems of stigma and discrimination make informed consent and confidentiality absolutely imperative for anyone providing testing services. Tests and results should be confidential. If people don't have faith or don't believe that the results will be kept confidential, they won't use the service. Test results should always be given individually and in private. It is impossible to maintain confidentiality in a group situation, so they should never be given in groups. If results are not kept confidential, those who test positive may be rejected by families and friends, lose their jobs, be barred from school or may even be subjected to violence.

Pre- and post-test counselling. This is a must. If someone learns s/he is HIV-positive, the psychological effects can be devastating. Some may even harm themselves or commit suicide. It is extremely important that any testing service provide qualified counsellors as part of its package. They can help those learning that they are positive know the facts about their condition and situation and how best to cope with it. They can also refer them to additional services they may need, such as where to get treatment. It is just as important that those who test negative for HIV also receive counselling. Many who test negative are so overjoyed or relieved at the result that they neglect counselling. However, they have most likely been involved in risk-taking behaviors or situations that led them to fear that they had been infected and to get tested. Counselling can give them the facts about the risks they are taking, and advise them on strategies to avoid those risks. Without counselling, they might be back before long, filled with fear that they have been infected and seeking another test.

Psycho-social support and counselling. There may be students who are already HIV-positive, know it and are having a difficult time coping with it. There may also be students who have HIV-positive or ill members of their households and are having difficulty coping with that. They may need more extensive counselling than can be provided in a school setting. Teachers and schools need to know where this counselling is available in their area.

Reproductive health services. Many clinics offer reproductive health services. These can be good places for young people to obtain contraceptives, especially condoms, and information about HIV, other sexually-transmitted infections and how to avoid them. Some NGOs involved in HIV prevention also distribute condoms. Both men and women are welcome at reproductive health clinics and should be encouraged to make use of them, either on their own or with their partners. Many, however, may still be reluctant to visit a reproductive health clinic, so it would be helpful if schools and teachers know which NGOs operating in their area offer health services.

STI or sexually transmitted infection clinics. These clinics can test people for a variety of sexually-transmitted infections. Research shows that having a sexually-transmitted infection increases a person's susceptibility to HIV.

Anti-retroviral therapy. Those who can access anti-retroviral therapy, or ART, can live for many years, even decades, with HIV. Anti-retrovirals are drugs, which slow down the reproduction of the virus, reduce viral load (the amount of virus present in the body) and work to repair the immune system. There are several drugs that do this, but for ART to be effective, it must be taken in combination every day for the rest of the patient's life. The earlier a person starts ART the more effective it will be, which is another reason why it is important for people to know their HIV status. Patients on ART suffer fewer illnesses and lead relatively normal lives.

There are several problems, however, with ART. Chief among them are cost and availability. Anti-retroviral drugs (ARVs) are expensive and not available in many places, usually in less developed or poorer areas. Many groups are advocating reducing their cost and making them more available. Furthermore, as they are relatively new, no one can be certain how long they will be effective, or if patients will develop resistance to them. Lastly, adherence is an issue. Patients must take ARVs every day or they will be ineffective.

Harm reduction and drug treatment programs. It is important for students who are taking drugs to know what drug treatment programs are available in their area. If they are injecting drugs, knowing where to find Harm Reduction (HR) programs is essential. A Harm Reduction program is a comprehensive package of policies and programs, which attempts primarily to reduce adverse health, social and economic consequences of mood-altering substances to individuals, drug users, their families and their communities (WHO Bi-regional Strategy for Harm Reduction 2005-2009). The HR program may include outreach for behavior change modification, health promotion, distribution of clean needles and syringes, counselling and referral services for primary health care and treatment, including provision of anti-retroviral drugs.

Services for key populations vulnerable to HIV. Particular sub-groups of young people, such as girls, ethnic groups, injecting drug users, men who have sex with men, sex workers and mobile populations, may be at heightened risk of HIV. If specific programs or services for these sub-groups exist, it is imperative that schools make connections with them so that all young people can have access to culturally appropriate services tailored to their needs.

What Schools and Teachers Can Do

School principals and teachers are well placed to build links between schools and other relevant services by—

- Knowing what services are available in the local area for young people and connecting young people with them;

- Educating other teachers to do the same;

- Inviting service providers to talk to parents, teachers and students about the types of services their organization provides and the benefits of accessing such services;

- Establishing referral protocols and memorandums of understanding with relevant services; and

- Encouraging students to access such services where they do exist, and countering the shame and stigma, which may be associated with the use of such services.

CHAPTER III

FOCUS SHEETS

Males Having Sex With Males (MSM)

This sheet looks at the vulnerability of male individuals who are having sex with other males. This is an issue that is often neglected in the educational setting, which tends to focus on heterosexuality as the socially-accepted norm. Consequently, it needs to be addressed carefully in school, ideally through the official curriculum.

Males Who Have Sex with Males (MSM)

MSM stands for *males who have sex with males*, which may also mean *men having sex with men*.[1] The former terminology denotes the inclusion of younger males while the latter is more of the adult men. In the context of HIV and AIDS, the terms "homosexual" and "gay" are not used because there are MSM who also have sex with females. They don't necessarily think of themselves as homosexuals or gays. *Men who have sex with men* is a term that identifies a behavior.

Many MSM do identify themselves as gays or homosexuals, and are proud of their identity. In some countries, strong gay rights movements have emerged to decry discrimination against gays and lesbians. Other countries have laws that prohibit such behaviors and label the sexual orientation as illegal.

Studies show that MSM exists in every nation and society;[2]there are no exceptions. MSM may be less visible in some countries because of stigma and discrimination, but they are there.

On the average, somewhere between 12% and 15% of men in most countries identify themselves as having had sex with other men at some point in their lives.[3] Some men, especially young men who are of school age, experiment with MSM behavior during the process of discovering their own sexuality. However, not all will go on to identify themselves as gay or homosexual, or continue MSM behavior later in life.

Transgenders

Transgender people are those who believe that they were born as "a woman in a man's physical body." Some try to live as members of the opposite gender, and may have sexual reassignment surgery to do so. Transgenders who engage in high risk behaviors, like unprotected anal intercourse, put them at higher risk for HIV, as with the MSM in general.

Rejection by society leads some transgenders to become sex workers. The rejection may have psychological effects. Craving for love and approval, some transgenders

may be too willing to please partners and clients, or unwilling to assert themselves and insist on safe sexual practices. This makes them more vulnerable and at even greater risk of HIV infection.

There are also women who have sex with women.[4]They may choose to identify themselves as gays or lesbians. For biological reasons, they are less at risk of getting HIV and AIDS than MSM.

The HIV Situation Among MSM

The HIV and AIDS situation among MSM is alarming. In places where HIV infection rates in communities of MSM have been measured, the rates of HIV infection have been very high. A recent study of some groups of MSM in Bangkok, Thailand, found that 28% were living with HIV. In Phnom Penh, Cambodia, a 2000 survey found 15% infected. A 2003 study found that 18.8% were infected in Mumbai, India.[5]

In the Philippines, there is an estimated 90,000 to 340,000 males who are having sex with other males, based on the DOH estimates in 2005. The HIV infection rate is at 0.0 to 0.4% and is relatively low. However, the MSM population is hidden in society and is usually hard to reach during outreach services and even for HIV counselling and testing.

The National AIDS Registry of the DOH in 2005 reported 1,171 number of HIV cases transmitted through homosexual intercourse.

The country's response in preventing HIV among MSM is focused on peer education/counselling and other behavior modification or change strategies to lessen the risk of HIV by abstinence and promoting safer sex. Most of these are provided by NGOs and/or MSM-oriented groups or organizations (See Appendix H).

HIV and MSM

MSM are especially vulnerable to HIV infection for cultural and biological reasons. Many governments ignore MSM in their HIV prevention programs, and so MSM do not get the information or services they need to protect themselves.

Stigma and discrimination also inhibit MSM from seeking information on their own. Many do not wish to reveal their sexual orientation to others for fear of social repercussions. This may also inhibit them from seeking and accessing sexual health services.

Biological factors also make MSM vulnerable to HIV, owing to the transmission of HIV through semen and other body fluids exchanged during sexual activity. MSM who engage in anal intercourse is of higher risk of HIV infection. The anus does not naturally produce lubricants for sexual activity, and so during intercourse it may sustain small tears or abrasions that expose blood vessels. This provides a direct

pathway for the virus to enter the bloodstream, if the partner is HIV-positive and the sex was unprotected. Anal intercourse, whether between men or between men and women, is a high-risk behavior. Men are also more likely to have casual, non-committal sex than women. In a scenario where men are having sex with men, it follows that there will probably be more casual sexual activity taking place. Coupled with lack of knowledge about safe sexual practices, there will then be more opportunities for HIV infections to be transmitted. Furthermore, many MSM also have sex with women. Some may be married, some may have girlfriends, some may be students. Their female partners may know nothing about their MSM behavior. If a man has unprotected sex with another man who is HIV-positive, he may become infected as well.

What Needs to Be Done

- MSM must be included in the national HIV and AIDS prevention, treatment, care and support programs;
- MSM must utilize the health services offered at any given facility. Health care systems must not discriminate against them; they must be MSM-friendly;
- Groups and organizations that can reach MSM with information and health care services must be allowed to work free of harassment from law enforcement;
- Behavior modification towards behavior change by focusing on abstinence and safer sex should be promoted;
- Public service campaigns should raise awareness and acceptance of MSM and reduce stigma and discrimination;
- MSM must be afforded all the same rights and protection as other members of society;

What Schools Can Do

- Teach HIV preventive education, including sex education and reproductive health;
- Include the subject of MSM in preventive education lessons and discussions;
- Accept the possibility that there might be MSM among their students;
- Combat prejudice, promote tolerance and acceptance, identify and dispel myths;
- Use a life skills-based approach to school subjects;

- Link the school to outside services and HIV-service organizations that are MSM-friendly or MSM-oriented;

- Enact and enforce a zero-tolerance policy about violence against MSM.

What Teachers Need to Do

Sexual diversity is part of human nature. It exists in every country and culture, regardless of whether or not some people choose to recognize and accept this fact.[6]

People generally become aware of their sexuality and sexual orientation during their school years. This can be an exciting time of discovery and experimentation. It can also be a confusing time full of questions, doubts and insecurities especially if young people have a sexual orientation that is not the same as the majority of people around them.

Teachers need to be aware of, and be sensitive to, sexual diversity. Some of their students may probably be exploring or discovering MSM behavior. When teaching about sexuality and human relations, reproductive health, and HIV and AIDS, it is important to include information about MSM to enable them to prevent HIV infection.

MSM have the same rights as others to the knowledge and tools they need to protect themselves from health risks. As with other young people, they have the right to grow to their fullest potentials as contributing members of society, and should be encouraged to do so. MSM are often the targets of stigma and discrimination, and one reason for this is because people think their sexual orientation is abnormal. This is not so. MSM should not be discriminated against and stigmatized.

Initiatives to educate teachers should not stop there. It should also extend to the school curricula, in particular, the subject of Health Education, which includes HIV preventive education and sex education. These subjects need to be taught for the protection of all young people. Leaving MSM out of these topics and discussions may put the lives of these young people at risk.

Sex Workers and Their Clients

This sheet looks at the vulnerability of people involved in commercial sex, either as service providers and/or as clients. It covers people engaged in paid sexual activity as the main source of livelihood and those who occasionally venture into sex in exchange for favor or monetary rewards. This also focuses on the environmental and psychosocial predisposition in entering commercial sex work, which puts them at risk of HIV and other sexually transmitted infections.

Commercial Sex Workers

Women's prostitution – and in some countries, boys' and youngsters' – make them a group at high risk and, more fundamentally, a socio-cultural endangered group, consequently more exposed to HIV infection, with specific difficulties in avoiding it and having access to consistent medical care.

For girls and women, entering into commercial sex work often results from being left without support by their husbands or regular partners or, for children and youngsters, being abandoned by parents and becoming forsaken mothers. As regards youngsters mostly from developing and poor countries, girls' or boys' prostitution is the obvious consequence of poor families' migration to the big urban areas, structural unemployment, extreme poverty, lack of basic education allowing them to find a job, or even the necessity to finance their school or university education. There have been reports that some young women, boys and students had ventured into commercial sex activity in exchange for money for tuition fees and other financial needs.

Aside from the societal/cultural stigmatization linked to prostitution, especially in male-to-male commercial sex, professional sex workers cannot refuse unsafe sexual practices, and very frequently, cannot identify their customers if they get infected. Likewise endangered are young girls forced into early sexual practices, since older men or "connoisseurs" are keen on having intercourse with young girls or minors. In extreme cases, some young women may even have been forced into sex work within the family group or raped for reasons of "sexual cleansing." Extreme poverty can make women turn to occasional prostitution as a form of informal payment for food or transportation.

The HIV Situation Among Sex Workers and Their Clients

Estimates put the number of people involved in commercial sex work at around half a million. The estimate is, of course, affected by the time the estimation was conducted, because of the direct relationship between poverty and prostitution. There may be more than 1,000 female sex workers infected with HIV, based on the DOH estimates in 2005, which also places the number of female sex workers as at risk group to be between 112,000 to almost 200,000 during the same year. Using the surveillance data from the Integrated HIV Behavioral and Serological Surveillance (IHBSS) of the DOH, which is being conducted yearly since 1993, the prevalence rate

of HIV among female sex workers (FSW) is between 0.06 to 0.34%. The rate has not exceeded 1% prevalence, which is within the national goal. However, it should be recognized that the frequency of sexual activity of the sex workers will impact greatly on the HIV epidemic, especially if safe sex is not practiced and if there is low knowledge of preventing HIV among the said population.

According to the National AIDS Registry, the main mode of transmission is through heterosexual intercourse--at around 90%. This also includes the transmission occurring in sexual activities between sex workers and clients, casual sex and sex with regular partners.

In the Philippines, there is a program for the prevention and control of sexually transmitted infections, including HIV, being implemented at the local government units called the Social Hygiene Clinic (SHC). In some cities, the said facility is called Reproductive Tract Infection and Reproductive Health Clinics, to eliminate stigma and discrimination against clients seeking medical care there. SHC is a specialized sexually-transmitted infection (STI) clinic that caters to entertainment workers, including commercial sex workers, where STI screening, STI case treatment and management, counselling and HIV prevention education is conducted by trained personnel. This has contributed to the control of STI among commercial sex workers and has been very crucial in implementing local policies and programs for HIV and other sexually-transmitted infections.

Sex Work and HIV

Considering the frequency of sex activities and the number of sexual partners, female sex workers are at higher risk of contracting HIV and other STI. Female sex workers engaging in unprotected sex with clients who may be infected with HIV put themselves in great danger of getting the virus. It is important for these individuals to be equipped with condom negotiation skills to costumers not wanting to use condoms. However, their inferiority status as paid sex service providers makes negotiation difficult in most cases. In addition, foreign clients coming from countries of higher HIV prevalence may also increase their vulnerability and chance of being HIV-infected.

Role of the School and the Teachers

The importance of a life skills-based education (LSBE) cannot be over-emphasized. The teaching approach that should be used in preventive education is LSBE. It should start with equipping the students with knowledge and understanding of HIV and AIDS. This will develop critical thinking skills that will enable students to face their problems and make decisions that will promote a healthy lifestyle. Since one of the major causes of getting into sex work is poverty, LSBE will equip the students with productive and entrepreneurial skills that will enable them to become self-reliant.

Preventive education should also take into consideration the characteristics of adolescents. This stage is an experimental stage when adolescents want to have a

taste of the “forbidden.” They should be taught problem-solving skills that will help them explore different alternatives to problem solutions and the probable consequences of their actions; forewarned is being forearmed.

Injecting Drug Users

Young people are vulnerable to drugs. Drug taking, especially injecting drugs, can significantly increase vulnerability to HIV and AIDS. Drugs and substance abuse education should be an important component of all educational programs for adolescents

Injecting Drug Users (IDUs)

Injecting drug users are people who use needles or syringes to inject drugs, such as heroin, morphine, cocaine or methamphetamines into their bloodstreams. IDUs are included among the population targeted for HIV prevention, treatment, care and support programs, since among all the groups, they are the most vulnerable to HIV and have the highest infection rate.[1]

The Situation Among Injecting Drug Users

IDUs are key drivers of the HIV and AIDS epidemic in Asia and the Pacific.[2] In many countries in the Asia-Pacific Region, HIV first appeared among IDUs and sex workers before seeping into the general population. In 2005, 349 cases of IDUs were found to be HIV-positive.

IDUs by the Numbers.[3]

- In Malaysia, 55% of people found to have HIV between 1998 and 2001 were IDUs;
- In Chennai, India, 64% of IDUs were HIV-positive in 2003;
- In Ho Chi Minh City, Viet Nam, about half of all sex workers who injected drugs were found to be HIV-positive in 2001;
- In the Sichuan province of China, 5% of street-based sex workers inject drugs and report low levels of condom use with customers;
- In the Kalimantan province of Indonesia, health officials estimate that of the 3,000 who are HIV-positive, 2,300 of them are IDUs;
- In Surabaya, Indonesia, nearly 70% of male IDUs who buy sex do not consistently use condoms.

HIV and IDUs

The most efficient method of transmitting HIV is to inject it directly into a person's bloodstream. Sharing contaminated injecting equipment does exactly that. It is even more high risk, as far as transmitting HIV, than unprotected sex.

When a needle or syringe is injected into a person's blood vessel, some of that person's blood remains in the needle or syringe after it is withdrawn. If that blood contains a virus, such as HIV, the needle or syringe becomes contaminated. When that contaminated needle or syringe is shared by another person, the infected blood will be injected into that person.

People share contaminated needles because they may lack access to their own injecting equipment, they may not have the money to buy new needles and syringes, or simply because they may not be aware of the risks of using such.

IDU-driven HIV epidemics often start with injecting drug users who are young, male and sexually active.[4] Some are in school when they start. Young people – from all levels of society – are prone to experimenting with new and risky behaviors. Teachers may not even realize that some of their students may have begun experimenting with drugs.

All drug users are vulnerable to HIV. All mind-altering drugs, whether injected or not, can make people more vulnerable to HIV infection. When intoxicated, people make different decisions or engage in risk behaviors than they would in a sober state. They may, for example become less likely to insist on condom use.

IDUs live among us. Drug users don't live in isolation. In the early stages of the epidemic, HIV may infect mainly populations of drug users and other key populations vulnerable to HIV, but it doesn't remain contained there. IDUs may have wives, husbands, children, girlfriends and boyfriends, or casual sexual relationships with multiple partners who may not be using drugs. Through sexual relationships, IDUs may pass on the HIV virus to others. They may also pass it on through parent-to-child transmission.

It is a common misconception that injecting drugs dampens sexual desire or ability, and so IDUs are not very sexually active. The fact is, surveys in Asia and the Pacific show that IDUs are more sexually active than many other population groups.[4] Much of their sex is commercial sex – sex that is bought or sold.

Sex work and drug use: the deadliest mix. While the majority of sex workers are not IDUs, a very high percentage of IDUs sell or buy sex.[5] Since sex workers have more partners than most other people, the most dangerous combination of risk behaviors is injecting drug use and sex work. An injecting drug user selling sex can be lethal.

The population of female sex workers is large compared to the population of female IDUs. Nonetheless, the percentage of female IDUs who sell sex is very high. IDUs who are men who have sex with men also have been found to sell sex.

IDUs also buy sex. Surveys around Asia and the Pacific show that in many countries, more often than not, this sex is unprotected.[6] This creates more opportunities and pathways for the virus to spread. Condoms are used even less often with their partners who are not sex workers.

What Needs to Be Done

Drug use or addiction is often viewed by many in society as a law-enforcement issue; others say it is primarily a health problem. Drug use and addiction can be treated. As a consequence of viewing drug use as a law-enforcement issue, drug users have relatively high rates of imprisonment. This only worsens the HIV epidemic.

HIV spreads rapidly in settings where people are confined in close quarters for long periods of time, like in prisons, jails, juvenile corrections facilities, reform schools and remand homes. Most people confined in such places are eventually released. If they have become infected while confined, they may infect others when they return to their communities. Prisoners may also receive visits from wives, husbands, girlfriends or boyfriends, during which time they may spread the virus to those who are not incarcerated. Preventing the spread of HIV in prison settings, therefore, helps protect the general population.

In prison or confinement settings, MSM behavior is common and often unprotected. Violence and forced sex are also frequent occurrences. Furthermore, although it is against the rules, drugs and injecting equipment are available in many prisons. Since injecting equipment can be difficult to get inside prisons, needles and syringes are often shared. These are usually contaminated with HIV and other infections. This makes prisons a favorable place for HIV transmission.

For the sake of public health and stopping the spread of HIV, drug users should be treated, not punished. The following interventions can be provided to them:

- Drug dependence treatment, including substitution drug treatment-- People who use drugs regularly may have developed a physical or psychological dependence on the drugs; this is a medical issue and problem that can be addressed with medical treatment and counselling;

- Outreach providing IDUs with information on risk reduction, HIV and AIDS education, and referral to services;

- Access to clean needles and syringes, bleaching equipment, and condoms;

- Voluntary and confidential counselling and testing for HIV;

- Treatment of sexually transmitted infections of IDUs;

- Anti-retroviral therapy for those in need;

- Interventions for key populations vulnerable to HIV, such as young people, prisoners and sex workers who inject drugs.

Education and drug use. Drug users also need education. They have the right to know how to protect themselves from HIV, as well as their sexual partners and unborn children.

Since many IDU-driven HIV epidemics start with IDUs who are young, school is an important place to address this problem. Schools can respond to students and assist them in getting the support and services they need to deal with drug problems. Research shows that a safe and supportive school environment increases protective factors and reduces the risk of drug problems from developing. Education helps build resilience.

Teachers and school staff can play a critical role in intervening early with students to prevent the start or escalation of drug-use problems and the risks of HIV. Teachers need to be trained to assume that role.

Abstinence from drug use is clearly the best way to prevent HIV transmission and should therefore be encouraged as much as possible. However, promoting abstinence and penalizing drug use are unlikely to curb all use of injecting drugs.

Young people need honest and accurate information about drugs, the dangers of injecting drugs and substance abuse, the risks of unprotected sex and the facts about HIV and AIDS.

Scare tactics don't always work. They can make drug use seem attractive as a way to rebel against adults. Good quality education leads to people thinking through their choices.

Drug education programs deal with the areas of peer pressure, addiction, health effects and social implications of drug use, legal issues, and outside services and agencies that can assist in any critical situation.

While peer pressure can lead to drug use, peer network can also be useful in relaying help and information to drug users, and in alerting teachers as to who is vulnerable or at risk.

What schools and teachers can do

- Provide HIV preventive education;
- Provide life skills-based drug education programs;
- Raise the issue of drugs and give honest and accurate information about them;
- Provide counselling for students;
- Link the school to outside support services;
- Develop peer network to reach those at risk or already using drugs, and provide them with information and help;
- Develop school policy and procedures for dealing with students with drug dependency and related problems;
- Train teachers on how to recognize and deal with drug use among students;
- Involve parents and the community, where appropriate.

Migrant Workers and their Spouses

This Focus Sheet explores the growing number of migrant workers who work overseas, specifically the Overseas Filipino Workers (OFW)—their vulnerability to HIV and AIDS brought about by having unprotected sex either with sex workers or other individuals who are HIV-positive.

The Filipino Migrant Workers

The migration of Filipino workers to other countries has long been documented, with the "first wave" of migrants leaving the country in the 1900s up to 1946. These Filipino migrants worked in plantations in Hawaii and Guam, and by 1934, more than 120,000 plantation workers were under contract.

During the 1970s, migration for overseas labor was institutionalized by the Philippine government as a stop-gap measure against the worsening economic crisis. Nearly a century after the "first wave" of migrants, the Philippines has become the second leading exporter of human labor, sending large numbers of workers to Saudi Arabia, Hong Kong, United Arab Emirates (UAE) and Japan, among others.

Overseas Filipino Workers have been hailed as the country's "new heroes", remitting billions of dollars annually and helping to prop up the national economy. Unfortunately, like all other "heroes," OFWs face arduous tasks and confront difficult situations in their host countries, sometimes putting their lives and welfare at risk.

The Situation Among Migrant Workers

Currently, there are about 8 million Filipinos overseas-- approximately 10 percent of the total Philippine population. Among them are 200,000 seafarers at sea at any given time. Data from the Commission on Filipinos Overseas show that of these overseas Filipinos,

40% are contract workers
35% are emigrants or permanent residents
25% are undocumented

Today, overseas work is no longer viewed as temporary, but is considered a permanent option for work.

The statistics from the National HIV and AIDS Registry of the Department of Health indicates that since 1998, the number of infected migrant workers has been steadily rising. Infections have also been recorded with female spouses of OFW, most of whom were seafarers. As of July 2007, 35% of the total registered cases were OFWs. The high percentage of OFWs in the National HIV and AIDS Registry may be attributed to

the conduct of mandatory testing among OFWs, whether as a pre-departure or on-site requirement for overseas employment

HIV and Migrant Workers

Studies by the Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia) show that migrant workers today are among the most vulnerable when it comes to abuse, exploitation, discrimination, ill health and disease, including HIV and AIDS.

HIV and AIDS are a threat to the health and welfare of OFWs. Due to the conditions inherent in overseas employment, as well as factors present even before they leave the Philippines, OFWs are vulnerable to HIV and AIDS and other health problems.

There are predisposing factors that set the stage for HIV and AIDS infection among migrant workers:

1. ***Low knowledge about HIV and AIDS.*** Although awareness of HIV and AIDS among Filipinos is generally high, the knowledge level about the basic facts on HIV and AIDS is quite low. RA 8504 provides that all OFWs and diplomatic, military, trade, and labor officials and personnel to be assigned overseas shall undergo or attend a seminar on the cause, prevention and consequences of HIV and AIDS before certification for overseas assignment. The low level of knowledge of migrant workers in spite of the law may be attributed to the large number of workers who are illegally recruited for work abroad.

2. ***Knowledge that does not translate into behavior change***. Migrant workers may have adequate knowledge on HIV and AIDS but this does not result in behavior change, which reduces the risk of HIV transmission.

3. ***Low knowledge of migration realities.*** First time OFWs are not well-prepared for the difficulties and vulnerabilities brought about by their overseas work.

4. ***Low condom use/misconception about condoms***. Condom use among Filipinos is generally low. The Young Adult Fertility study of Raymundo showed that only 47% among 15-24 year-olds use condom during a paid sex experience.

5. ***Attitude of Invincibility***. The misconceptions that HIV and AIDS affect only people, such as gays, prostitutes, and those who are promiscuous, gives the migrant worker a false feeling of being protected from the infection.

6. ***Changing demographic profile***. Many OFWs are in their reproductive age, and may have been sexually active even before they started to work abroad.

7. ***Indebtedness during the recruitment process***. Many OFWs come from poor families and have to borrow money to pay the placement fees. To pay off this

indebtedness, they work overtime or engage in part-time sex work to earn extra income.

8. ***Increasing feminization of migration***. Women are more at risk of HIV and AIDS due to both physiological and socio-cultural factors. The Philippine Overseas and Employment Administration (POEA) data show that 70% of the total number of newly-hired workers are women.

9. ***Absence of HIV post-test counselling***. Republic Act 8504 mandating pre- and post-test counselling is often not provided by testing centers because of the large numbers of OFWs.

10. ***Homesickness, loneliness and social isolation***. Being away from home intensifies the need for belongingness, warmth and comfort, contributing to the factors that enable the OFWs to establish sexual and social relationships.

11. ***Absence of social shackles***. Being away from family, friends and community affords the OFWs with a certain degree of personal space and freedom, which could lead to many possibilities, including sexual activities.

12. ***Poor health-seeking behavior***. Many OFWs do not tell their employers that they are sick because they are afraid that they might be fired or they would rather remit the money to their families than to spend it on their own health.

Role of School and Teachers

Migrant workers include young people, many of whom are fresh from school. The schools have a role of developing their character and shaping their values and attitudes to help them cope with the strangeness of working in a foreign land, and of the homesickness and loneliness at being away from their loved ones. Attitudes and values cannot be developed in a state of ignorance. The primary responsibility of the school is to teach the facts about HIV and AIDS so that when the students graduate to the field of work, they will know how to protect themselves.

Schools should also teach the families of the migrant workers, which include children and young people of school age, skills to cope with having a family member who is away and of maintaining a wholesome family life that will give the absent family member the emotional support that s/he needs.

Schools should also teach the children of migrant workers coping skills to deal with HIV, if the latter is found to be HIV-positive. The family should be supportive of the migrant worker and should provide the understanding and love that are needed, especially at this stage.

Women and Girls

This sheet explores the vulnerability of women and girls to HIV infection, the Philippine situationer as far as this group is concerned, and what schools and teachers can do with the issue.

Gender Inequality is the Root of the Problem

Gender is not simply one's sex – whether one is male or female. Gender is a concept of what it means to be a man or woman in a given society. It defines the roles, responsibilities, capabilities and behaviors expected of men and women in society.

UNESCO defines gender inequality as women (and girls) and men (and boys) having unequal conditions for realizing their full human rights and for contributing to, and benefiting from, economic, social, cultural and political development.[1]

It's no secret that relationships between women and men tend to be unequal. Men are valued more highly and hold positions of power over women and girls in most societies. Gender inequality creates several conditions that make women and girls more vulnerable to HIV.

The Situation of Women and Girls and HIV

The face of HIV and AIDS pandemic is changing. It is a face that is becoming increasingly female. When the HIV and AIDS epidemic first appeared during the 1980s, the HIV-positive people were overwhelmingly male. This is no longer so. Globally, 18.7 million men and boys and 17 million women and girls are living with HIV and AIDS.[2]

In the Asia-Pacific region, 5.2 million men and boys, and 2 million women and girls are HIV-positive, but the trends show that this gap is narrowing because the number of women being infected is rising.[3]

Gender by the numbers.

1. A review of 113 studies from five continents found that teaching HIV and AIDS education in schools was effective in reducing early sexual activity and high-risk behavior.[4]

2. Worldwide, 115 million children, the vast majority of which are girls[5], are not attending primary-school.

3. Surveys in 11 countries showed that women with some schooling were five times more likely than uneducated women to have used a condom the last time they had sex.[6]

4. A study of eight sub-Saharan African countries showed that women with eight or more years of schooling were up to 87% less likely to have sex before the age of 18, compared to women with no schooling.[7]

5. In Southeast Asia, only 13% of young women were able to correctly identify two prevention methods and three common misconceptions about HIV and AIDS.[8]

6. In Vietnam and Cambodia, 30 percent of young women believed that HIV could be contracted through supernatural means. Nearly 35 percent believed a healthy-looking person could not be living with HIV.[9]

The Vulnerability of Women and Girls

UNAIDS defines vulnerability as the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment, which are beyond the control of a person or particular social group. Women and girls, particularly from poor communities, are among those with a pronounced vulnerability to HIV infection as a result of unequal gender relations.[10]

A number of factors make women and girls more vulnerable to HIV than men and boys biological, social, cultural and economic.

Biologically, research shows that females are more vulnerable than males to HIV and other STIs during sexual intercourse with an infected partner. Young girls are even more vulnerable because their reproductive tracts are still immature and considerably more sensitive to being torn or damaged.[11]

Beyond biology, the social, cultural and economic factors that make women and girls more vulnerable all have a common cause.

Economic vulnerability. In societies, women and girls live in circumstances that make them economically dependent upon men. This is not because they are less capable than men. Many households are headed by strong, independent women. Women become dependent when they are denied access to and control of resources and the right to make decisions for themselves and their families. They are sometimes denied the right to work, or are paid less than men for doing the same work. In some countries, if their husbands or male partners die, they are not legally entitled to the family's land or inheritance because they are female. This explains why women and girls make up a disproportionate share of the poor.

A woman or girl who is economically dependent upon her husband or male partner often has little power to persuade him to be faithful, check his HIV status or use a condom for fear she will be cast out and left destitute. Poverty or economic necessity can force some women and girls into sex work, selling their bodies for money, food or

other basic necessities for themselves or their families. Poor women and girls are more vulnerable to HIV.

Lack of education. Girls are often denied education in many societies. As they are not expected to be bread winners and are often less valued, families see no point in sending them to school.[12] The rate of HIV infection is higher among out-of-school girls than those who are attending school. Lack of education makes women and girls more vulnerable to HIV.

Double standard of sexuality. In most societies, young men are encouraged or expected to have multiple sex partners. Young women are expected to abstain or be faithful. For young women, knowledge about sexuality is equated with promiscuity. This makes it inappropriate and possibly dangerous for women to obtain the information and services they need in order to protect themselves from HIV infection. The same holds true for other sexually-transmitted infections and pregnancy. Double standards make women and girls more vulnerable to HIV.

Violence against women. According to the World Health Organization, violence against women and girls is a global health crisis; it exists in all societies. It takes place in the home and in public places, such as the workplace. It occurs in schools to girl students by male pupils and even in some instances, male teachers. Clearly, the school should be a place that is free from violence against women and girls. At the same time, it should play a role in combating it.

Violence and the threat of violence against women are often a cause of HIV infections. They make it difficult or impossible for women and girls to abstain from sex, to get their partners to be faithful or to use a condom. When women and girls have control over their own bodies, they are less likely to get HIV.

Violence can also be a consequence of a woman or girl learning and revealing to her partner that she is HIV-positive. Fear of violence also prevents women and girls from seeking prevention, care, treatment and support services. Violence and the threat of violence make women and girls more vulnerable to HIV.

Women are more stigmatized than men by HIV and AIDS. Stigma and discrimination are among the worst consequences of HIV and AIDS. Women and girls suffer from this more than men because of cultural double standard regarding sexuality. If a man becomes infected with HIV, people say he was foolish or unlucky. However, if a woman or girl is HIV-positive, it is often assumed that she has been promiscuous and therefore viewed as a bad person.

What Needs To Be Done

There is growing evidence that girls who stay in school are less likely to be infected by HIV. When girls stay in school through the secondary level, the chances of them becoming infected with HIV as compared to their out-of-school counterparts are

significantly lower. With each year of education, young women become more knowledgeable, independent and better equipped to make good decisions about their sexual lives. Greater knowledge and education also lead to greater income opportunities, which help to keep women and girls out of the trap of poverty that can lead to HIV and AIDS.

UNESCO believes that HIV preventive education helps school children to acquire the knowledge, skills and attitudes needed to help them adopt healthy lifestyles and practices, which will decrease their vulnerability to HIV infection.

Specifically, the following actions can help protect women and girls from HIV:

1 Promote and protect the human rights of women and girls.

2 Advocate for gender equality.

3 Promote zero tolerance of all forms of violence against women and girls.

4 Ensure that women and girls have access to knowledge, tools and services for HIV prevention and reproductive health so that they can make informed choices about their sexual and reproductive health.

5 Ensure equal and universal access to HIV and AIDS care, treatment and support programs.

6 Don't stigmatize women and girls who are HIV-positive. Support their organizations and networks.

7 Support Education for All.

What schools and teachers can do

1 Give teachers the training, teaching and learning materials and other support they need to teach HIV preventive education effectively in school.

2 Create safe and supportive learning environments for students, especially girls, by instituting zero tolerance for sexual exploitation and violence. Implement clear guidelines for dealing with such allegations.

3 Provide scholarships/grants to subsidize school fees to keep girls in school.

4 Involve parents and the community so that they are sensitized to, and support, HIV preventive education.

5 Provide life skills-based education as this supports the participation of all students across the school environment.

6 Ensure that teachers avoid gender stereotypes, promote girls' leadership and self-esteem, and actively promote gender equality in the school setting at all times.

7 Include age-appropriate information on sexual and reproductive health and HIV preventive education.

8 Connect with out-of-school services for counselling and reproductive health.

Orphans and Vulnerable Children

This sheet is about another group vulnerable to HIV and AIDS—orphans and other children—who are affected by HIV in different ways, and how they can be helped by education.

Children can be Affected by HIV

A *child*, as defined by the Convention on the Rights of the Child, is any individual under 18 years of age.

The lives of many children who may not have HIV themselves are affected when family members have HIV and AIDS. Families face increased poverty and stress when adults are too sick to continue with paid employment, to farm their land, or to attend to their business. Mothers who are ill find it more difficult to care for young children, and young children themselves may end up caring for younger siblings or sick parents.

In addition to children who are living with HIV-infected parents who are sick or dying, there are many who have been orphaned by AIDS.

The Situation on Orphans and Other Vulnerable Children

There are half a million children orphaned by AIDS in the Asia-Pacific region.[1] A child orphaned by AIDS is a child who has lost one or more parents to the disease. In the next 10 years, the number could be three times higher, unless nations scale up their HIV and AIDS programs to effective levels.[2] Of the eight million people living with HIV in the Asia-Pacific Region, half a million are children.[3] This number will also rise if our local governments maintain the current level and reach of their prevention programs. Prevention programs need to be scaled up to national levels. These programs must also have components designed specifically for children. Children require different prevention, treatment, care and support approaches. All too often, programs ignore children, leading UNICEF to say, "Children are the missing face of AIDS.''[4]

A child may be HIV negative and his/her parents may still be alive, yet s/he can still be affected if s/he has a parent, family member or caregiver, neighbor or friend who is HIV-positive. The psychological, social, behavioral and economic effects on children living in these circumstances can be wide-ranging and severe.

Filipino parents who are HIV-positive are usually reluctant to tell their children about their status because they want to protect their children from HIV-related stigma and discrimination. Even infected children are not told about HIV. As long as society continues to discriminate against people with HIV and AIDS, parents will continue to keep the truth about HIV and AIDS from their children (UNICEF).

Orphans and vulnerable children by the numbers [5]

- There are about half a million children orphaned by AIDS in the Asia-Pacific Region.

- More than 11,000 children were newly infected with HIV in 2005 in the Asia-Pacific Region.

- About 8,500 children in the Region are in immediate need of anti-retroviral therapy.

- Pediatric treatment for HIV and AIDS can boost annual survival rates by anywhere from 50% to 95%.

Children Vulnerable to HIV

HIV and AIDS can affect infants and young children in one of three ways. They may be--

- Infected with HIV
- Affected by HIV
- Vulnerable to HIV

Children can be infected with HIV in different ways.

- Pregnancy, birth or breastfeeding, if the mother is infected with the virus;

- Receiving infected blood transfusion;

- Treatment with unsterilized medical equipment, such as needles, syringes or surgical instruments;

- Sexual abuse involving penetrative vaginal or anal sex.

Children who are vulnerable to HIV. Children without parents or who are not living with their parents because of war or economic reasons, are more vulnerable to sexual abuse and exploitation. Refugees and displaced children are particularly vulnerable. Children living in difficult circumstances and those involved in risk-taking behaviors are more vulnerable to HIV. Children living with a parent, sibling or caregiver who has HIV may become depressed or suffer from other emotional disturbances because of the burden of caring for a relative who is ill, or because of stigma and discrimination from the community.

Children living in abusive situations are also vulnerable. They may be infected through sexual abuse. Street children are extremely vulnerable because they are out-of-school, prone to be abused and usually lack adult guardian or a caregiver.

Children living in the aforementioned circumstances suffer from emotional pain. They may take drugs or alcohol to deal with their pain. With their judgment impaired, they are more vulnerable to rape or to engage in unsafe sex. They are therefore at greater risk of contracting HIV.

Poverty enhances vulnerability. The need to work to support one's family or the inability to pay school fees keeps children from getting an education. Studies show that children who stay in school are less likely to be infected with HIV.[6] Some researchers believe that the most effective way to stop the spread of the epidemic among children is to allot a major share of resources and interventions for them.

Children who are differently-abled or mentally challenged and from ethnic groups are also vulnerable as they are sometimes refused the right to receive education and access to health care systems.

Children suffering from the trauma of parental loss or abuse may become emotionally withdrawn, despondent, fearful of further loss or abandonment, or angry at the injustice of their situation. These feelings often lead to destructive and high-risk behaviors. Difficulty concentrating in class, social isolation and violent outbursts are common manifestations of the grief and anxiety these children are experiencing. Adolescence is a particularly turbulent time, hence the loss of parental guidance, combined with a sense of hopelessness or depression, can lead young people to engage in reckless and often self-destructive behavior, such as substance abuse or unsafe sex.

The loss of material support that a parent provides exposes children to increased health risks. Malnutrition in the early stages of a child's life can cause irreversible stunting and cognitive damage, impeding a child's healthy physical and intellectual development.

Older children may find themselves having to carry the burden of providing for an ailing parent or dependent siblings. Working long hours to support themselves and their families may prevent them from coping with the demands of schooling. Poor classroom performance, sporadic attendance and increased drop-out rates are symptomatic of the material deprivation that many orphans and vulnerable children (OVC) experience.

Role of Schools and Teachers

Schools and teachers need to be aware of the problem. It is especially important for teachers to be aware of the impact of HIV and AIDS on children. Teachers can play a valuable and crucial role in recognizing the needs of children who are affected by HIV at home and providing them with understanding and support at school. They can help break the cycle of vulnerability that puts these children at risk of contracting HIV in the future.

Children need care and support. With so many myths and misconceptions surrounding HIV and AIDS, children may be ostracized, rejected or isolated at a time when they need care and support more than ever. People, and especially their peers, may believe that they are at risk of being infected by these children. Some may believe that these children or their parents have been infected because they are "bad" people.

Schools and teachers have a vital and tremendous role to play in reducing stigma and discrimination against orphans and vulnerable children. They can influence the ideas, attitudes and behaviors of children in their care. More than that, teachers are role models and respected members of the community, hence they can likewise influence the ideas, attitudes and behavior of parents and other adults.

No one can defeat stigma and discrimination alone. It requires partnership and collaborative efforts among schools, teachers, parents, religious and spiritual leaders, business people and community leaders. As a valued community institution, schools can be a nexus around which these collaborative efforts are organized.

Schools and teachers can do a lot for orphans and vulnerable children.

- Eliminate school fees so that orphans and vulnerable children can stay in school.

- Use whatever funds they can find to support poor children, orphans and vulnerable children's ability to stay in school by providing meals, books and other material needs.

- Discuss openly stigma and discrimination related to HIV and AIDS so that other children will understand the issue.

- Do not tolerate stigma or discrimination in school.

- Teach life skills-based education so that children will understand HIV and AIDS, how they can prevent being infected, and how they can make good choices about their lives.

- Link the school with outside services that provide prevention, treatment, care and support services for children vulnerable to HIV or living with or affected by HIV and AIDS.

- Link the school with poverty alleviation programs and services to keep poor children in school, as poverty heightens vulnerability to HIV and AIDS.

- Invite people living with HIV and AIDS to meet with and talk to students so that their fears are dispelled.

- Reach out to parents and other community members to support the school's efforts.

- Train teachers to recognize and deal with children who may be experiencing emotional or other problems because of HIV and AIDS or the effects of HIV and AIDS on their families.

- Make sure school counsellors are trained to deal with these issues.

- Organize peer network for outreach to affected and vulnerable children and children engaged in risky behaviors.

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GLOSSARY

In the context of HIV and AIDS you may come across the following terms and acronyms. This list is not exhaustive, which means that you may not find all the words and acronyms relevant to HIV and AIDS here. Most of these terms and definitions are drawn from the "UNESCO Guidelines on Language and Content in HIV- and AIDS-Related Materials."[1]

Advocacy – Influencing outcomes - including public policy and resource allocation decisions within political, economic, and social systems and institutions that directly affect people's lives

Affected by HIV and AIDS – HIV and AIDS have an impact on the lives of those who are not necessarily infected themselves, but who have friends or family members who are HIV-positive. They may have to deal with similar negative consequences, for example, stigma and discrimination, exclusion from social services, etc.

AIDS (Acquired Immune-Deficiency Syndrome) – AIDS is a range of conditions – a syndrome – that occurs when a person's immune system is seriously weakened by HIV infection. Someone who has HIV infection has antibodies to the virus, but may not have developed any of the illnesses that constitute AIDS.

Antibodies –Proteins that the body makes to attack foreign organisms and toxins (often called antigens) that circulate in the blood; antibodies are usually effective in removing antigens from the body. Following an infection by some organisms, such as HIV however, the antibodies do not get rid of the antigen. They only mark its presence. When found in the blood, these 'marker' antibodies indicate that HIV infection has occurred.

ART (Anti-retroviral Therapy) – A treatment that uses anti-retroviral medicines to suppress viral replication and improve symptoms; effective anti-retroviral therapy requires the simultaneous use of three or four anti-retroviral medicines, otherwise known as highly active anti-retroviral therapy.

ARV (Anti-retroviral drugs or medicines) – Medication used to fight infection by retroviruses, such as HIV infection; these medicines reduce a person's viral load, thus helping to maintain the health of the patient. However, anti-retroviral drugs cannot eradicate HIV entirely from the body. They work by suppressing the activity or replication of retroviruses, such as HIV.

Bacteria – Microbes composed of single cells that reproduce by division; bacteria are responsible for a large number of diseases. Bacteria can live independently, in contrast with viruses, which can only survive within the living cells that they infect.

Bisexual – A person who is sexually attracted to both males and females

Candidiasis--Commonly called yeast infection or thrush, it encompasses infections that range from superficial, such as oral thrush and vaginitis, to systemic and potentially life-threatening diseases, such as cancer and AIDS.

CBO – Community-based organization

Cell – All living organisms are composed of one or more cells, which are autonomous self-replicating units.

Child – Any human being under the age of 18, according to the Convention on the Rights of the Child

Clinical trial - A study that tries to improve current treatment or find new treatments for diseases; drugs are tested on people under strictly controlled conditions.

Concentrated epidemic – An epidemic is considered concentrated when less than one percent of the general population, but more than five percent of any particular group, is infected.

Condom – A sheath unrolled over the erect peni; male condoms made from latex or polyurethane prevent conception and transmission of HIV and other STIs; female condoms are available, as well. They are a pouch made of polyurethane inserted into the vagina before intercourse and held in place by a loose inner ring and fixed outer ring. The female condom prevents conception and provides protection from STIs. Unlike the male condom, it does not depend on the man's erection.

Diagnosis – The determination of the existence of a disease or condition

Discrimination – A legal term in which a person or persons are denied their rights or treated unfairly because they are different

Empowerment – Attempts to enable the target population to take more control over their daily lives; the term is often used in connection with marginalized groups, such as women, homosexuals, or sex workers.

Epidemic – The rapid spread of a disease through a demographic segment of the human population, such as everyone in a given geographic area (e.g., a military base or similar population unit) or everyone of a certain age or sex (such as the children or women of a region); epidemic diseases can be spread from person to person or from a contaminated source, such as food or water.

Epidemiology – The branch of medical science that deals with the study of the incidence, distribution and control of a disease in a population

Gay and lesbian – Common terms for people who are sexually attracted to others of the same sex; 'gay' can be applied to both males and females, while the term 'lesbian' is reserved for females.

Generalized epidemic – An epidemic is considered generalized when more than one percent of the total population is infected.

Gender—What it means to be a man or woman in a given society

Heterosexual – A person sexually attracted to persons of the opposite sex

High-risk behavior –Activities that increase a person's risk of transmitting or becoming infected with HIV; examples of high-risk behaviors include unprotected vaginal or anal intercourse (without a condom) or using contaminated injection needles or syringes; often referred to as an unsafe activity.

HIV (Human Immunodeficiency Virus) – The retrovirus that causes AIDS in human beings

Homosexual – A person sexually attracted to persons of the same sex

Immune system - The body's defense system that prevents and fights off infections

Incubation period – The time interval between HIV infection and the onset of AIDS-defining illnesses

IDU – Injecting drug user

Life skills - A large group of psycho-social and interpersonal skills, which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life

Maternal antibodies – In an infant, these are antibodies that have been passively acquired from the mother in utero. Maternal antibodies to HIV continue to circulate in the infant's blood up to the age of 15-18 months, making it difficult to determine whether the infant is HIV-positive or not.

Micro-organism - Any organism that can only be seen through a microscope, e.g., protozoa, bacteria, fungi, and viruses

MSM – Males who have sex with males

Monogamy – Having sexual relations with only one partner

Opportunistic infection – Infection caused by organisms that do not normally cause disease in people whose immune systems are intact; some of the most common

opportunistic infections indicating that someone has AIDS are PCP (pneumocystic carinii pneumonia), oesophageal candidiasis and toxoplasmosis.

Orphans – Children whose parents have died; with respect to AIDS, orphans are usually defined as children under the age of fifteen who have lost one or both parents due to AIDS.

Pandemic - A disease prevalent throughout an entire country, continent or the whole world

Pathogen – An agent such as a virus or bacterium that causes disease

Peer education – A teaching-learning methodology that can develop, strengthen, and empower young people to take an active role in influencing policies and programs for themselves

Plasma – The fluid portion of the blood

PLHIV – People living with HIV

PTCT – Parent-to-child transmission (of HIV)

PPTCT – Prevention of parent-to-child transmission

Prevalence rate – A measure of the proportion of people in a population affected with a particular disease at a given time; prevalence and incidence should not be confused: Incidence applies only to the number of new cases, while the term prevalence applies to all cases, old and new.

Rape – Sexual intercourse with an individual without his or her consent

Safer sex – Sexual activities that are not likely to transmit HIV; safer sex involves sexual expressions in which partners make sure that blood, semen, vaginal mucus and menstrual blood from one person do not come into contact with the other person's bloodstream or mucous membranes (vulva, vagina, rectum, mouth and/or nose). This can be prevented by the use of male or female condoms.

Serological testing – Testing of a sample of blood serum

Seronegative – Testing negative for HIV antibodies

Seropositive – Testing positive for HIV antibodies

Sexual assault – Any undesired physical contact of a sexual nature perpetrated against another person; while associated with rape, sexual assault is broader and the specifics may vary according to social, political or legal definition.[2]

Sex worker - A sex worker has sex with other persons with a conscious motive of acquiring money, goods, or favors, in order to make a fulltime or part-time living for her/himself or for others.

Sexually-Transmitted Infections (STIs) – Infections that can be transmitted through sexual intercourse or genital contact; HIV is essentially a sexually-transmitted infection.

Stigma – Prejudice against people because they are different

Symptom –A medical sign indicating the nature of the disease

Vaccine - A substance that contains antigenic components, either weakened, dead, or synthetic, from an infectious organism, which is used to produce active immunity against that organism

VCCT – Voluntary confidential counselling and testing

Viral Load: The quantity of the virus in the bloodstream; the viral load of HIV is measured by sensitive tests that are unavailable in many parts of the world.

Virus – Infectious agent responsible for numerous diseases in all living beings; they are extremely small particles and, in contrast to bacteria, can only survive and multiply within a living cell at the expense of that cell.

Vulnerable Children – Children who, because of their circumstances or situation, are at risk of being HIV-positive, or children who are affected by the epidemic because a parent, sibling or caregiver is HIV-positive; children may be vulnerable because of their involvement with drugs or sexual behaviors. They may be vulnerable if they have no caregiver, like street children.

WSW – Women who have sex with women

Young People – People between the ages of 15 to 24, as defined by many UN agencies

APPENDICES

Appendix A

Republic Act No. 8504

"Philippine AIDS Prevention and Control Act of 1998"

AN ACT PROMULGATING POLICIES AND PRESCRIBING MEASURES FOR THE PREVENTION AND CONTROL OF HIV AND AIDS IN THE PHILIPPINES, INSTITUTING A NATIONWIDE HIV AND AIDS INFORMATION AND EDUCATIONAL PROGRAM, ESTABLISHING A COMPREHENSIVE HIV AND AIDS MONITORING SYSTEM, STRENGTHENING THE PHILIPPINE NATIONAL AIDS COUNCIL AND FOR OTHER PURPOSES.

- Art. 1 Education and Information

  The purpose of which is provision of timely, accurate, adequate, appropriate and relevant HIV education and information so that persons and communities shall think and act in ways that protect themselves from HIV infection, minimize the risk of HIV transmission and decrease the socio-economic impact of HIV/AIDS. HIV/AIDS education and information shall consist of knowledge, skills and attitude, and competencies accessible and available to all Filipinos.

  Sec 4. HIV/AIDS Education in Schools

  DepEd, CHED, TESDA shall integrate HIV instruction on the causes, modes of transmission and ways of preventing HIV/AIDS and other sexually-transmitted diseases in subjects taught in public and private schools at intermediate, secondary and tertiary levels.

  HIV/AIDS education shall be integrated into but not limited to Science and Health, *Edukasyong Pantahanan at Pangkabuhayan* (EPP), *Sibika at Kultura*, Good Manners and Right Conduct (GMRC), and *Filipino* at the elementary level; in Science and Technology, Social Studies, Physical Education, Health and Music (PEHM) and Values Education at the secondary and tertiary levels.

  All teachers shall be required to undergo training in HIV.

- Art. II Safe Practices & Procedures

Donated blood, tissue and other organs should be tested for HIV. Universal precautions should be practiced for surgical, dental, embalming, tattooing, etc.

- Art. III Testing, Screening & Counseling

Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the

country, or the right to travel, the provision of medical service or any other kind of service of the continued enjoyment of said undertakings shall be deemed unlawful.

- Art. IV Health Support & Services

Provision of basic health and social services for individuals with HIV shall be assured. PLWHA shall be afforded basic health services in all government hospitals.

LGU shall provide community-based HIV/AIDS prevention and care services. Training for livelihood, self-help cooperative programs shall be made accessible and available to all persons with HIV/AIDS. The DOH, in coordination and in cooperation with concerned government agencies and non-government organizations shall pursue the prevention and control of sexually-transmitted diseases to help contain the spread of HIV infection.

DOH and PhilHealth and other public and private insurance agencies shall implement an insurance coverage for PLWHA.

- Art. V Monitoring

DOH shall establish a surveillance program to determine and monitor the progression of HIV/AIDS in the Philippines, for the purpose of evaluating adequacy and efficacy of the countermeasures being employed.

- Art. VI Confidentiality

All health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of any medical record, file, data, or test results are directed to strictly observe confidentiality in the handling of all medical information, particularly the identity and status of persons with HIV.

- Art. VII Discriminatory Acts & Policies

PLWHA cannot be denied access to--
- Employment and livelihood
- Admission in schools
- Travel & habitation
- Appointive office
- Credit & Insurance
- Health Care
- Decent burial service

- Art. VIII Philippine National AIDS Council

PNAC shall be the central advisory, planning and policy-making body on the prevention and control of HIV/AIDS in the Philippines.

Declaration of Policies

- Promote public awareness
- Extend full protection to suspected or infected HIV/AIDS persons
- Promote safety and universal protection in practices or procedures
- Address conditions that aggravate spread of HIV infection
- Recognize the role of affected individuals in propagating messages about HIV

Appendix B

Republic of the Philippines
DEPARTMENT OF EDUCATION CULTURE AND SPORTS
Meralco Avenue, Pasig, Metro Manila

Office of the Secretary

November 25, 1996

DECS MEMORANDUM
No. 445 s. 1996

IMPLEMENTING THE SCHOOL-BASED AIDS EDUCATION PROJECT IN ALL SCHOOLS NATIONWIDE

To: Bureau Directors
Regional Directors
Directors of Services/Centers and Heads of Units
Schools Superintendents
Heads of Private and Elementary and Secondary Schools
Vocational School Superintendents/Administrators

1. The Acquired Immune Deficiency Syndrome (AIDS) has increasingly become a public health problem in the Philippines. As of June 1996, the Department of Health has confirmed 779 HIV-positive cases. However, it is estimated that there are currently about 35,000 HIV-infected individuals in the country, and this number will increase to over 90,000 by the year 2000. The epidemiology of the diseases shows that NOW is an opportune time to make a positive impact in controlling the spread of the disease. Because there is still no cure for AIDS, and any universal preventive vaccine is not yet available, the only viable tool to stop the rapid spread of HIV/AIDS is EDUCATION.

2. In response to the problem, the Department of Education, Culture and Sports shall implement the School-Based AIDS Education Project, which aims to develop matured and responsible studentry imbued with desirable health values, which can assist them in making rational decisions that can lead to a satisfying, productive and quality life. The Project has five components, namely: (a) Information, Education and Communication (IEC); (b) Co-Curricular and Ancillary Services; (c) Teacher/Staff Development; (d) Community Outreach; and (e) Research, Monitoring and Evaluation. Enclosed is the Project Document for ready reference and as a guide for its implementation.

3. Regional directors and school administrators are enjoined to support the effective implementation of the Project, specifically in its IEC and Staff Development components. The Regional and elementary and Secondary divisions, and the School Health and Nutrition Units/Sections shall take the

lead in monitoring the Project, in close coordination with the members of the regional and division working committees on Health and Nutrition. School Health and Nutrition personnel, and elementary and secondary division personnel shall intensify advocacy activities on the prevention of HIV/AIDS and in the development of healthy behavior among the students.

4. Widest dissemination of this Memorandum is desired.

(Sgd,) **RICARDO T. GLORIA**
Secretary

Incl.
As stated

Reference:
N o n e

Allotment: 1-2-3-4—(m>o> 1-87)

To be indicated in the Perpetual Index
under the following subjects:

HEALTH EDUCATION
OFFICIALS
PROJECTS
SCHOOLS
STUDENTS
TEACHERS

Appendix C

Integrating HIV Prevention in the Basic Education Curriculum *

Evelina Maclang-Vicencio, Ph.D.
Executive Director, G.U.R.O.
Miriam College Teacher Institute
Professor of Curriculum Studies

Like many terms in education, integration has as many definitions as there are curricularists who have attempted to study and promote the concept. Integration has been called a plethora of terms which include core, fused, shared, unified, thematic, interweaving; holistic approach, connectedness of subjects; interdisciplinary, cross-disciplinary, multi-disciplinary, transdisciplinary, pluridisciplinary; and in Filipino *pinag-isa, pinagsama, pinagsanib, pinagsap*.

Through the years, there have also been changes in the concept of integration. The traditional concept of integration looks at it as a combination of subjects (like Science and Health; Music, Arts, Physical Education, and Health Education or MAPEH). The modern concept sees integration of skills and learning strategies (like critical thinking skills in all learning areas) including addition of topics and subjects not recognized as unique disciplines (e.g., prevention of HIV).

Congruent with the varied definitions are different modes of integration, which can be applied in the prevention of HIV.

Webbed or Thematic Approach. The thematic approach subordinates subject matter to a theme, allowing the boundaries between learning areas to blur. A theme related to HIV Prevention can be chosen for a week or a month and lessons in different learning areas can revolve around the theme.

Correlation or Cross-Curricular Approach. Integration of concepts or content includes correlation or cross-curricular approach. Cross-curricular connections are between two or more learning areas that are made by teachers within the structure of their subjects. So, a teacher of Health Education studying prevention of HIV may request one or more teachers (e.g., reading in English or Filipino, Arts, etc.) to relate their lessons to HIV prevention.

Holistic Approach. Integration that happens within the learner includes holistic and immersed approaches. Holistic integration addresses the needs of the whole child (the integration of cognitive, physical, affective, moral, and spiritual dimensions) and offering a curriculum that provides the context in which new knowledge makes sense.

Problem-Centered or Action Approach. In the action or problem-centered approach, students tackle HIV prevention through real-life problems. The approach makes use of community-based action projects that provide opportunities to engage in individual

and group action in the school and community. These are the steps in the problem-centered approach: Identify, Investigate, Discuss, Plan, Act, Reflect.).

Inclusion Approach. Inclusion makes use of topics related to HIV prevention as examples in the lesson.

Add-on Approach. Add-on appends a unit on HIV prevention in the learning area, for example in Science and Health.

Special Events Approach. Special events suggest that the celebration of World AIDS Day on December 1 be observed as part of the curriculum.

The varied definitions and modes of integration, though overwhelming and oftentimes confusing because of the thin line distinguishing them apart, should not be viewed as a weakness but as a blessing. It opens the field wide for critical and creative educators; in other words, different schools can do integration differently.

The following criteria can be applied for the productive integration of HIV prevention in the curriculum:

1. Integration should foster accomplishment of the major goals of preventing HIV in each area; it should not be superficial.
.
2. Integration should be natural and not artificial.

3. Integration should be true to the subjects being integrated so that they do not disrupt the coherence of the subjects, e.g., English. HIV prevention should appear as integration and not an intrusion into or an invasion of English.

4. Integration must be feasible—Some activities may not be feasible because they may be too expensive or pose risks to the physical safety of the students, for example, handling a syringe.

5. Finally, integration should enhance the subjects being integrated. The study of HIV prevention should enhance Science and Health at the elementary level.

Now let us go to specific steps in developing an integrative approach. Are you interested in a tried and tested formula? A "tried and tested formula" for integration using the thematic approach as an example follows. I am using the word LEADER because that is what you are –dynamic leaders; otherwise you would not have been chosen to attend this workshop. The general steps using the letters of LEADER can be used for any mode of integration. The first step is—

L--EARN – Gather all your constituents and learn about HIV and AIDS. Know everything about HIV and AIDS; discussing problems and issues. More often than not, ignorance causes misconceptions about the subject.

E--XPLORE.—In the next gathering, know all about integration and brainstorm all possible modes you can think of. This should be a free-wheeling session where all ideas are accepted and there is no evaluation.

A—DAPT—This is the time to evaluate the ideas generated during the brainstorming session and to adapt one or more approaches, after consideration of practicality and feasibility in terms of resources.

D—ESIGN—Develop the framework and operationalization of the integration mode chosen. The steps in the design will vary according to the mode of integration chosen.

E—XECUTE—Plan the monitoring scheme; implement the designed integration.

R—EVIEW—Evaluate the approach.

Let me end with an anecdote about a little boy who asked his father for help in repairing his broken toy. When the job was done, the boy looked up and said, "Father, when I try to do things by myself, they go wrong. But when you and I work together, they turn out just fine." So, for the health of our nation, for the good of our learners, for our own good, let us join hands and work together for the prevention of HIV in our country; then it won't be a surprise if HIV is completely eradicated.

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*Paper presented at the Workshop on the Adaptation to Philippine Situation of the HIV Prevention Information Kit for Teachers sponsored by UNESCO Bangkok at the Cebu Normal University on 24 September 2007.

Appendix D

Integration of HIV and AIDS Concepts in the Elementary Curriculum
(Sample Points of Entry Across Some Learning Areas)

Learning Area / Grade Level	Science and Health	*Heograpiya, Kasaysayan at Sibika (HEKASI)*	*Edukasyong Pantahanan at Pangkabuhayan (*EPP)
5	**People** • Hygienic practices in caring for the reproductive organs • Healthy habits to keep the reproductive organs healthy	***Suliraning panlipunan*** • *Mga Suliraning panlipunan* • *Tungkulin ng mga kababaihan sa paglutas ng mga suliranin* • *Mga paraan /programa sa paglutas ng suliraning panlipunan*	*Pangangalaga ng katawan sa panahon ng pagbibinata at pagdadalaga* *Pag-aalaga ng may-sakit, matanda at iba pang kasapi ng mag-anak*
6	**Healthy Person** • Personal practices in maintaining one's health • Prevention of common illnesses and diseases	*Edukasyon at kalusugan ng mamamayan sa pagpapaunlad ng bansa* *Pambansang isyu/ suliraning nakapipigil sa pag-unlad ng bansa*	

Appendix E

Sample Lesson Plan Integrating HIV and AIDS in the Elementary School Curriculum

Learning Area : Science and Health
Grade Level : Grade V
Time Allotment : 1 hour
Key Concept : Sex Roles
Entry Point : Physical, social and emotional changes in males and females during puberty

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I. Objectives

Given varied activities, the pupils are expected to:

1. Discuss the advantages and disadvantages of cultural sex-role expectations for persons of the opposite sex.
2. Clarify sex perceptions and feelings about roles society forces upon the gender.
3. Talk about what it is to be a boy or a girl, in the presence of the opposite sex, but without rebuttal from them.

II. Subject Matter

Sex Roles

References:
Values in sexuality. A new approach in sex education, pp.71-75; BEC Science and Health

Materials: 1 Manila paper to be used as a chart
marking pen for each group
Integration: HIV and AIDS
Value Focus: Respect for members of the opposite sex

III. Procedure

A. Activity

1. Tell the pupils that the class will explore the advantages and disadvantages of being a girl or a boy. For most of the time, they will be working in same-sex groups. The girls' groups will be thinking about what it is like to be a boy, and vice versa.

2. Form into same-sex groups of six to eight members.

3. Direct pupils to look at the chart you have prepared:

Disadvantages of being a _____	Advantages of being a _____

Say, "Boy's groups take a sheet of Manila paper and mark it off in the same way as the chart is divided. After you have written in the two headings at the top, write the word *GIRL* in the two blanks at the top heading. Girl's groups, prepare your sheets in the same way, and write the word *BOY* in the two blanks.

"In your separate groups, list as many advantages and disadvantages as you can think of. List only items, which *most* people in your group agree with and are serious about."

4. Allow 15 minutes for this process in same-sex groupings. Give a warning five minutes before you are ready to call time.

5. When the first group appears to have finished, give the next set of directions:

   "When you have completed both columns of the sheet to the satisfaction of everybody in your group, exchange lists with a group composed of the opposite sex.

   "Read the list of the opposite sex. Discuss in your same-sex group how you feel about their perceptions regarding the pluses and minuses of being a member of your sex. Which of their observations does your group agree with? Where do you disagree? Are there different reactions within your own group to these perceptions? Explore them."

B. Analysis

Allow 10 minutes, and then say, "Now, we are going to have an opportunity to hear how people feel about their *own* sex roles, about the advantages and disadvantages they experience as boys or girls.

"Each group chooses _____pupil(s) to participate with other members of the same sex in this discussion. These representatives will sit together in the center of the room, while the other pupils observe them and listen to their feelings and perceptions. Since the participants are encircled by silent observers, this process is called fishbowl." (Anywhere between five and eight pupils of the same sex may occupy the fishbowl.)

1. Take a circle of chairs in the center of the room, leaving two chairs vacant.

   "Will the representatives come to the center? We will flip a coin to see whether the boys or the girls will talk first."

   After the coin flip, say:

   "There are two vacant chairs in the circle. If any of the rest of the pupils of the same sex as those within the fishbowl want to say something, they may move into these chairs. After you have said your piece, please vacate the chair so someone else can occupy it.

   "The pupils in the fishbowl are the speaking members of the discussion. The opposite sex is to remain silent during the fishbowl discussion."

2. In the fishbowl discussion, the pupils tell how they feel about their own sex roles. Time allotted may be varied.

3. Reverse—have the opposite sex form the fishbowl and proceed as before.

C. Abstraction

   Ask the pupils what they learned about sex roles from the activity, the general agreements and disagreements about sex roles, and the perceptions of individual pupils.

   Through exploring the positive and negative aspects of sex roles, pupils are able to see the "flip side"—that for every advantage enjoyed by the opposite sex, there may be disadvantages. This realization will enable pupils to be more emphatic towards the opposite sex, and to be less simplistic in their analysis of opposite-sex behavior.

D. Application

   As a result of the exercise, how will they treat members of the opposite sex? How will they show respect for the opinions of others?

IV. Evaluation

Each pupil will prepare his/her own chart and check whether s/he agrees/disagrees which each entry.

Appendix F

Integration of HIV and AIDS Concepts in the Secondary Curriculum
(Sample Points of Entry Across Some Learning Areas)

Learn-ing Areas. Yr. Level	**Science**	**Tech-nology & Live-lihood Education (TLE)**	**Music, Arts, Physical Education & Health (MAPEH) (Health Education)**	***Araling Panlipunan***	***Edukasyon sa Pagpapahala-ga (EP)***
First Year				***Mga suliraning panlabas na nakaka-apekto sa bansa*** *(Kalusu-gan)*	
Second Year	**Biology** Reproduc-tion:Ill effects of sexually-transmitted diseases and risks of contami-nation from various sexually-transmitted diseases, especially AIDS		**Reproductive-**related Issues and problems		***Mga Makabulu-hang Pakikipagka-wa*** *(Mga bunga ng hindi wastong pamamahala ng emosyon)*
Third Year			**Prevention and Control of Diseases** Communica-ble and non-communicable diseases	***Populasyon, Kalusugan at Pag-unlad*** *Mga makaba-gong sakit na nagbabanta sa buhay ng tao*	
Fourth Year		**Home Nursing**	**Prevention and Control of**		***Ang Moral na Pagkatao***

		Diseases: Signs and symp-toms, causes and treatment	**Diseases** 10 leading causes of Mortality; 10 leading causes of Morbidity		*(Ang moral na kilos at mga isyung moral sa makabagong panahon hal., Pre-marital sex, homosexuality, prostitusyon, atbp.*

Appendix G

Sample Lesson Plan Integrating HIV and AIDS in the High School Curriculum

Learning Area : MAPEH (*Edukasyong Pangkalusugan*)
Year Level : Second Year
Time Allotment : 1 Hour
Concept : Disease Prevention and Control
Entry Point : Communicable Diseases (HIV-AIDS)

I. **Objective:** At the end of the lesson the student should be able to—
   A. Simulate how the immune system works in a healthy person;
   B. Explain how HIV damages the immune system.

II. **Subject Matter**
   Disease Prevention and Control
      The Immune System

   Reference: *Action for youth. AIDS training manual* of the League of Red Cross and Red Crescent Societies and the World Organization of the Scout Movement, pp. 69-70.

   Materials: Costume for each member or name tag with the name of the characters represented

III. **Procedure**

   A. Activity

      Simulate how the immune system is damaged by HIV. This can be rehearsed the day before the lesson by a group pre-assigned to do so.

      Cast: Juan
      Juan's immune system—a group of students
      HIV
      An infected wound
      Storyteller

      The Storyteller stands at the side of the room and reads the script of the story.

      STORYTELLER: This is the story of how a healthy immune system works and how HIV damages the system.

(Juan comes forward and stands in the middle of the room).

STORYTELLER: Juan is protected from infection by his immune system.

(A small group of students, holding hands in a circle, surround Juan).

STORYTELLER: When he gets an infection, his immune system fights the infection and Juan becomes well again).

(An infected wound comes forward, Juan looks in pain. The wound tries to break through the immune system circle, but they don't let him and he goes away).

STORYTELLER: Juan had sex with a sex worker. Now Juan has become infected with HIV because the sex worker carries the virus and they had unprotected sex.

(HIV comes forward and starts to fight with Juan's immune system. HIV manages to get inside the immune system circle. HIV hits one of the members of the group who falls down and dies).

STORYTELLER: Since HIV has managed to get inside the immune system and kills a part of it, the immune system is now weak and cannot fight HIV. Since the immune system is now damaged, it becomes unable to fight off other infections.

(The rest of the immune system members fall on the floor).

STORYTELLER: Juan starts to get sick and develops AIDS. He falls down and dies.

Our immune system normally protects us from disease. When HIV gets into our body, it damages the immune system. The immune system eventually becomes weak and cannot fight off infection. Our body can no longer cope with infections. It is the infections that kills a person who is infected with HIV).

The end.

B. Analysis

1. How does the immune system work?
2. How do people get infected with HIV?
3. Why was Juan infected with HIV?
4. Who is not at risk of getting HIV?

5. How did HIV affect Juan's life?
6. What should Juan have done to keep himself from getting infected? 7. How easy or difficult is it to do these things?

C. Abstraction

1. What is the work of the immune system?
2. How does the immune system work?
3. How does HIV damage the immune system?
4. How can you keep your immune system healthy?

D. Application

1. What healthful practices can help you protect your immune system from infections?
2. What unhealthful practices should you avoid to keep your immune system healthy?

IV. Evaluation

Have the students prepare a self-checklist of the healthful practices they will do to prevent infections and to maintain good health. Tell them that you will collect the checklist at the end of each week.

Appendix G

Agencies, Government and Non-Government Organizations and Institutions that Provide HIV and AIDS-Related Services

Philippine GOs

Philippine National AIDS Council
Address: 3rd Floor Building 12
Department of Health
Sta. Cruz, Manila
Tel.: (632) 743-0512
Fax: (632) 338-6440
Trunkline: 743-8301 local 2254,2256, 2257
E-mail: naspcp@doh.gov.ph
The central advisory, planning and policy-making body for the comprehensive and integrated HIV and AIDS prevention and control program in the Philippines

National AIDS STI Prevention and Control Program (NASPCP)
Address: 3/F Bldg 13 DOH Compound, Rizal Avenue, Sta. Cruz, Manila
Tel.: 742 8301 locals 2350-2352
In charge of the health sector and provides technical leadership among local governments and other stakeholders; develops policies, coordinates, monitors, provides logistics (augmentation) and technical assistance for the health sector; under the National Center for Disease Prevention and Control of the Department of Health.

HIV and AIDS Hospital Treatment Hubs

1. **Research Institute for Tropical Medicine (RITM)**
   Alabang, Muntinlupa City

2. **San Lazaro Hospital (SLH)**
   Qiricada, Manila

3. **Philippine General Hospital (PGH)**
   Taft Avenue, Manila

4. **Ilocos Regional Training and Medical Center (ITRMC)**
   San Fernando, La Union

5. **Vicente Sotto Sr. Memorial Medical Center (VSSMMC)**
   Cebu City

6. **Davao Medical Center (DMC)**
   Davao City

7. **Baguio General Hospital and Medical Center**
   Baguio City

8. **Bicol Regional Training and Teaching Hospital**
   Legaspi City

9. **Western Visayas Medical Center**
   Iloilo City

10. **Corazon Locsin Montelibano Memorial Regional Hospital**
    Bacolod City

11. **Zamboanga Medical Center**
    Zamboanga City

Treatment Hubs that provide comprehensive HIV prevention, treatment, care and support services

Philippine NGOs

1. Action for Health Initiatives, Inc. (ACHIEVE)
Address: 162-A Sct. Fuentabella Ext., Barangay Sacred Heart, Kamuning, Quezon City 1103
Tel: (63) (2) 414-6130
Fax: (63) (2) 426-6147
Email Add: achieve@pacific.net.ph / achieve_caram@yahoo.com
Contact Person: Ms. Malu Marin – Executive Director
Projects– Target Sectors:

- Capability Building - Seminar/Workshop/Training – Migrant Workers, Migrant Workers Living with HIV/AIDS (MWLHA),
- Advocacy – Migrant Workers, Migrant Workers Living with HIV/AIDS (MWLHA), female spouses of seafarers and stakeholders
- Researches - Migrant Workers, Migrant Workers Living with HIV/AIDS (MWLHA
- Publications - Migrant Workers, Migrant Workers Living with HIV/AIDS (MWLHA), female spouses of seafarers and stakeholders

2. AIDS Society of the Philippines, Inc (ASP)
Address: 4/F Rm. 401 Doña Felisa Syjuco Bldg.
1872 Remedios St., cor. Taft Ave., Malate, Manila 1004
Tel: (63) (2) 536-5694 / 536-5509 / 523-1334
(63) (2) 524-1261 loc. 143 & 144
Fax: (63) (2) 536-5512
Email Add: aidsphil@pacific.net.ph / sbw@pacific.net.ph
Contact Person: Dr. Carlos C. Calica – President
Project – Target Sectors

- Capability Building - Seminar/Workshop/Scientific Meeting – NGO workers, medical and paramedical professionals
- Resource Center Management – students, NGOs
- Publications - ASP members, NGOs, donors
  - AIDS Media awards 2003 Media Practitioners
  - Evaluation of the effectiveness of the Award Winning AIDS Media Awards Novelette as a means to promote HIV/AIDS awareness among the Filipino–general public
- Storytelling Caravan – Children (grades 5 & 6)
- Ethical Guidelines in AIDS investigations – Doctors & NGOs
- Media Reporting on Sexuality & Safe Sex in selected South East Asian Countries: A Content Analysis Media – South East Asian Countries

3. DKT Philippines, Inc.
(Philippine Social Marketing Program)
Address: Suite 801, The Linden Suites
37 San Miguel Ave., Ortigas Center, Pasig City 1600
Tel: (63) (2) 687-5567
Fax: (63) (2) 631-1652
Email add: dkt@frenzy.com.ph / www.frenzy.com.ph
Contact Person/s: Mr. Terry L. Scott – Country Director;
Mr. Benny L. Llapitan Jr. – Marketing Director
Project – Target Sector

- Social Marketing – Male and female of reproductive age, youth, young couples, CSWs, general population, program managers (NGOs), LGUs, commercial and non-traditional outlets
- Condom Promotion and Education – male and female reproductive age, youth, young couples, CSWs, general population, community health providers
- Frenzy Mobile Outreach Team ARHS, AIDS Education –youth (in-school and out-of-school)
- NGO Collaboration – Local NGOs with programs on FP, Reproductive Health, HIV/AIDS/STI
- LGU Collaboration – LGUs with programs on FP, Reproductive Health, HIV/AIDS/STI

Branch Office/s**:** Cebu, Davao

4. Health Action Information Network (HAIN)
Address: 26 Sampaguita Ave., Mayapa Village II, Barangay Holy Spirit, Quezon City 1127
Tel: (63) (2) 952-6409
Fax: (63) (2) 952-6312
Email Add: hain@info.com.ph / www.hain.org / www.kalusugan.org
Contact Person: Dr. Edelina dela Paz – Executive Director
Projects – Target Sectors:

- Capacity Building
  - Training – men and women
  - Sexuality and RH – NGOs,POs,GOs
- AIDS Action Asia-Pacific ed. (Newsletter) – health workers
- Research Methods for Reproductive and Sexual Health (Training Course) – Researchers from NGOs and GOs
- Clearinghouse for Dissemination of Appropriate STD/HIV/AIDS Information (Info exchange through Information Technology) – Policymakers, health workers, and other stakeholders training
- Research - youth
- Resource Center Management – general population

5. ***Lunduyan Para sa Pagpapalaganap, Pagpapataguyod at Pagtatanggol ng Karapatang Pambata***
Address: 17-17A Casmer Apartment, Del Pilar corner Don Jose St., Bgy. San Roque, Cubao, Quezon City 1109
Tel: (63) (2) 913-3464
Fax: (63) (2) 911-4867
Email Add: chrights@info.com.ph
Contact Person: Ms. Irene V. Fonacier-Felizar – President, CEO and Chief Mentor
Project –Target Sector:

- Capability Building
  - Counseling – children, youth
  - Training – teachers, youth
- Community Mobilization
  - Peer Educators Mobilization –SK officials, youth, organizations, barangay officials, community children and young people
  - Innovative ARH Interventions – communities, schools, GOs, NGOs
- Operationalizing RH through the use of various art forms like theater, visual arts, music and dance
  - "*Dulaan sa Kalye*" (DSK) – children, young people & caregivers
- Resource Center - students, children in the community
- Care & Support Services – PHIV & PWAs & children
- Networking / Advocacy –NGOs, GOs, LGUs, children's organization, youth organizations, PPOs, caregivers
- Researches – children, caregivers
  - Publications – children, youth, community people, children and youth in sex work

6. Philippine HIV/AIDS NGO Support Program, Inc. (PHANSuP)
Address: Mezzanine, Brickville Condominium 28 N. Domingo St., New Manila, Quezon City 1112
Tel: (63) (2) 726-6921 / 726-6922 / 727-0322 / 414-8299
Fax: (63) (2) 415-4381
Email Add: phansup@info.com.ph / www.phansup.org

Contact Person/s:

- Mr. Alejandro M. Torres – Secretary of the Board of Trustees
- Mr. Antonio S. Enderiz – Administrative & Finance Manager
- Ms. Helen O. Orande – Program Manager

Project – Target Sectors:

- Community Mobilization through provision of Financial Support – other NGO/CBO/PPO especially those in underserved areas of the country
- Capability Building through provision of various Technical Support efforts – other NGO/CBO/PPO, especially those in underserved areas of the country
- Information Management, including IEC development & production – other NGO/CBO/PPO, especially those in underserved areas of the country
- Networking/Advocacy – National & local government & donors, national & international NGOs, the academe, communities

7. Philippine Legislators' Committee on Population and Development (PLCPD)

Address: Rm. 611 Northwing Bldg., House of Representatives Batasan Complex, Quezon City 1126
Tel: (63) (2) 931-5001 local 7430
Fax: (63) (2) 931-5354
Email add: plcpd@skyinet.net / www.plcpdfound.org
Contact Person/s:

- Mr. Roberto Ador – Executive Director
- Mr. Ramon San Pascual – Deputy Executive Director

Project – Target Sectors:

- Capability Building
  - Seminar/Workshop/Training – legislative advocacy workers, civil society volunteers, members
  - Study visits – members
- Community Mobilization – members
- Networking/Advocacy – GOs, NGOs, POs, cooperatives, academe, media, church, business, other citizen's group

8. Philippine NGO Council on Population Health and Welfare, Inc. (PNGOC)

Address: 38-A San Luis St., Pasay City 1300
Tel: (63) (2) 551-6285
Fax: (63) (2) 834-5008
Email add: pngoc@pacific.net.ph / www.pngoc.com
Contact Person/s:

- Dr. Eden R. Divinagracia, PhD – Executive Director
- Ms. Chi Balledo – Senior Program Officer

Project – Target Sectors:

- Capability Building - Seminar/Workshop/Forum – NGOs, GOs, Civil society
- Networking/Advocacy – NGOs, GOs, women, youth, men
- Researches – women, health workers, GOs, NGOs
  - Family Health Management by and for Poor Settlers

    - FAMUS Knowledge, Attitude and Behavior Study
    - Focus Group Discussion on Family Health
- Publication – NGOs,GOs, LGUs, women, youth, legislators
    - ICPD Link
    - The Philippine NGO Experience in RH (monograph)

9. Pinoy Plus Association, Inc.

Address: c/o Remedios AIDS Foundation, Inc.
1066 Remedios cor. Singalong Sts., Malate, Manila 1004
Tel: 524-0924/524-4507
Fax: 522-3431
Email add: pinoy_plus@yahoo.com / pinoyplus@edsamail.com.ph
Contact Person: Mr. Noel Pascual - Officer-in Charge (OIC)
Project – Target Sectors:

- Capability Building - Workshop/Training – PLWHAs and families
- Community Mobilization - Peer to Peer Support group – PLWHAs
- Support Services to PLWHAs
    - Care & Support - PHIV/PWAa, & affected families
    - Livelihood – PHIV / PWAs
- Networking / Advocacy – PHIV / PWAs, Community

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

Address: 2613-2615 Dian St., Malate, Manila, 1004
Tel: (63) (2) 484-0894/ 484-0895/ 832-6239
Fax: (63) (2) 404-2911
Email add: pafpi@edsamail.com.ph/ pactionphil@netscape.net
Contact Person/s:

- Mr. Joshua Formentera – President/ Executive Director
- Mr. Jesus A. Ramirez – Program & Development Manager

Project – Target Sectors:

- Capability Building
    - Peer Education/Counseling – PLWHAs, Affected Families \(immediate, secondary)
    - Seminar/Workshop/Training – PLWHAs, Affected Families (immediate, secondary)
- Community Mobilization and Education
    - Information Dissemination (Basic HIV Education) / IEC materials distribution – Barangay Councils, Community Volunteer Health Workers, Sangguniang Kabataan, Pos,
    - Peer Support Group Meetings – PLWHAs, Affected Families
- Support Services to PLWHAs
    - Access to treatment
    - Assistance on benefits claims (OWWA, SSS)
    - Referrals (confinement, medicine, burial, livelihood, legal)
    - Temporary Shelter

- Counseling
- Home & Hospital visits
- Alternative Complimentary Therapy

- Working – government agencies, pharmaceutical companies (local/foreign), private sectors, NGOs (foreign)
  - Treatment (Clinical Trials, Treatment Management, Access)
  - Importation and sustainable supply or ARV, prophylaxis and supplementary
- Advocacy – schools and workplace
- Documentation Report on the First National Consultation and Consensus Meeting on Access to Treatment

Branch Office/s: Makati City

11. Precious Jewels Ministry (PJM)
Address: P.O. Box 3356 Metro Manila 1099
Telefax: (63) (2) 921-8076
Email add: pjewels@pacific.net.ph
Project – Target Sectors:

- Ms. Lorraine Anderson – Executive Director
- Ms. Charity Arellano – Social Work

Project – Target Sector:

- Capability Building - Seminar/Workshop/training youth, women
- Community Mobilization – youth
  - Peer Support Groups –youth children, adults
- Support Services – PLWHAs children & families
- Advocacy – children with chronic groups
- Networking – child welfare groups
- Researches – children with chronic illness

Branch Office/s: San Lazaro Hospital

12. Remedios AIDS Foundation, Inc. (RAF)
Address: 1066 Remedios cor. Singalong Sts., Malate, Manila 1004
Tel: (63) (2) 524-0924/524-4831
Fax: (63) (2) 522-3431
Email Add: reme1066@skyinet.net / www.remedios.com.ph / www.youthzone.com.ph
Contact Person/s: Dr. Jose Narciso, Melchor C. Sescon, FPOGS – Executive Director
Project – Target Sectors**:**

- Capability Building - Hotline project – women, youth, general public Remedios Hotline 524-0551/ Women's AIDS hotline 524-4427
- Counseling
  - Face to face – general public
  - Internet relay chat (undernet: youthzone) – youth
- Seminar/Workshop/Training/Post Graduate Courses – general public, workplace, students, women, OFWs, MSM, professionals

- Community Mobilization
  - Peer educators mobilization – sex workers, workplace
  - Peer to peer support group – youth, PLWAs
- Resource Center Management – general public, students, professionals, medical allied courses, researchers
- Anonymous Clinics/Testing/STD Case Management (Remedios Health Laboratory) – sex workers, general public, MSM
- Anonymous ARH Clinic (kalusugan@com) – adolescents
- Support Services to PLWHAs - Care & support
- Networking/Advocacy – government agencies, private sectors, legislators, policy makers on Republic Act 8504 (AIDS Law)
- Information Education Communication (IEC) Materials – general public, women, youth, workplace, sex workers, MSM, paramedical courses
- Shopping Mall-Based Youth Center (Youth Zone) – youth
- Publications
  - Training Manuals/Modules on RH
  - HIV/AIDS Prevention – Care and Support Manuals

Branch Office/s: Tutuban Center Mall – Manila, Colonnade Mall Cebu City

13. Samahan ng Mamamayan Zone One Tondo, Inc. (ZOTO)
Address: Blk. 13 Lot C 1-3 Maya-maya St. Phase 2 Area 2 Dagat-dagatan, Navotas
Tel: (63) (2) 285-0254
Fax: (63) (2) 288-0370
Email add: zoto@i-next.net

14. The Salvation Army, Inc.
Address: 1414 L. Guinto Sr. St., Ermita, Manila 1000
Tel: (63) (2) 524-0086 to 88
Fax: (63) (2) 521-6921
Email add: saphil1@phil.salvationarmy.org
Contact Person/s: Ms. Alma Villanueva-Acub, RN – Coordinator HIV/AIDS Program & Integrated Mission
Project – Target Sectors:

- Capability Building (Phase 1-4 training) – volunteers in the community
- Community HIV/AIDS Awareness – general group in the community
- Pre- and Posttest Counseling – high risk clients in the community
- Community Discussion – general group in the community
- Resource Center Management – students, community
- Referral/Pastoral Care – community, PLWHAs
- Expansion Areas – The Salvation Area
- Community Integration of Patients Living with HIV/AIDS – PLWHAs
- Livelihood (Microfinance) – families in the community
- Networking

Branch Office/s: Nationwide

15. The Library Foundation (TLF)

Address: 2607 Mercedes St., Malate, Manila 1000
Tel: (63) (2) 400-8375
Fax: (63) (2) 400-5006 telefax
Email add: tlf@tlfmanila.org / www.tlfmanila.org
Contact Person/s:

- Mr. Ferdie Buenviaje – Executive Director
- Mr. Glen A. Cruz – Program Coordinator

Project – Target Sectors:

- AIDS Prevention Program
  - HIV Workshop – MSM
  - Safer Sex promotion – MSM
  - Policy Advocacy – MSM
- Capacity Building for community development – MSM, gay, bi-sexual, transgender organizations
- Human Rights Program
  - Community organizing – MSM, gay, bisexual, transgender organizations
  - Legislative Assembly MS, gay, bisexual, transgender organizations

16. Trade Union Congress of the Philippines (TUCP)

Address: TUCP-PGEA Compound, Masaya cor. Maharlika Sts.
UP Diliman, Quezon City 1101
Tel: (63) (2) 922-2185
Fax: (63) (2) 921-9758 telefax
Email add: tucp@easy.net.ph
Contact Person/s:

- Atty. Democrito T. Mendoza – President
- Mr. Ariel B. Castro – Director for Education

Project – Target Sectors:

- Capability Building - Seminar/Training – male workers, male union members and their families
- Community Mobilization
- Public Events
- RH Service Delivery
- Research
- Networking/Linking – GOs and NGOs
- Information, Education, Communication (IEC) Activities

17. UP Center for Women's Studies Foundation, Inc.

Address: Magsaysay cor. Ylanan Sts., UP Diliman, Quezon City 1101
Tel: (63) (2) 920-6950
Fax: (63) (2) 920-6880
Email add: cws@up.edu.ph/ www.upcws.org
Project – Target Sectors:

- Capability building

    - Counseling – UP Community, general population, women
    - Seminar/workshop/Training – GOs, LGUs, women
- Community Mobilization – men, women
- Resource Center Management
- Researches – Academe
- Networking/Advocacy – UP campuses
- Publications
    - Review of Women Study
    - *Pananaw*
- Healing Center/ Family Center/Day Care – UP community
- Development & Maintenance of the Regional Information Resource
- Facility – Women in Local Government, scholars, researchers, and public administrators
- Enhancing Reproductive Health Advocacy through the production of IEC materials – women, policy makers, legislators, health workers
- Production of advocacy kit based on the results of the Quantitative study on the Beliefs, Attitudes, Perceptions and Behavior of Young People about Identity, Sexuality and Health Study – Guidance counselors of State Universities, parents, NGOs and policy makers
- Qualitative Study on the Behavior, Attitudes, Beliefs and Perceptions of Researchers, scholars
- Healing wounded families and healing peaceful communities

Community-based

- GAD Capability-Building of Regional Women's Center
- Resource Center – GAD resource person, researchers, scholars, GAD
- Monitoring the progress and Impact of Intervention Programs
- Violence Against Women and Children (VAWC) – scholars, researchers, volunteer workers, counselors

18. Woman Health Philippines, Inc

Address: 129-A Matatag St., Barangay Central, Quezon City 1100
Tel: (63) (2) 927-3319
Fax: (63) (2) 435-5254
Email add: womanhealth@skyinet.net / womanhealth@surfshop.net.ph
Contact Person/s:

- Ms. Gladys Fe Rio Malayang – Executive Director
- Dr. Florence M. Tadiar – President

Project – Target Sectors:

- Capability Building - Seminar/Workshop/Training
- Community Mobilization
    - Peer educators-community health workers
    - Mobilization/Activities – community youth workers
- Anonymous Clinics/Testing STD Case Management – clients from different areas

- Networking/Advocacy – participating agencies, GOs, NGOs, LGUs
- Researches
- Publications

United Nations
Educational, Scientific and
Cultural Organization

UNESCO Asia and Pacific Regional Bureau for Education
Bangkok
P.O. Box 967, Prakhanong Post Office,
Bangkok 10110, Thailand
Email: bangkok@unescobkk.org
Website: www.unescobkk.org

United Nations
Educational, Scientific and
Cultural Organization

UNESCO National Commission of the Philippines
Department of Foreign Affairs Building
2330 Roxas Boulevard, Pasay City
E-mail: unescoph@mozcom.com
Website: www.unescoph.org

The Philippine Adaptation Team, Cebu Normal University,
24-25 September 2007

1st row (L-R): Ms. Emmy Anne Yanga, UNACOM; Ms. Violeta Maravilla, Lahug Elementary School; Ms. Girlie Laluna, Baybay National High School; Ms. Ma. Leonora Tingatinga, Iloilo National High School; Ms. Minang Asalan, Madrasah Regional Coordinator; Ms. Katrina Padilla, SEA-CLLSD

2nd row: (L-R) Mr. Joel Atienza, DOH; Ms. Rosanne Wong, UNESCO Bangkok; Amb. Preciosa S. Soliven, UNACOM; Dr. Evelina Vicencio, Miriam College; and Dr. Susan Gregorio, PNAC

3rd row: (L-R) Ms. Raylene Manawataw, Lusatan Elementary School; Ms. Bonita Lingga, A. Montes II Elementary School; Ms. Gwendenilla Villarante, CNU; Ms. Daylinda Lim, Sto. Niño SPED Center; Ms. Cleofe Romagos, PNP Cebu City; Ms. Susan Anfone, Abellana National High School; Atty. Dominiciana Bandala, CNU; Ms. Juvelyn Pañares Otero, Cebu City National High School; Ms. Annie Manzano, UP Visayas; Ms. Petronila Fidellaga, TESDA Reg. VII; and Sr. Ana J. Amar, Colegio de San Immaculada Concepcion

4th row (L-R): Mr. Anghel Espiritu, OUMWA, DFA; Dr. Matilde Mayonila, DepEd Cebu; Mr. Venancio Esparagera, Camp Capulogan National High School; Mr. Jose Tuguinayo, DepEd Central Office; Ms. Elsie Colo, Hipodromo Elementary School; Ms. Shalaine Lucero, DSWD; Mr. Julius Daño, CNU; Mr. Eldy Oñas, DepEd Central; Dr. Jonathan Neil V. Erasmo, DOH Cebu City; and Mr. Rogelio Vicencio, BSP.