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EDUCAIDS

Towards A Comprehensive
Education Sector Response

A Situation Analysis of
the Education Sector
Response to HIV, Drugs
and Sexual Health in
Brunei Darussalam,
Indonesia, Malaysia,
the Philippines and
Timor-Leste

Synthesis Report 2012

A Situation Analysis of the Education Sector Response to HIV, Drugs and Sexual Health in Brunei Darussalam, Indonesia, Malaysia, the Philippines and Timor-Leste

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This report was prepared as a desk study through a synthesis of five situation-response analyses (SRA)s undertaken in Brunei Darussalam, Indonesia, Malaysia, the Philippines and Timor-Leste. It was prepared by David J. Clarke, Independent Researcher Specializing in Education Sector Response to HIV and AIDS, former Senior Education Advisor for DFID on HIV and Education and currently domiciled in Bangkok, Thailand. It was organized and edited by Ahmad Afzal, the HIV & AIDS and School Health Coordinator of the Education Unit in UNESCO Office, Jakarta. Appreciation is conveyed to authors/ministries of the individual country reports for reviewing this synthesis, as follows: For Brunei Darussalam - Dk Mas Joliwane Pg Tejudin and the team at Curriculum Development Department, Ministry of Education; For Indonesia – Professor Irwanto and the AIDS Research Centre Team at Atma Jaya Catholic University; For Malaysia - Dr. Faridah Abu Hassan and team at Educational Planning & Research Division (EPRD), Ministry of Education; For the Philippines – Professor Evelina Maclang-Vicencio and team at University of the East; For Timor-Leste - Remegio, Alquitran, Consultant based in UNESCO Antenna Office in Dili and Ministry of Education Staff. Further gratitude goes to Justine Sass, the UNESCO Bangkok Regional HIV and AIDS Adviser for Asia and the Pacific for her comprehensive review and edits.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMTP	AIDS Medium-Term Plan
ARMM	Autonomous Region of Muslim Mindanao
ARH	Adolescent Reproductive Health
ART	Antiretroviral Therapy
ASEAN	The Association of Southeast Asian Nations.
ATS	Amphetamine-Type Stimulants
BALS	Bureau of Alternative Learning Systems
BCC	Behavior Change Communication
BDAC	Brunei Darussalam AIDS Council
CHED	Commission on Higher Education
CRIS	Country Response Information System
CSO	Civil Society Organization
DepEd	Department of Education
DOH	Department of Health
DOLE	Department of Labor and Employment
EMIS	Education Management Information System
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FHE	Family Health Education
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GO	Government Organization
HDSHE	HIV and AIDS, Drug and Sexual Health Education
HACT	HIV and AIDS Core Teams
HAIN	Health Action Information Network
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IATT	Inter-Agency Task Team

IEC	Information, Education and Communication
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
ITGSE	International Technical Guidance on Sexuality Education
LAC	Local AIDS Council
LGU	Local Government Unit
LSBE	Life Skills Based-Education
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoEC	Ministry of Education and Culture
MoH	Ministry of Health
MoNE	Ministry of National Education
MDG	Millennium Development Goal
MTR	Mid-Term Review
MSM	Men who have Sex with Men
NADA	National Anti-Drug Agency
NGO	Nongovernmental Organization
NSP	National Strategic Plan
OFW	Overseas Filipino Worker
OSY	Out-of-school Youth
PEERS	<i>Pendidikan Kesehatan Reproduksi dan Sosial</i> (Reproductive Health and Social Education)
PLHIV	People living with HIV
PNAC	Philippine National AIDS Council
PROSTAR	<i>Program Remaja Sehat Tanpa AIDS</i> (Healthy Life Style Program for Youth Living Without AIDS)
SAEP	School-Based HIV and AIDS Preventive Education Programme
SAQMEQ	The Southern and Eastern Africa Consortium for Monitoring Educational Quality
SHNC	School Health and Nutrition Center
SRA	Situation-Response Analysis
STI	Sexually Transmitted Infection

SWOT	Strengths, Weaknesses, Opportunities and Threats
TESDA	Technical Education and Skills Development Authority
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
WAD	World AIDS Day
YDI	Youth Development Index

Executive Summary

1. Purpose of this synthesis report

This is a synthesis of situation-response analyses (SRA) on the education sector response to HIV, drugs and sexual health undertaken in five countries: Brunei Darussalam (2012), Indonesia (2010), Malaysia (2012), the Philippines (2012) and Timor-Leste (2012). These were undertaken during the period 2010-2011 with support from UNESCO Jakarta (Regional Office for Science and Cluster Office for Education). The five SRAs were developed in close consultation with the Ministry of Education (MoE) of each country and in most cases have received official statements of endorsement from each respective ministry.

The objectives of this synthesis report are to:

- Provide an overview of the current state of HIV and AIDS, drugs and sexual health activities in the education sector in the five countries;
- Identify the policies, programmes and resources for HIV and AIDS, drugs and sexual health education that are missing or weak in the education sector;
- Provide evidence-based information for future education sector HIV and AIDS, drugs and sexual health education planning and prioritisation; and
- Make recommendations on where to properly allocate resources to support the missing or weak responses.

The five SRAs used broadly similar methodologies to review education sector policies, strategies, capacities and programmes in the area of HIV, drugs and sexual health education. The methods included desk research, curriculum review, interviews with key informants and focus group discussions. The Philippines SRA also included a knowledge and attitude test and SWOT analysis.

2. Brief overview of the five countries

While all five countries in this study are located within insular South East Asia, there are significant differences among them in terms of their history, population, economy and education systems. Brunei Darussalam and Timor-Leste are both small states with estimated populations of 400,000 (2009) and 1,066,582 (2010) respectively. The former has one of the highest GDP per capita in Asia, accruing mainly from oil and gas production and the latter is among the lowest. Indonesia has the largest population estimated at around 245 million (2011). It is a vast country with significant natural resources. The Philippines also has large and ethnically diverse population at an estimated 92 million people (2010) with 87 languages spoken. It has significant natural resources including minerals. Malaysia is a middle-income country with an emerging multi-sector economy and an estimated population of nearly 29 million (2011). It also has significant natural resources including oil and gas.

The differences in the five countries in development, governance and scale makes comparison difficult. Brunei Darussalam is categorised by UNDP (2011) as having *very high human development* status, Malaysia with *high human development*, Indonesia and the Philippines with *medium human development* and Timor-Leste with *low human development*. One cultural factor they all have in common is the importance of religion in society, whether Christianity or Islam (or both), and this has a strong bearing on both the situations and the responses to HIV, sexual health and drugs.

3. The Five SRAs

The five SRAs differed in several ways. Brunei Darussalam was the only MoE that undertook the analysis itself. The range of participation was variable. The Indonesia and Philippines SRAs were the most participatory in approach. The depth of the analysis varied. Since all SRAs relied heavily on desk research, the quantity and quality of available literature and data was a critical issue. Some countries have invested more than others in strategic information for HIV and related issues and this results in better quality data being available for SRAs. Indonesia, for example, has good data on young people.

There were limitations noted in each SRA. In the case of Brunei Darussalam, this was a new way of working and presented challenges in terms of obtaining feedback from stakeholders and data gaps. In Malaysia not all the identified key stakeholders were available for consultation. Detailed information on HIV at State (sub-national level) was not available. In the Philippines knowledge and attitude tests undertaken involved a small sample size and statistically valid comparative analyses between genders and among age groups cannot be made. The findings from the four study sites with the highest number of HIV cases cannot be generalised to the national level. The Timor-Leste SRA was limited in terms of time constraints and logistical limitations. It was not possible to make site visits outside of Dili.

4. Situations of HIV, drugs and sexual health

While the HIV epidemics vary considerably from country to country and even within the larger countries, the five countries all share the characteristics of Asian epidemics identified by the Commission on AIDS in Asia (2008) in that the HIV epidemics occur primarily in key affected populations: sex workers and their clients/partners, men who have sex with men (MSM) and people who inject drugs. Sex work is central to the epidemics (UNAIDS, 2010). However, MSM have high rates of HIV prevalence in Indonesia and the Philippines. Injecting drug use was fuelling the epidemic in Indonesia earlier in the epidemic, while now heterosexual sex is the primary mode of transmission. Transgender people have high rates of HIV infection in Indonesia. In other countries data on transgender people is not widely collected. Along with people living with HIV (PLHIV), transgender people often face stigma and discrimination, which impede the effectiveness of prevention efforts. The majority of PLHIV in the five countries are men, but women as partners of injecting drug users, clients of sex workers and some MSM are likely to account for a growing proportion of HIV infections.

Patterns of the epidemic vary between and within countries. HIV prevalence across the countries is either *low* (Brunei Darussalam, the Philippines and Timor-Leste) or *concentrated* (Indonesia and Malaysia). No country has a generalised epidemic, although the Papuan provinces in Indonesia are experiencing this with an estimated HIV prevalence rate of 2.4% (2009). The lowest HIV prevalence rate is in Brunei Darussalam. While the epidemic is stable in Malaysia, HIV prevalence is increasing in the Philippines. Across the five countries around 450,000 people are estimated to be living with HIV (2009) with the largest number in Indonesia and Malaysia.

Each of the five countries in this synthesis study has taken steps to obtain strategic information so as to better understand the specific nature of the HIV epidemic primarily for the purpose of planning an effective national response. There is a predictably strong emphasis on key affected populations (MSM, sex workers, people who inject drugs, and transgender people). Most of the countries have undertaken research on the vulnerability and risk factors among young people concerning HIV,

sexual health and drug use. While, the quantity and quality of this research varies considerably, there is sufficient information to identify key issues concerning the situation of young people and to plan appropriate programmatic responses. Many of these countries have also had challenges collecting data from young people among key populations and there appears to be a gap in knowledge with much of what we know coming from broad-based 'general youth' surveys. It is therefore important to continue investing in research in this area.

Levels of awareness of HIV tend to be high, but comprehensive knowledge is less common. Misconceptions about HIV persist including myths about transmission through sharing cups and handshaking. Levels of HIV knowledge correlate with higher levels of education in Timor-Leste (DHS-2010) and are higher among men than women.

The factors that affect vulnerability and risk to HIV, sexual health problems and drug use vary considerably across the five countries. They are broadly consistent with international research findings concerning sex, drugs and young people. The factors, which provide an agenda for strengthening HIV, sexual health and drugs education, include the following:

- Presence of stigma and discrimination;
- Limited access to information and services for young people, especially females;
- School dropout;
- Gender-based violence;
- Early initiation of injecting drug use;
- Access to pornography on-line;
- Family problems;
- Early initiation in sex work (especially in the Philippines);
- Lower levels of HIV knowledge in rural areas;
- Prevalence of misconceptions about HIV and AIDS;
- Low levels of comprehensive HIV knowledge among young people; and
- Changes in culture and sexuality and increasing sexual activity among young people.

Sexual health issues are more complex. Data on young people and their sexuality are limited in the five countries. Even in Brunei Darussalam with its very low HIV prevalence, sexually transmitted infections are up to 10 times more common which is indicative of risk-taking behaviours. In Indonesia, some children begin sexual experience as early as 13 years of age and drug taking can also start at a similar age. Adolescent cultures in Malaysia are changing and dating is becoming an accepted norm among teenagers, though sexual debut takes place on average at age 19.

Drug use is an issue in all of the countries especially when alcohol consumption is included. In Brunei Darussalam, drug use is very uncommon. New threats are evidenced across the region particularly exposure to pornography through the Internet.

Continuing participation in education through secondary level is known to be broadly protective for adolescents and this applies to HIV and other STIs. Here the picture is mixed and in most of the countries there is more to be done to boost school survival. Brunei Darussalam has high levels of participation in secondary education. Indonesia has a significant number of children who drop out of junior and secondary school.

The Philippines has a low survival rate in secondary education. Timor-Leste has yet to achieve universal primary education.

Religion plays an important role in the lives of most people in the five countries and religious values are important in constraining risk behaviour as well as conditioning what is possible and desirable as a policy response. In these contexts, however, those most affected by the epidemic including MSM, transgender people, people injecting drugs, transgender people, and people living with HIV may be stigmatised as morally unacceptable.

5. The Response

5.1 National Responses

All five countries in this study have put in place national responses to HIV and AIDS as well as national responses to drug abuse. These responses, while ostensibly multi-sectoral, are dominated by the health sector, a trend that has been strengthened by steps to expand access to treatment and care. The focus of HIV prevention efforts has generally been to provide targeted services to key affected populations. The education sector response as a component of the multi-sectoral HIV strategy has become a lower priority as the general population is considered to be at low risk or in the case of children at school, no risk.

In Brunei, the emphasis is on health promotion and the achievement of a healthy lifestyle. Interventions to prevent HIV, other STIs, unwanted pregnancy and drug abuse are delivered through both Government and NGO programmes. There are strong penalties under the law (civil and Shari'a law) for drug consumption and supply as well as for sexual crimes (e.g. close proximity and forbidden sexual intercourse). Indonesia has focused on HIV prevention and Behaviour Change Communication (BCC) with key affected populations in successive National HIV/AIDS Plans. Harm reduction programmes have been introduced for people who inject drugs, but there is little evidence that these programmes are reaching young people due to constraints such as parental consent, and stigmatizing attitudes among service providers. Malaysia has a similar approach though there appears to be a stronger emphasis on meeting the needs of HIV-infected and affected children in the National HIV/AIDS Plan. The Philippines also now focuses on BCC for key affected populations, but in the previous plan (2005-2010) had included strategies for children in school. Timor-Leste similarly prioritises key affected populations in its National HIV and AIDS Plan.

It is very clear that the education sector response to HIV is becoming a lower priority in National HIV and AIDS Plans in the five countries. This is in line with the recommendations of the Commission on AIDS in Asia. However, this strategic approach risks neglecting the needs of young people in terms of the knowledge and skills they will need to become healthy adults. As is evidenced in the situation analyses in the previous section, young people do need education about sexual health, drugs and HIV/STIs. In order to provide an enabling environment for preventing HIV and drug abuse, it is important to have an educated population, one that does not hold misconceptions or is discriminatory towards PLHIV and key affected populations. This is where education can play an important complementary role with health sector interventions.

5.2 Education Sector Responses

Education sector responses to HIV, sexual health and drugs vary across the five countries. The country responses are summarised in terms of the important

components of an education sector response.

5.2.1 Policy and strategy

The countries have put in place a variety of policy responses for HIV, drugs and sexuality education. Only Indonesia has a specific education sector policy or strategy on HIV, sexual health and drugs education. It also appears that some countries lack specific policies on school health (e.g. Timor-Leste). The Philippines has a national law on HIV prevention which prescribes policy for education (Republic Act 8504, 1998), including the specification of curriculum content. In practice, the curriculum is the main policy document on HIV, sexual health and drugs. Only Indonesia includes a strategy for HIV and drugs education in its Education Sector Strategy. No country has a time-bound and costed sector-specific strategy for developing HIV and drugs education or school health.

Indonesia has put in place policy through the *HIV/AIDS Prevention Strategy through Education* to integrate HIV into school curricula and guide how teachers should be informed and trained to carry out the mandate. Although this policy document was disseminated nationally, it appears to be neglected. The SRA found that many in the field were unaware of it. In 2008 MoEC Decree No. 39 on *Guidance and Supervision of Student Activities (Pembinaan Kesiswaan)* was enacted in which HIV and Drug Abuse prevention are mandatory activities. In the current Education Sector Plan (2010-2014), life skills education is the strategy for preventing HIV and drug abuse.

The Philippines has had national legislation in place on HIV education since 1998 that mandates the education sector to integrate HIV preventive education in formal and non-formal education from the elementary through the tertiary level and in technical education. However, the law has not been well-disseminated and implementation is not strong. This was also observed to be the case in Indonesia. In the Philippines, all schools have policies and rules on student discipline related to HIV, drugs and sexual health education, but not all have them printed in student handbooks for students and parents' information. They are discussed in the classroom and in Parent-Teachers Community Association meetings.

5.2.2 Managing the Response

Policies require implementation arrangements, including dissemination mechanisms, in order to be effective. This can require the establishment of specific institutional capacity to take this forward or adding the responsibility to existing arrangements. In large education systems, it is important to decentralise implementation to provincial or state levels. In all education systems, it is important to build implementation capacity in the school itself and in the community.

The five countries are implementing a range of management responses. In practice, the school health framework appears to be critical for implementation. In Brunei Darussalam, capacity to implement HIV and drugs education has been established in the Health Promotion Centre of the Ministry of Health (MoH) and in key NGOs (BDAC and BASMIDA). Indonesia had appointed a focal point for HIV in the Ministry of Nation Education (Director of the National Centre for Physical Quality Development), although this position is now dissolved and the government has decided to integrate the responsibility into several different directorates.

With the exception of the Papuan provinces, there has been limited capacity-building in Provincial Education Offices. Malaysia has not put in place any specific management arrangements for HIV and drugs education. The MoH is responsible for school health. The Philippines has established a complex set of arrangements for

coordination and management of the HIV response. This includes an Education Committee in the National AIDS Commission (PNAC), mainstreaming responsibilities in existing bodies such as Department of Education (DeEd), CHED and TESDA. The School Health and Nutrition Centre of DepEd plays the key coordination role as the focal point on HIV and AIDS. Timor-Leste has appointed a focal point for HIV who is also the School Health Coordinator within the National Directorate for Curriculum and Materials Evaluation. Otherwise management arrangements are recognised to be very limited.

5.2.3 The Curriculum

The strategy that has been adopted by the five countries is curriculum integration to enable teaching and learning to take place on HIV, sexual health and drugs. Content for these topics has been integrated into the curricula of all five countries. With the exception of Timor-Leste, which includes it in Science/Social Sciences at grade 6, HIV is generally introduced in secondary education. Often information about HIV is strongly bio-medical in approach and not related to actual contexts in which students live. HIV is included in Biology (Indonesia and Timor-Leste), Social Studies (Indonesia), Physical Education and Health (Indonesia, the Philippines, and Timor-Leste), Science (the Philippines) and Religion (Indonesia and Timor-Leste). Similarly sexuality issues including SRH are usually covered in Biology or Science during secondary education (e.g. Brunei Darussalam, Indonesia and Malaysia). Drugs education is included in secondary curriculum in subjects such as Physical Health (Brunei Darussalam and Malaysia), Biology and Science (Brunei Darussalam, Indonesia and Malaysia), Social Studies (Indonesia), Health and Values Education (the Philippines) and Religion (Brunei Darussalam, Indonesia and Malaysia). The link between injecting drug use and HIV is not always made (e.g. in Indonesian textbooks). Life-skills based HIV education is being introduced in Indonesia, Malaysia, the Philippines and Timor-Leste.

In general, curricular content on HIV tends to be superficial. Moreover, the integration of HIV, sexual health and drug issues in multiple subjects risks the fragmentation of learning and the loss of a logic model in prevention. In the Philippines, HIV education is not explicitly integrated in the basic curriculum, although there are many topics in different learning areas that relate indirectly to sexuality and HIV. Content on HIV may be incomplete and not comprehensive. For example in Indonesia most textbooks address how HIV is transmitted but do not include myths and misconceptions. Some content on HIV is prejudicial, for example HIV can be portrayed as an affliction of the promiscuous, perverted or deprived (as in some Indonesian textbooks). There are also inaccuracies in textbooks e.g. AIDS is a disorder of the circulatory system (the Philippines –subsequently revised).

HIV prevention methods including condoms are given limited attention (e.g. in Indonesia). Sexual abstinence is the preferred method until marriage in all five countries. With drug abuse education, methods of prevention and of helping students to deal with real life situations tend to be inadequate and/or lacking.

In Indonesia, HIV has been included in the school curricula in junior and senior secondary schools through the *minimum standard requirements of subject matter* known as KTSP 2006, providing guidelines for school textbook writers and teachers. But reference to KTSP 2006 in textbooks is not coherent, with varying quality.

Health education is an important vehicle for HIV, sexual health and drugs education. It is particularly important in Malaysia, the Philippines and Timor-Leste. In the Philippines, at the high school level, HIV education is integrated only in P.E. and Health. Brunei Darussalam emphasises the importance of moral and values education

through religious education and the Malay Islamic Monarchy syllabus. Across all five countries religious values are important in education and in HIV, drugs and sexual health education.

It was found that HIV, sexual and reproductive health, and drug abuse are subjects of interest to students in Indonesia and Malaysia. However, many students are not satisfied with what they learn from textbooks and they look for further information in popular media or cyberspace without supervision.

5.2.4 Co-curricular activities

Co-curricular activities can very usefully complement a curriculum-based approach. All five countries have some co- or extra-curricular activities that may be supported by NGOs or CBOs in some schools, which include HIV, sexual health and drugs education. There is a lack of data on the coverage of these programmes. These appear to be important in that they allow for a more participatory student-centred form of learning experience.

Brunei Darussalam provides a range of voluntary activities including a youth-led HIV awareness programme (*HAPPY*) and life skills programme (*LESTAR*). Peer education and life skills-based HIV education are implemented in Malaysia through the PROSTAR programme. Targeted activities are implemented in high-risk contexts for drug abuse through the Excellent Anti-Drug school initiative (*SEGAK*). Camps for life skills development are held in Malaysia for students who have been identified through random screening tests as taking drugs (*The Student Intervention Programme*). In the Philippines, attention is given to the annual World AIDS Day commemoration as a means of raising awareness.

A risk of reliance on NGO-implemented activities is that they can lead to a fragmented programme of learning activities that are disconnected from the curriculum. They can also fall outside any accountability framework in the school. It is important therefore that capacity is built in schools to ensure that such co-curricular activities are coordinated with the curriculum as far as possible.

5.2.5 Teacher training and classroom practice

Effective teachers are critically important to the success of school-based HIV, drugs and sexuality education. This entails the provision of quality teacher training, teaching and learning materials, guidance for teaching, professional supervision and support. It is clear that insufficient attention has been given in enabling teachers to be effective in the classroom with the curricula that have been developed.

The five countries have generally not developed specific teacher training curricula and materials for teachers in pre-service training for HIV, drugs and sexuality education. Such training as has been given tends to be delivered as in-service training and on an ad hoc basis. It appears that only limited numbers of teachers have received comprehensive in-service training in HIV, drugs and sexual health education subjects in an interesting and engaging manner. Brunei Darussalam has trained school counselors on HIV and related issues. In the Philippines, HIV education is included in the annual training of School Health personnel.

In general, there are few resources available for teachers. In Timor-Leste teaching and learning materials either for HIV, drugs or reproductive and sexual health are very limited. Teacher training materials have been developed in a number of countries. In Indonesia, the MoEC has been collaborating with UN Agencies (UNICEF, UNESCO and UNFPA) and NGOs in publishing teachers and training

manuals on sexual and reproductive health, HIV, and drug abuse. Due to lack of resources, however, distribution and utilisation of these materials are very limited.

Little is known about actual classroom practice. It is likely that some of the teaching is conducted in a didactic manner emphasising the mastery of facts rather than practicing skills and engaging in participatory learning activities. This is being addressed through various life skills-based education (LSBE) initiatives. Textbooks give little support to the teacher in developing creative teaching and learning strategies (e.g. Indonesia). Where the HIV, drugs and sexual health education is not compulsory, it risks not being taught by teachers who focus on the core curriculum (e.g. Malaysia). Other implementation problems that were reported by teachers in Malaysia include lack of time to deliver the curriculum; lack of adequate training on life skills /HIV education; confusion about differing guidance on HIV education and training is not compulsory. Limited training, guidance and materials are also issues in Timor-Leste.

In Indonesia, many education sector stakeholders mentioned difficulties in discussing sexual health with their children and students. They admitted to lacking adequate knowledge about HIV and AIDS and appropriate strategies in teaching HIV education. The SRA findings suggest that a lack of correct information about HIV might be common among teachers, parents and community leaders, as well. The findings likewise suggest that misleading information and unhealthy sexuality are being transmitted from stakeholders to students.

5.2.6 Supervision and support

There appears to be very limited professional supervision and support available to teachers who teach HIV, drugs and sexual health education. This is an area that needs further attention at school level in particular.

5.2.7 Learning outcomes

The most important result of HIV, sexual health and drugs education is the learning achieved, whether in terms of knowledge, values and attitudes or skills. Little is known about the learning outcomes of HIV, drugs and sexual health education in the five countries. It was not possible to undertake any assessment in the SRAs and this represents a very significant gap in our data. Little is known about assessment methods in the five countries in this area. In the Philippines, teachers make use of objective and subjective tests as well as alternative assessment tools to evaluate skills and values-based instruction on HIV, drugs and sexual health education. FGDs in Malaysia revealed that students had limited knowledge about HIV and other STIs.

5.2.8 Monitoring and evaluation

No country has put in place a specific M&E framework for HIV, drugs and sexual health education. The Philippines has a comprehensive National M&E framework for HIV and AIDS developed by the Philippine National AIDS Council as well as for drug education, formulated by the Dangerous Drugs Board, but none for sexual health education. Unfortunately, the structure to carry out M&E for HIV and AIDS is hampered by lack of funds.

6. Conclusions

All five countries are delivering HIV, drugs and sexual health education through the national curriculum and with co-curricular activities. As the Philippines SRA notes, there have been gains and there have been glitches. The curricular content has been

prepared in line with local culture and religious beliefs. Content is not comprehensive, nor does it closely match the sexual risk factors or reflect the everyday lives of the learner. It tends to be theoretical and bio-medical in nature. There is, therefore, scope for reform in order to bring the subject more alive for the learner and to make the content more comprehensive (e.g. to include more on means of prevention, access to services, treatment education etc).

All five countries place a strong emphasis on the importance of values in preventing HIV and drug abuse. This appears to be an important contribution to reducing risk behaviours. In the Philippines, the importance of the value of gender equality in practice in the classroom is mentioned as a positive factor by learners in FGDs. It is less clear that values and attitudes towards PLHIV and most at risk populations are being positively addressed.

Teachers need more support if they are to teach the curricula effectively. This involves the development of pre-service training, in-service training and supervision/support mechanisms at school level. There needs to be a stronger emphasis on building capacity at the school level. Importantly, there needs to be some attention to learning outcomes. The experience of The Southern and Eastern Africa Consortium for Monitoring Educational Quality (SAQMEQ) in southern Africa in developing a standardized regional HIV test in order to assess learning outcomes may be of interest to the five countries and to the Association of Southeast Asian Nations (ASEAN) generally.

School health arrangements appear to be critically important in implementing HIV, sexual health and drugs education. There seems to be a need to develop comprehensive school health policies to reflect this as well as strengthen school health implementing arrangements at central and decentralised levels down to the school. Such policies should be supported by the preparation of school health strategic plans for effective implementation. These would include a framework for M&E at school level.

Finally, each country appears to have developed its own response individually. There seems to have been little cross-country sharing and learning. This should be addressed.

7. Recommendations to countries and to UNESCO

7.1. The Situation

- a) Invest in obtaining better strategic information about adolescents/young people concerning sexual health, drug use and HIV risk and vulnerability
- b) Consider commissioning comprehensive studies on the Situation of Young People, which include comprehensive consultations with young people to better reflect their interests, assets, vulnerabilities/risks, needs and aspirations;
- c) Examine the documentary good practices concerning Situation Analyses of Young People e.g. Zambia and Viet Nam.

7.2. The Response

- d) Consider developing comprehensive school health policies and strategies in part to reflect current practices in HIV, drugs and sexual health education and in part to help strengthen the effectiveness of the implementation of current approaches. Existing policies should be reviewed as part of that process. Engage and consult with civil society, including parents and pupils. Clarify criteria and arrangements for NGOs

working with schools to develop a better enabling environment for effective programmes;

e) Strengthen management arrangements to implement policies on school health, HIV, sexual health and drugs education at central (e.g. a Task Force), decentralised and school/community levels. Strengthen community participation and parental education;

f) Strengthen curriculum development practices for HIV, sexual health and drugs education. Review current curricula in the light of the IATT criteria for effective curriculum-based HIV programmes, EDUCAIDS and UNESCO sexuality guidelines. Consider addressing issues of gender more centrally, including masculinities and GBV;

g) Strengthen curriculum implementation at school level through school-based management. Ensure that teachers in HIV, drugs and sexual health education are adequately trained, supervised and supported and that adequate teaching and learning resources are available in all schools;

h) Identify key gaps in current provision such as stigma and discrimination and address these in the curriculum and co-curricular activities;

i) Continue to strengthen values education ensuring that positive values are promoted concerning HIV prevention and PLHIV;

j) Focus more strongly on assessing learning outcomes in relation to HIV/SRH and drugs issues. Consider developing a standardized test for the five countries similar to that constructed by SAQMEQ in Southern Africa;

k) Promote cross-country learning across the five countries. Establish a network of School Health/Sexuality and Drugs Education focal points and create a website for the purpose of sharing information and promising or innovative practices;

l) Develop EDUCAIDS country snap shots of the HIV, drugs and sexual health and education responses for all five countries.

Main Report

A Situation Analysis of the Education Sector Response to HIV, Drugs and Sexual Health

Brunei Darussalam, Indonesia, Malaysia, the Philippines and Timor-Leste

Synthesis Report

Section 1. Introduction

1.1. Purpose

This is a synthesis of situation/response analyses (SRAs) on the education sector response to HIV, sexual health and drugs undertaken in five countries: Brunei Darussalam, Indonesia, Malaysia, the Philippines and Timor-Leste.

These SRAs were commissioned by the UNESCO Office, Jakarta through its Education Unit. They were funded under the UNAIDS Unified Budget and Work-Plan (UBW) and UNESCO Regular Programme Budget which covers all five of the cluster countries in the study.

UNESCO is the lead for UNAIDS for ensuring quality education for an effective AIDS response. As the convener of EDUCAIDS, the UNAIDS Global Initiative on Education and HIV & AIDS, UNESCO is working globally to support a comprehensive education sector response in collaboration with governments, National AIDS Commissions, UN and other development partners and civil society organizations.

This synthesis report aims to describe and analyse the situation regarding the status and scope of the education sector response to HIV, drugs and sexual health across the five countries. The information collected and reported is intended to provide an overall picture of the education sector response to these issues and inform how this can be further strengthened. The results of the study will support strengthening of coordination, implementation, M&E and scaling-up of education programmes. This report can be used as a background document for the development of medium-term strategic plans involving different sub-sectors and institutions of the education sector, UN agencies, NGOs and donor organizations.

The objectives of this synthesis are to:

- Provide an overview of the state of sexual health, drugs and HIV and AIDS activities in the education sector in the five countries;
- Identify the policies, programmes and resources for sexual health, drugs and HIV education that are missing or weak in the education sector;
- Provide evidence-based information for future education sector HIV and AIDS, drugs and sexual health education planning and prioritisation; and
- Make recommendations on where to properly allocate resources to support the missing or weak responses.

1.2. Methods

The five SRAs used broadly similar methodologies to review education sector policies, strategies, capacities and programmes in the area of HIV, sexual health and drugs education. The methods included desk research, interviews and focus group

discussions with key informants. This synthesis paper attempts to identify commonalities, differences and lessons learned. It has been prepared as desk based study and has not involved any additional research.

Section 2. The situation of HIV, drugs and sexual health

2.1 The Situation/Response Methodology

The **Situation Analysis** is a commonly used approach to provide strategic information for policy development and planning. A situation analysis has been an integral part of the national AIDS planning process guidance provided by UNAIDS (1999). Typically, this analysis has looked specifically at the factors that favour or impede HIV transmission and the factors that favour or impede treatment and care for those living with HIV and for their families. Coupled with this, countries have undertaken a **Response Analysis**, in which assessments of all of the relevant interventions in a priority area, not just those that are part of the official national programme, are made. This includes community-organised activities and those organized by private companies, academic organizations, and NGOs that contribute to the national response. On the basis of the findings of these linked **Situation/Response Analyses** (SRAs), the formulation of a strategic planning process deals with the question of what should be done about the HIV situation in the country in the future.

The SRA approach has been introduced in the context of the education sector response to HIV and AIDS, but is not yet a mainstream practice. One of the earliest such SRAs was undertaken in Jamaica in 2006 and an analytical framework was developed specifically for the education sector (Clarke, 2010a). In Asia, SRAs have already been conducted in Cambodia (MoEYS, 2007) and Nepal (MoE, 2009) in HIV education and school health. Clarke, 2010b). SRAs have typically investigated the situation of children/young people in terms of their vulnerability and risk to HIV and the adequacy of the education sector response regarding preventive education and the mitigation of the impact of HIV and AIDS, including addressing stigma and discrimination. This usually includes an assessment of the drugs and sexuality issues, often with a strong focus on sexual and reproductive health (SRH). Some SRAs, notably those in the Caribbean region (e.g. Guyana and St Lucia) have broadened their scope to assess school health issues more generally.

Some countries in the region have undertaken wider-ranging situation analyses of the situation of adolescents/young people/youth e.g India (2006), Nepal (2009) and Viet Nam (2003) (Clarke, 2010b). These have multi-sectoral applications and thus extend in scope beyond the compass of the education sector response.

Process in the SRA approach is as important as the ultimate product - the report of findings. A participatory approach helps to promote stakeholder involvement, provide voice for excluded populations and enable dialogue on technical issues. Ideally, the approach should involve the meaningful participation of those most at risk and affected, especially people living with HIV. Given the range and diversity of stakeholders, a fully inclusive approach necessitates the investment of time and resources, both human and financial. Education sector SRAs have tended to vary in terms of the extent to which stakeholder participation is factored into the process. To proceed with limited resources, some have involved the use of rapid assessment techniques. In all cases, the SRAs provide snapshots of HIV and related issues at a particular point in time. It is therefore necessary to revisit these on a periodical basis, in line with the planning cycle, to review and update them.

Finally, the use in planning and policy development of the completed SRA is the acid test of the effectiveness of the process. In Cambodia, as well as in Guyana and Jamaica, the SRA was used to inform the development of a medium-term strategic plan for the education sector on HIV/school health. In Nepal, work has been recently undertaken to prepare such a plan.

2.2 Introduction to the five SRAs

2.2.1 Brunei Darussalam

The Brunei Darussalam SRA was carried out by the Ministry of Education (MoE) by a team from the Curriculum Development Department. The methodology was primarily desk-based, although some key informant interviews were undertaken with the stakeholders from the Ministry of Health (MoH) and the Brunei Darussalam AIDS Council (BDAC). It represents the first national review of the education sector response on HIV, drugs and sexual health issues.

2.2.2 Indonesia

The Indonesia SRA was prepared by the AIDS Research Centre, Atma Jaya Catholic University. The methodology involved desk research and some primary data from field visits to four provinces. A number of key informant interviews and focus group discussions were held with policy makers at the Ministry of National Education and Culture (formerly the Ministry of National Education), NGOs, school principals and teachers, and secondary school students. The SRA focused on Jakarta, Maluku, Papua, the Riau Islands and West Kalimantan. The Indonesia SRA was the first to be undertaken (2010) and it provided the model for the other four SRAs in this study.

2.2.3 Malaysia

The Malaysia SRA was prepared by an independent consultant in collaboration with the Ministry of Education (MoE). The methodology included a combination of desk reviews, key informant interviews and focus group discussions. Participating stakeholders included school principals, guidance counselors, health education teachers and students from government schools. Visits were undertaken in Kuala Lumpur and Selangor State.

2.2.4 The Philippines

The Philippines SRA was prepared by a team from the University of the East in collaboration with the Department of Education (DepEd). Data for the SRA were gathered through desk reviews, content analysis of curricula and textbooks, key informant interviews with education and health officials, knowledge and attitude tests, focus group discussions, and strengths-weaknesses-opportunities-threats (SWOT) analyses. Knowledge and attitude tests were administered to students and stakeholders in Manila, Cebu, Davao and Cavite before the FGD and SWOT analyses were conducted in each site. An official of the Department of Health (DOH) of Davao City, an official of the Bureau of Alternative Learning Systems (BALS) of the Department of Education (DepEd), and the members of the Education Committee of the Philippine National AIDS Council (PNAC) were interviewed.

2.2.5 Timor-Leste

The Timor-Leste SRA was prepared by an independent consultant in collaboration with the Ministry of Education (MoE). The methodology was primarily desk research,

although key informant interviews were undertaken with MoE staff, school principals, Ministry of Health, UN agencies, NGOs, Faith-Based Organisations (FBOs) and the National AIDS Commission. School visits were made in the capital city of Dili.

2.2.6 Observations

The five SRAs differed in several ways. Brunei Darussalam was the only MoE that undertook the analysis itself. The range of participation was variable. The Philippines SRA was arguably the most participatory in approach. The depth of the analysis varied. Since all SRAs relied heavily on desk research, the quantity and quality of available literature and data were critical issues. Some countries have invested more than others in strategic information for HIV and related issues and this results in better quality data being available for SRAs. Indonesia, for example, has good data on young people.

There were limitations noted in each SRA. In the case of Brunei Darussalam, this was a new way of working and presented challenges in terms of obtaining feedback from stakeholders and data gaps. In Malaysia not all the identified key stakeholders were available for consultation. The self-assessment process can also be seen as a limitation in that critical analysis is less likely. Detailed information on HIV at State (sub-national level) was not available. In the Philippines, attitude tests undertaken involved a small sample size and statistically valid comparative analyses between genders, and among age groups cannot be made. The findings from the four study sites cannot be generalised to the national level. The Timor-Leste SRA was limited in terms of time constraints and logistical limitations. It was not possible to make site visits outside of Dili.

The situation analysis component from the five country SRAs is summarised below.

2.3. The Situation in Brunei Darussalam

2.3.1 HIV in Brunei Darussalam: low HIV prevalence

Brunei Darussalam has very low HIV prevalence. The first case was reported in 1986. In the period to December 2011, there has been a total of 72 reported cases (UNGASS 2012 country report). These have been found predominantly among men. There are 49 persons known to be living with HIV in the country.

The most common mode of HIV transmission is through sexual intercourse and largely heterosexual, but some involving men who have sex with men. The latter are a difficult group to target as consenting same-sex relations are illegal and there are no formalised groups or associations that deal specifically with MSM issues.

The highest number of recorded HIV cases was in 2009 (11 cases); in 2010, the number was only five cases. The first HIV-related death was reported in January 1990 and the latest occurred in 2010. Eight cases of mother-to-child transmission have been recorded.

The number of other STI cases is approximately 7 to 10 times higher, which indicates the existence of unprotected sex (UNGASS 2010 country report). In 2009, there were 592 STI cases reported (444 Gonorrhoea cases, 84 Chlamydia cases and 64 Syphilis cases). However, there was a drop in the total number of STI cases from 592 in 2009 to 348 in 2010. According to the Ministry of Health (MoH) Disease Control Division (2010), in 2009, out of 592 cases of STIs, 386 (65%) were among those aged 11 to 30 years.

2.3.2 Young People and Vulnerability

Limited data on young people and sexuality

There has been very limited assessment of the sexual health and drug education needs of young people. The Youth Development Index (YDI), which was carried out in 2008 among young persons aged 15-30 years. This gives an indication of the level of performance on a self-report basis in eight domains including: *Health, Self-Development, Leisure Activities, Values and Identity, Self-Potential, Multimedia Exposure, Community Integration* and *Social Issues*.

In terms of *Health*, the respondents' self-reported assessments scored 86.8 per cent i.e. 'very good' level ('Physical Health' 94.6 per cent and 'Healthy Lifestyle', 79 per cent). The *Physical Health* sub-domain measures the absence of obesity, asthma, diabetes, cancer, high blood-pressure, kidney problems, STIs and mental health problems. So overall, according to this measure, the youth participating in this study believe that they are physically healthy.

In terms of *Self-Development*, youth reported themselves to be 60 per cent or above in most of the sub-domains. However, the 'no depression' sub-domain (52.7 per cent) and 'self-control' sub-domain (50.6 per cent), received lower scores. These figures could indicate a challenge to overcome depression as well as to exercise self-control when faced by pressure to smoke cigarettes, consume alcohol, engage in risky sexual behavior or use illicit drugs. In the domain of *Values and Identity*, the respondents scored 71.1 per cent. They scored the highest in the sub-domain of 'Islam' (74.5 per cent), which indicates the importance of religious values in this context.

Finally, the *Social Issues* domain looks into (i) 'No Truancy and Loitering', (ii) 'No Sexual Problems', (iii) 'No Bullying, Violence & Discrimination', (iv) 'No Alcohol & Drugs', (v) 'No Crime and Vandalism', and (vi) 'No Poverty' as indicators. The general score for this domain is 86.8 per cent, which is rated 'very high'. For 'No Sexual Problems', the score is 97.1 cent and for 'No Alcohol and Drugs', the score is 92.6 per cent. These results suggest that youth perceive themselves to be sexually conservative (e.g. waiting until marriage). It also appears to indicate that alcohol consumption and drug use are not common among youth.

Low vulnerability, but some risk factors

The available data indicate a likely low vulnerability of young people to issues relating to HIV, drugs and sexual health issues. Despite this, there is a need to take action. According to MoH, there are factors that contribute towards increasing vulnerability and risk. Firstly, not all young people are aware of HIV and its modes of transmission. Increasingly access to surrounding countries in South East Asia with higher HIV prevalence rates could increase the potential for HIV exposure by those undertaking risk behaviours. Secondly, the increasing number of detected STI cases among young people is of concern. There is evidence that individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV infection through sexual transmission. Thirdly, the unmarried teenage pregnancy cases exceeds 100 annually, which is quite significant with regards to the total population of this small country and indicates unprotected sex.

2.4 Indonesia

2.4.1 HIV in Indonesia: a concentrated epidemic

Indonesia is currently facing a concentrated, but growing HIV epidemic. In most provinces, the epidemic is concentrated within key populations such as female sex workers (10.4 per cent), clients of sex workers (0.8 per cent), trans-gender people (24.4 per cent), MSM (5.2 per cent), and people who inject drugs (52.4 per cent). It is estimated that approximately 3.1 to 3.6 million Indonesians or 1.5 per cent of the population are using drugs. Most are multi-drug users and 27 per cent are estimated to be addicted to drugs. Among them, 7 per cent or approximately 200,000 are injecting drug (heroin) users. Most infections largely occur through unsafe injecting drugs and heterosexual transmission. This reflects the underlying factors which are shared by other countries in Asia and the Pacific region, i.e. sexually active young and older males who are engaged in commercial sex, low condom use, and growing numbers of sexually active people injecting drugs who are also engaged in commercial sex.

Annual reported cases of HIV clearly indicate that most infections occur within the 20-40 age-group. The estimated HIV national prevalence in 2009 among the 15-49 age group was 0.2 per cent (0.1 per cent - 0.3 per cent). In the Provinces of Papua and West Papua, HIV prevalence has increased to 2.4 per cent among the general population between ages 15-49 years old, and considerably higher amongst the indigenous Papuans in the highlands. The current HIV situation there is serious, having spread to the general population and driven almost exclusively by unsafe sexual intercourse.

Despite 20 years of increasingly concerted effort, largely downstream, to prevent the spread of the epidemic, the number of new cases of HIV infection continues to rise. By the end of 2009, it was estimated that 333,200 people were living with HIV. The number of reported cumulative cases had risen sharply from 2,682 cases in 2004 to 19,973 by December 2009. The majority of HIV infections are among men (75 per cent) and 25 per cent are among women.

2.4.2 Young people and vulnerability

Early initiation in risk behaviours

HIV infection among young people may be growing as rapidly as infections among adults. Some risky behaviours, especially injecting drug use, begin at a young age. The IBBS (Integrated Bio-Behavioral Survey, 2007) among most at risk groups found that the first time that respondents engaged in risky behavior, including unsafe heroin injection and unsafe sex, was around 13 to 20 years old. This study confirms earlier findings by the Center for Health Research, University of Indonesia that high-risk sex was initiated as early as 13-14 years old (MoH & WHO, 2003). A study by FHI and the Atma Jaya Catholic University HIV and AIDS Research Center (2010), found that initiation in illicit injecting drug use including heroin was between the ages 13 to 16 years old.

Vulnerability as a result of school dropout

Adolescents who are not in school tend to be at greater risk than those who remain in education. The number of school-aged children (5-19 years old) in the country is 62.7 million (BPS– SUPAS, 2007). Unfortunately, not all are in school. According to the National Socio-economic Survey 2006 (Susenas, 2006), the net participation rate

in elementary school was 93.5 per cent, junior secondary school was 66.52 per cent, and senior secondary school was 43.8 per cent. Poverty is attributed as the major cause of dropout.

Barriers to information and services

Adolescents and young people, especially females, face continuing legal and cultural barriers to accurate and appropriate information on sex, sexuality, contraception or birth control technology and safe abortion. They also face continuing cultural and institutional barriers to STI treatment and consultation. Family planning services are restricted to legally married couples (BKKBN and WHO, 2004). Recently Law No. 52/2009 on Population Development and Development of the Family was enacted to substitute Law No. 10/1992. Article 5 of this new law assures that every citizen has the right to obtain information and get education related to his/her reproductive rights. In Chapter 2, articles 20 to 29 states that the government is responsible for providing information, services, and technology for family planning including IEC materials on reproductive health for (prospective) married couples and adolescents.

2.5. Malaysia

2.5.1 HIV in Malaysia: a concentrated epidemic

Malaysia is experiencing a concentrated HIV epidemic with HIV prevalence estimated at 0.5 per cent of the adult population (15-49 years). The first case of HIV was detected in 1986. As of 2009, 87,710 cases have been reported. It is estimated that 105,471 people are currently living with HIV (MoH, 2010). The majority (90.8 per cent) of cumulative HIV cases are reported among men while less than 9.2 per cent of this total are women and girls. Children aged 13 and below accounted for 1.0 per cent of cumulative total of HIV infections. 35.9 per cent of reported infections are among youth population aged between 20-39 years old who inject drugs. The annual number of reported new HIV cases has declined from a peak of 7,000 in 2002.

HIV remains a notifiable disease under the Prevention and Control of Infectious Diseases Act of 1988 (Act 342). Screening for HIV is conducted throughout the country via a number of national health programmes. As far as possible, the MoH has tried to encourage the adoption of a voluntary, ethical and internationally acceptable approach to HIV screening such as Provider-Initiated Testing and Counselling.

The scale of STI infection is considered to be very much under-represented (MoH, 2010). This is due to under-reporting and under diagnosis, asymptomatic manifestation of STIs as well as patients preferring to access the private healthcare facilities to treat STIs rather than in public hospitals and clinics. Some also prefer to self-treat through alternative medicine. Despite the existence of the Prevention and Control of Infectious Diseases Act of 1988, which requires reporting of incidences of syphilis, gonorrhoea, chancroid and HIV, most cases of STIs are not reported by private practitioners.

2.5.2 Drug use and marginalised youth

It is reported that drug use continues to occur particularly amongst the socio-economically marginalized sections of society and amongst students and youth. The National Drug Agency reports that more than 300,000 drug users were detected between 1988 and 2008: 12,352 drug users were detected between January and

December 2008, 6,413 of whom were repeat offenders. The majority of drug users are male (98 per cent). It is speculated that for every identified drug user, there may be as many as 3 to 4 users who have eluded detection and arrest.

The age breakdown amongst teens and youth detected in drug use in 2008 are: 13 – 18 years old (account for 2 per cent); 19 – 24 years old (17 per cent); 25 – 29 years old (20 per cent). 55 per cent of cases detected used drugs as a result of peer influence, while 21 per cent used drugs for fun. Another 15 per cent of users were curious about drugs. Heroin is the most commonly used drug in Malaysia at 40 per cent, while users of Amphetamine-Type Stimulants (ATS) account for 14 per cent of total detected cases in 2008. Injecting drug use is also found among transgender people, with a recent study finding that 3.1 per cent of transgender respondents had injected drugs in the previous year.

Most HIV infections have been found among methadone maintenance therapy clients. ATS use is reported to be on the increase. Methamphetamine is available in crystalline and tablet form. The potential for further spread of HIV may occur by injecting of ATS, although there is limited information on ATS use in Malaysia. The overlap between injecting drug use and sex work is of concern for HIV transmission, with people who use drugs reporting buying and selling sex, and sex workers engaging in drug use. This can have a significant impact on the course of the HIV epidemic in the country. Once HIV is firmly established in injecting drug use and sex work populations, transmission to sexual partners is bound to occur. Though nine out of ten HIV infections are among men, the proportion of new infections among women continues to grow.

2.5.3 Young people and vulnerability

Social change and sexuality

The process of rapid economic development, which has seen increases in urbanisation and industrialisation, has increased the challenges facing adolescents. Social change has occurred as result of increased affluence, erosion of community influence and globalisation, which has increased access to international media, including sexual and violent content. Stresses have been experienced in the family with family breakdown on the increase. The need to improve parenting practices has been identified as a social policy issue (MoH, 2007). Peer pressure on adolescents is a social factor, associated with risk behaviours, that needs to be addressed. It can be harnessed for more positive development outcomes.

There has been very little research on adolescence and sexuality development in Malaysia. This represents a critical gap in social policy data and analytic work. The most recent situation assessment of youth in was carried out in 2002 (UNESCAP, 2002). The main findings included that dating is an accepted norm among teenagers, but only 1 per cent of those surveyed admitted to ever having sexual intercourse. The Durex Sex Survey and the National Population and Family Development Board's Adolescent Sexual Reproductive Health (2003) reported increased numbers of young people engaging in sexual intercourse before the age of 18.

Stigma and discrimination

Various surveys have shown a relatively high level of knowledge on HIV and its modes of transmission among Malaysians, but misconceptions and stigma remain pervasive (UNESCAP, 2006).

Limited access to information and services

The fact that HIV is relatively confined to selected high-risk groups fosters a widespread perception among Malaysians that they are not at risk as long as they and their partners are not under those high-risk categories, even if they have multiple partners.

Most young people are not provided with information, counselling or support when they experience stress owing to biological changes that affect their behaviour, attitude, personality and lifestyle. Parents are often unprepared or unable to give sufficient advice and reassurance to their children or are reluctant to discuss the issues. Therefore, youth often share experiences of biological changes and sexual relationships among themselves.

Exposure to pornography

A situation assessment (UNESCP 2002) found that over two-thirds of youth aged 13 to 19 years had at least some exposure to materials such as magazines, films and videos containing explicit or implied sexual connotations.

Experimentation with substance abuse

The UNESCAP situation assessment (2002) found substance abuse in various forms like smoking, glue-sniffing and ingesting cough medicines were reported by respondents as common.

Family problems

The UNESCAP situation assessment (2002) found that loitering or “lepak” was reported by adolescents to occur when the home environment was dull or unhappy, or if there is parental neglect or bad relations between the parents and the children.

Gender-based violence

Gender based violence (GBV) among adolescents, particularly girls has been identified as a neglected policy issue (MoH, 2007). Data are weak, and GBV is believed to be largely underreported. National prevalence data on violence against women (VAW) are unavailable (UNFPA, 2010).

2.6 The Philippines

2.6.1 HIV in the Philippines: low but rising HIV prevalence

The Philippines has low HIV prevalence, with reported HIV cases below 0.1 per cent of the population. Some 8,700 people are estimated to be living with HIV (2009). However, there is little room for complacency. The 2010 UNAIDS Global AIDS Report indicates that the Philippines was one of 60 countries worldwide with increasing HIV incidence of more than 25 per cent between 2001 and 2009. Of the 7,031 total HIV cases reported from 1984–2011, 80 per cent (5,643) were male and 20 per cent (1,377) were female. The age groups with the most number of cases were: 25-29 (26 per cent), 15-24 (21 per cent) and 30-34 (19 per cent). Meanwhile, there has been a decline in the proportion of HIV cases for Overseas Filipino Workers (OFWs) compared to non-OFWs, from 45 per cent in 2005 to 12 per cent in 2011 (DoH-NEC, 2011). DoH data show that all 17 regions of the country have reported new HIV infections. Among the sites with testing hubs, the top three areas

logging the highest incidence of HIV were Metro Manila, Metro Cebu, and Metro Davao, all highly urbanised and densely populated areas (DoH, 2010).

Sexual transmission

Sexual transmission is the predominant cause of HIV infection. Cumulative data from 1984 to 2011 indicate that 91 per cent (6,379) of people living with HIV were infected through sexual contact, 0.8 per cent (54) through vertical transmission from mother to child, and 2.4 per cent (172) through injecting drug use. Other modes of transmission include exposure to infected blood/blood products (20) and needle stick injury (3). There were no data available for 403 reported cases. Of those infected through sexual contact, 42 per cent (2,660) were infected with HIV through heterosexual contact (DoH-NEC, June 2011). One in five of sexually active young males reporting having paid for sex while 12 per cent had accepted payment for sex. Less than one percent of the young females reporting having paid or been paid for sex. Among those who had engaged in paid sex, only 31 per cent reported having used a condom. Only 19 per cent of female sex workers had received an HIV test in the last 12 months, and knew the results (IHBSS, 2009).

Unsafe sex between men has been the predominant mode of HIV transmission through sexual contact since 2008, despite probable under-reporting of HIV cases because of stigma and discrimination. Thus, in 2009 IHBSS, only 7 per cent of MSM had received an HIV test in the last 12 months and knew the results. MSM are also likely to have one or more female sex partners, which can indicate the potential for transmission to broader sexual networks.

Drug use

Among people who reported using drugs, 10 per cent were injecting (Atienza, et al., 2007). In the 2009 IHBSS it was reported that only 11 per cent of people who use drugs and who also sell sex, and 22 per cent of people who use drugs who were clients of sex workers had used a condom the last time they had sex, while 85 per cent reported the use of sterile injecting equipment the last time they injected. Injecting drug use still remains uncommon with an estimated 0.03 per cent to 0.05 per cent who were drug users in the period 2009 to 2010 (PNAC, 2011). The reported proportion of HIV cases transmitted through injecting drug use since 1984 is 2.4 per cent (172 cases) and the estimated HIV prevalence among injecting drug users in Manila was 0.2 per cent in 2009 (UNAIDS, 2010).

2.6.2 Young People and Vulnerability.

Young key affected populations

Young key affected populations include sex workers and their clients, MSM, and people who inject drugs. Vulnerable groups include overseas Filipino workers (OFW), young people and children in difficult circumstances (i.e., out of school youth and street children) (PNAC, 2010; 2008). Among the key affected populations surveyed by the IHBSS in 2009, only 32 per cent correctly identified HIV prevention methods and rejected major misconceptions. Only 14 per cent had received an HIV test in 2009 and knew the results (PNAC, 2010). Key affected populations are predominantly young: 65 per cent of MSM, 62 per cent of female sex workers and 55 per cent of injecting drug users are 15-24 years of age (PNAC, 2011).

School dropout

Out-of-school youth (OSY) are vulnerable to HIV infection especially those who might sell sex or use drugs. There are no current data estimates on the OSY population, but the 2003 Functional Literacy, Education and Mass Media Survey (FLEMMS) placed the OSY population at 11.6 million (PNAC, 2008a). Consequently, a balanced development and implementation of programmes, and provision of funding for populations at higher risk of HIV infection through the initiatives of the PNAC and the CSOs and DepEd's Alternative Learning System for the OSY needs to be achieved.

Limited condom acceptability

The Philippines is a predominantly Catholic country and the use of condoms as a family planning and HIV prevention device is not acceptable to most Filipinos, although it is endorsed by the DoH and the PNAC as a contraceptive and for STI prevention, as well as allowed by the Muslim religious leaders in the Autonomous Region of Muslim Mindanao (ARMM) for family planning (USAID, n.d.). The prevalence of condom use as a contraceptive was at 1.6 per cent in 2006, which had declined from 2.1 per cent in 2004 (NSCB, 2006). There are no available data indicating the prevalence of condom use by the general population for STI prevention. For sex workers, the 2009 IHBSS found that condom use with their most recent clients was at 65 per cent for females and 30 per cent for males; and 32 per cent for MSM the last time they had anal sex.

Early initiation in risk behaviours

Risky behaviours among the youth aged 15-24 years include early sexual initiation, unprotected sex, having multiple sexual partners, paying for and/or engaging in paid sex. The 2009 IHBSS reported that the initiation to sex and drug use among youth takes place between the ages of 14-19 years. However, the National Demographic Health Survey found that only 2 per cent of young women reported that they had experienced sexual intercourse before the age of 15. Among young workers, risky sexual behavior (e.g., early sex, unprotected sex with multiple sex partners and casual sex) is high, slightly higher among call centre workers (40 per cent vs. 27 per cent) and is more pronounced among MSM for call centres in Metro Manila and Metro Cebu (UPPI, 2010). Risky behaviours among call centre employees have been a cause of concern as youth account for the majority of the employees, many of whom are either young graduates or still studying.

Low uptake of services

Raymundo (2002) found that 25 per cent of young females and 29 per cent of young males experienced health problems and symptoms, such as painful urination and abnormal vaginal/penile discharges, including warts or ulcers on the penis. In spite of this, only 18 per cent of young females and 21 per cent of young males had sought medical help for their problems. In 2008 the National Demographic Health Survey (as cited in PNAC, 2010) reported that among women aged 15-49, only 0.07 per cent were tested for HIV and knew the results.

Lack of information and misconceptions about AIDS

In spite of the many HIV information campaigns, there is a lack of information and misconceptions persist among young people. The Young Adult Fertility and Sexuality Study (Raymundo, 2002) reported that most (60 per cent) young people aged 15-27 believed that there was no way for them to contract HIV. Similarly, although

awareness and knowledge of HIV prevention and transmission was high among young workers, very few felt that they were at risk of HIV infection (UPPI, 2010).

Among the young women aged 15-24 surveyed by the NDHS in 2008 only 20.7 per cent correctly identified HIV prevention methods and rejected major misconceptions, while only 32 per cent of key affected populations correctly identified HIV prevention methods and rejected major misconceptions. Similarly, only 19 per cent of women aged 15-19 and 23 per cent aged 20-24 had comprehensive knowledge of HIV.

Results of the knowledge test in this SRA indicate that most students (63.04 per cent) have basic information about HIV and AIDS i.e. they know that sexual contact and injecting drug use are among the modes of transmission of HIV and that having multiple sex partners and the sharing of needles and syringes among drug users increase the risks of getting the infection. However, the findings yielded misconceptions about HIV. For example, some were unsure about whether healthy people could get infected with the disease (28.8 per cent). A third of the students also thought that they might be able to tell if a person is HIV-positive through physical appearance (i.e., weak or sickly); 14.6 per cent of the students believed that HIV could be transmitted through talking and 22 per cent were unsure. They were also uncertain about whether hugging or shaking hands with HIV-positive persons could transmit the disease (31.7 per cent). The percentage of students who were uncertain and who believed that HIV could be transmitted by drinking and eating from cups and plates of HIV-infected persons was 31.7 per cent.

Stigma and discriminatory attitudes

The perceived contagiousness of the disease identified in the knowledge test can help explain some of the attitudes or uncertainty about people infected with HIV; that family members infected with HIV should live separately from their families; that students infected with HIV should be isolated, that students whose parents have HIV should no longer be allowed to attend school, and that HIV-positive teachers should no longer teach children. Despite these reservations, most of the students and stakeholders were open to PLHIV serving as peer educators for HIV prevention programmes. On the other hand, almost half of the students would either stay away from men who have sex with men or were uncertain about avoiding them, while a few of the stakeholders would stay away from homosexuals to avoid contracting the disease. In addition, some Christian students mentioned that homosexuality is a sin.

2.7 Timor-Leste

2.7.1 HIV in Timor-Leste: low HIV prevalence

Timor-Leste is a low HIV prevalence country with 0.18 percent of the adult population estimated to be living with HIV (2010). The first case of HIV in Timor-Leste was detected in 2003. Although HIV prevalence in the general population appears to be low, prevalence among Female Sex Workers (FSW) and Men who have Sex with Men (MSM) are higher at 2.76 per cent and 1.33 per cent respectively, while there are no data on HIV infections among people injecting drugs. Moreover, data on the extent of drug use in Timor-Leste, in general, are limited.

The number of confirmed HIV cases is still relatively low, however, increasing numbers have been reported from one case in 2003 to 211 total reported cases in 2010. Data showed further that half of these cases are among people aged 25-44 years old. Males represent 53 per cent of all cases.

There are limited data about HIV. The Timor-Leste Demographic and Health Survey (TL-DHS) of 2009-2010 was the first national level population and health survey conducted in the country, and it is a rich source of information on knowledge, attitudes and behaviors on HIV. The survey found the following with regard to knowledge of HIV prevention:

- Generally higher among men than women. This is attributed to the level of education for which men have higher attainment than women as they tend to be given priority to finish school;
- Generally higher among younger women than among older women;
- Highest among the never-married group and particularly among those who have had sexual intercourse; it is lowest among those who were formerly married;
- Higher in urban than in rural areas. There is considerable variability across districts in knowledge of prevention methods. Among women, knowledge is highest in Dili, while among men, knowledge is highest in Manatuto;
- Correlated with higher levels of education. Women and men with higher levels of schooling are more likely than those with less schooling to be aware of various preventive methods;
- Knowledge of condoms and the role that they can play in preventing transmission of the HIV virus is much less common among women than among men (29 percent and 46 percent, respectively).

2.7.2 Young people and vulnerability

There are few studies on sexuality and related issues in Timor-Leste. Available data show that there are significant differences between sexual behaviors of young men and women. In one recent study of 1,000 young people (aged 15-24) in 5 districts, sixty percent (60 per cent) of young males reported having experienced sexual intercourse compared to 24 per cent of females. Although the country maintains a low HIV prevalence rate, there is evidence of high-risk behaviours including low condom use among MSM, female sex workers and uniformed personnel as well as increased exposure to drugs, including injecting drug use.

Section 3. National Responses

3.1 Overview

This section provides a response analysis for each of the five countries in this study on HIV, sexual health and drugs. They are taken from the respective country SRAs.

UNESCO has developed the EDUCAIDS framework for action (UNESCO, 2008a). This has two primary aims: to prevent the spread of HIV through education and to protect the core functions of the education system from the worst effects of the epidemic. It is the former rather than the latter which is most relevant in Asia and in the five countries in this study. This framework includes five essential components for promoting a comprehensive education sector response to HIV. These are:

- Quality education (e.g. rights-based, learner centred and inclusive);
- Content, curriculum and learning materials (e.g. integration into national curriculum; building knowledge and skills etc);
- Educator training and support (e.g. pre- and in-service training for teachers);
- Policy, management and systems (e.g. sectoral policies and strategies on HIV); and
- Approaches and illustrative entry points (e.g. school health and nutrition programmes; life skills education etc).

An important contribution to understanding the parameters of effective HIV education was made by the UNAIDS Inter-Agency Task Team (IATT) on Young People (WHO, 2006) in its review of evidence from HIV prevention programmes in developing countries. This included HIV and sex education in schools. Key findings of the review were:

- There is a sufficiently strong evidence base to support widespread implementation of school-based interventions that incorporate the characteristics of effective programmes and that are led by adults;
- There is strong evidence that these programmes reduce sexual risk behaviour;
- Nearly all school-based programmes have strong evidence for increasing knowledge.

The IATT review identified 17 characteristics of effective programmes. In terms of curriculum content and teaching methods, they:

- Focus narrowly on specific behaviours leading to clear health goals (e.g. prevention of HIV) such as abstaining from sex or using condoms; give clear messages about these behaviours; and address situations that might lead to them and how to avoid them;
- Address multiple sexual and psychosocial risk and protective factors affecting sexual behaviours such as knowledge, perceived risks, values, attitudes, perceived norms and self efficacy; and
- Use instructionally sound teaching methods that actively involve participants personalize the information and that are designed to change each group of risk and protective factors.

UNESCO has prepared technical guidance on sexuality education in 2 volumes (2009a and 2009b), which can support the development of curricula. A minimum package on sexuality education is set out which includes the goals of providing accurate information; providing children and young people with the opportunities to

explore values; attitudes and norms concerning sexual relationships; promoting the acquisition of skills and encouraging young people to assume responsibility for their own behaviour and to respect the rights of others. Current efforts in the five countries cover parts of these components. Regarding drugs education, there is currently no comprehensive technical guidance available.

HIV prevention efforts in Asia are largely focused on targeting most at risk populations in order to bring the epidemics under control. The Commission on AIDS in Asia (2008) recommended that HIV prevention be incorporated in the relevant sectoral programmes. Sex education should be provided in schools and colleges to equip young people with the information that can help them avoid or reduce risky behaviours. UNESCO (2008) has recommended three distinct strategies for Asia. These are:

- i) Improving the quality and scope of current approaches and curricula towards sex, relationships and HIV education to include sexual diversity, male to male sex, drug abuse and sex work;
- ii) Reducing stigma and discrimination of people who engage in risk behaviours as well as PLHIV: and
- iii) Promoting extra-curricular activities or linkage to services outside the school setting.

3.2 Brunei Darussalam

3.2.1 National HIV Response

The Disease Control Division of the MoH collates surveillance data on HIV and other infectious diseases. Residents of Brunei Darussalam (with yellow identity cards) are charged a nominal fee of BND\$1 for the use of health facilities (including outpatient, treatment and prescriptions). ARVs are provided free of charge. A challenge the MoH is ensuring that people living with HIV on treatment, stay on treatment. Other efforts are in place to prepare pregnant women to care for themselves and their future babies.

There are strong penalties under the law (civil and Shari'a law) for alcohol consumption and supply as well as for sexual crimes (e.g. close proximity and forbidden sexual intercourse).

Health promotion and HIV prevention

Under the MoH, the Health Promotion Centre (HPC) aims to promote a healthy lifestyle amongst Bruneians. Recently, the HPC has indicated that the MoH is planning to train school counsellors at the secondary schools on HIV prevention. Also highlighted is the need to send messages on HIV and AIDS to the school population ("Plan to", 2010). There is therefore potential for future collaboration between the MoH and the Ministry of Education (MoE) on HIV and AIDS.

NGO interventions

The Brunei Darussalam AIDS Council (BDAC) is a non-profit organisation established in 2000 to raise awareness of STIs, unwanted pregnancy and social issues. BDAC has a number of on-going programmes to help the council achieve its aforementioned objectives. These are presented in [Box 1](#) below.

Box 1. Brunei Darussalam AIDS Council Interventions

The Penyinar Club: This club is the youth division of BDAC. It aims to motivate youth to practice a healthy and positive way of living as well as to spread awareness on HIV and AIDS-related issues among youth. Its members include young people ranging from their early teens to late 20s. The club organises training, and religious and leadership programmes. In addition to addressing prevention issues, the club aims to eliminate stigma and discrimination as well as bring hope to those who are infected.

HIV Awareness Programme for Peers and Youth (HAPPY): HAPPY is a youth-led project that spreads HIV awareness including knowledge on teenage pregnancy and STIs throughout the 4 districts in Brunei Darussalam. It is a 2-3 hour programme that combines audio, visuals and group activities, which includes debates, discussions, presentations and games.

Life Skills Training (LESTARI): LESTARI is a 4day/3 night programme for young **people** to learn and practise various life skills in an interactive youth-friendly setting. It is a physically, mentally and emotionally challenging programme. The skills taught during the programme include: decision-making, time management, values, self-confidence; working under pressure, teambuilding and empathy. Basic information on HIV and AIDS is taught. The programme is conducted twice a year.

Training of Trainers Programme: In July 2011, BDAC in collaboration with MoH, MoE and Standard Chartered Bank, conducted a Training of Trainers (ToT) programme through a "Workshop on HIV and AIDS, STI and Teenage Pregnancy for School Counsellors". This workshop trained school counsellors and engages the education sector to respond actively on the issue.

BDAC has also reached out to youth clubs and youth camps, Scouts, Girl Guides, leadership camps, etc, in educating youth on HIV and AIDS, STIs and teenage pregnancy. It financial support comes from public donations.

Drugs prevention

Persatuan Basmi Dadah (BASMIDA) is a non-profit anti-drug abuse association. Its main objective is to carry out preventive drug education among young people and school children through annual campaigns. Its activities include:

- **Outreach Programmes:** These include competitions on anti-drug essay writing, poster making, oratory amongst school children, sports, anti-drug songs, fund raising concerts, exhibitions and anti-drug quizzes. Informational and educational reading materials are printed and distributed for free.
- **Counseling for Drug Users:** BASMIDA offers free counseling to inmates at the Treatment and Rehabilitation Centre of *Pusat Al-Islah* (PAI) and conducts training and refresher courses for qualified volunteer counselors.
- **Vocational Assistance:** BASMIDA also facilitates job placement and imparts or upgrades employment skills to former drug addicts (referred to *Rakan* BASMIDA). Several *Rakan* BASMIDA are currently employed by various construction and service industries. Others are continuously encouraged and supported to pursue self-employment. BASMIDA also assists by providing the necessary tools and marketing opportunities to help recovering addicts start-up their business.

3.2.2 The Education Sector Response

i) Policy and strategy

The vision of the Ministry of Education is to provide *Quality Education towards a Developed, Peaceful and Prosperous Nation*. This aims to ensure a knowledgeable society, so that the nation can compete in the global economy while still holding well-grounded social values and national identity. Within this vision, young people are to be equipped with the knowledge and skills to acquire roles benefitting their families, community and society. This includes having strong moral values and high standards of health.

The MoE established three themes for the 2007-2011 Strategic Plan:

- Professional, Accountable and Efficient Organisation;
- Quality Education; and
- Teaching and Learning Excellence.

As part of the *Professional, Accountable and Efficient Organisation* theme, the MoE aimed to ensure the effectiveness and the implementation of the national and school policies through the use of school appraisals. It also planned to provide the teachers with appropriate knowledge to carry out their roles efficiently. In providing *Quality Education*, the MoE sought to generate opportunities for the students to enhance their strengths and abilities. A well-balanced education was to be provided to equip the students with a wide range of knowledge and learning experiences. The restructuring of curriculum would try to ensure that it was in line with the social needs of the students. In terms of *Teaching and Learning Experience*, the MoE aimed to provide training for teachers so that they could use appropriate programmes and tools to motivate learning.

The Strategic Plan called for the enhancement of effective policy development. This included the continuous review of policies and the evaluation of schools' and institutions' curricula or programmes. There is as yet, no specific policy on HIV education or sexual health and drugs education (MoH, 2010). This represents a distinct policy gap. However, the MoE has begun to work in collaboration with the MoH and Brunei Darussalam AIDS Council (BDAC) to provide the students with learning experiences which are relevant to the current national and regional trends and issues on HIV, health and adolescence issues.

ii) The curriculum

Religious education

The current response to HIV, drugs and sexual health in the education sector puts considerable emphasis on a faith-based approach and the teaching of values and attitudes that will help prevent young people from engaging in risk behaviours.

All Muslim parents are to send their children to Religious School (*Sekolah Agama*) which takes 7 years to be completed starting from pre-school to year 6 (7 to 13 years of age). It takes a half-day and parents can choose to send their children to the morning or afternoon session. Based on Islamic teaching, this aims to equip children with understandings and the principles of Islam to preserve or rectify morality and foster positive values. The subjects taught in the Religious School include personality development and mysticism (*Tasawuf*), hygiene (*Taharah*), Islamic Crimes (*Jenayah*) and marriage (*Munakahat*). Students are also equipped with other knowledge and skills which relate to Islam and its values (*Jabatan Hal Ehwal Syariah*, 2011).

To enhance what the students have learned in Religious School, they are also taught Islamic Religious Knowledge in primary, secondary, technical and vocational schools

along with their other school subjects. This allows non-Muslims the opportunity to learn about the teaching of Islam along with its values and to be aware of acts described as crimes in Islam which include sexual crimes (adultery, proximity and pregnancy before marriage), misuse of drugs, consuming alcohol, etc.

The Islamic Studies Department emphasises the importance of shaping the moral values of students at a very young age. At pre-school, the students are already taught *Asuhan Ugama* (Religious Upbringing) which aims to emphasise moral values amongst the students. These values are further reinforced by teaching the students *Adab* in years 1, 2 and 3. Religious education addresses hygiene through the teaching of *Taharah* in year 6, which includes teaching the students how to perform ablutions (*wudhuk*), taking showers (*mandi wajib* and *mandi sunat*), cleaning the male and female body parts, shaving, etc.

Students are also introduced to issues concerning marriage through the teaching of *Munakahat*. This includes sensitive issues relating to sex, close proximity, puberty, marriage, etc. To prevent crimes against Islam, the students are taught *Jenayat*. They are informed about such crimes, many of which are in line with Civil Laws. The subject also covers sexual crimes, adultery, alcohol and drugs and social crimes along with penalties according to Islamic rules.

Sexual and Reproductive Health Education

Sexual and Reproductive Health (SRH) education is included in Biology (Year 8) and Combined Science (Years 9-11). The subject content includes human reproduction and STIs including HIV. The intended learning outcomes in Biology include being able to demonstrate an awareness of the causes and effects of HIV/STIs as well as describe ways to prevent HIV/STIs. Social interaction, social issues and the prevention of illegal and immoral activities is included in the Malay Islamic Monarchy syllabus (MIB) for year 7.

Drugs Education

Education about drugs is contained in Personal Health and the Environment (Years 6 and 8). Through this, students should be able to differentiate between medicinal drugs and harmful drugs, be aware of the harmful presence and consequences of drug trafficking and recognize the harmful consequences of smoking and alcohol consumption. The use and abuse of drugs is also contained in the curriculum for Combined Science (Years 9-11) and Biology (Years 9-11). This includes education about heroin. Prevention of drug abuse is included in the Malay Islamic Monarchy syllabus (MIB) for year 4. MIB is a national philosophy which helps in upholding the morality of the people of Brunei Darussalam and it is one of the core subject in the curriculum.

3.3 Indonesia

3.3.1 National Response

The national response to the HIV epidemic was started in 1987 by the Ministry of Health (MoH). As the epidemic progressed and more data became available, the approach went beyond bio-medical and disease models to include participation of different government sectors and community, especially the most affected communities.

As reported cases came from virtually all provinces from city and district levels, the

national response was scaled up rapidly. Various policies were formulated and commitments from local/provincial government were secured. Difficult decisions were taken to implement hundred percent condom use in commercial sex establishments and the provision of substitution therapy and clean needles and syringes for heroin-injecting drug users. Serious efforts have been made to improve care, support and treatment. ARV was made available free of charge in 2006 and is accessed by 25,384 PLHIV (2009). In 2009, at least 154 hospitals were providing HIV treatment and over 250 clinics were providing voluntary counseling and testing.

HIV prevention through behavior change communication has been one of the most important strategies to prevent HIV infections. In line with the recommendation of the Commission on AIDS in Asia (2008), the National AIDS Strategy is focused on the key affected populations. This is to maximize impacts within limited national resources. In the implementation of all National Plan and Strategies from 1994 through 2007, various IEC materials have been produced and distributed to key populations. The UNGASS country report of 2007 mentioned that over 40 per cent of key affected populations had been exposed to comprehensive behavioural change prevention programmes. The target was to increase the coverage rate to 80 per cent by 2014 (NAC, 2007; 2010).

According to the NAC National Strategy and Action Plan for 2003-2007, the education sector was expected to reach the population aged 10-14 and 15-24 through IEC and life-skills education. It was however, not a priority programme since most resources and attention were focused on most at risk populations (KPA, 2007). The lack of attention to the role of the education sector in HIV prevention was reflected in the UNGASS 2006-2007 country report which indicated that only 7 per cent (555 out of 8,030) of senior secondary schools in 20 provinces in Indonesia provided life-skills education which dealt with issues in reproductive health, drug use, and HIV (NAC RI, 2007). In the National AIDS Strategy for 2010-2014, mitigation of the impact of HIV on children is described as a national priority.

3.3.2 The education sector response

i) Policy and strategy

The education sector has been an important part of the National HIV/AIDS Strategy since 1994. Three years after the first National Strategy was formulated, The Ministry of National Education and Culture (MoEC) issued Decree No. 9/U/1997 on HIV Prevention through Education. According to this, all levels of education were instructed to improve knowledge on HIV, to improve awareness of healthy and responsible behavior, and to engage in activities to prevent the disease. HIV prevention education should be integrated into relevant subject matter in the curriculum of elementary to secondary education and through extracurricular activities. The Decree also suggested that teachers and education administrators be trained about HIV. Unfortunately, after the political reform 1999 (the stepping down of the New Order Regime), the role of the education sector was obscured by the implementation of Regional Autonomy (Law No 22/1999) and by strategic refocusing of the NAC National Strategy and Action Plan on key populations (NAC, 2007).

In 2008 MoEC Decree No. 39 on Guidance and Supervision of Student Activities (Pembinaan Kesiswaan) was enacted in which HIV and Drug Abuse prevention are mandatory activities. This opens opportunities to impart information on HIV and life skills within existing curricular and co-curricular activities.

In the current Education Sector Plan (ESP) 2010-2014, Life Skills Education is

emphasized and HIV is listed as an activity under Strategic Objective Number 6 '*Strengthening governance in ensuring excellent service to education*' together with drug use prevention: *Drug Abuse Prevention Education and HIV/AIDS*. Unfortunately the funding allocated in the ESP is small, indicating a continuing need for international support.

MoEC has issued terms of reference for the GANAS programme (Anti-Narcotics and HIV and AIDS Movement in School) to be implemented in 11 provinces and 11 districts/municipalities. This programme offers in service training for teachers and peer educators as well establishing a student-based task force to prevent drug abuse and HIV among senior secondary students. A series of guidelines and manuals is being published to assist teachers and students in the implementation of this programme.

ii) Management of the response

Since 1997, the education sector assigned the Director of the National Centre for Physical Quality Development as the focal point for the response to HIV. This centre was the driving mechanism for any activity related to HIV. In 2004, this centre published the "*HIV/AIDS Prevention Strategy through Education*" booklet, in collaboration with the General Secretary of MoEC, the Directors General for Primary, Secondary and Higher Education, Non-formal and Informal Education, Sports (now moved to Ministry of Youth Affairs and Sports) and the Head of MoEC R&D. This was renewed and reprinted in 2007. This booklet, which has yet to reach all districts, contains guidelines to assist teachers and other staff in education institutions to develop IEC materials, advocacy tools, and research, and teaching materials. It does not include any activities for care, support and treatment and impact mitigation.

The education sector response is decentralized to the Provincial level. In the Papuan provinces where the epidemic is generalised, direct and long-term impacts of HIV have been experienced by the education system. To deal with these, there has been an initiative by UNICEF and the Dutch Government to integrate HIV information into the curriculum beginning in 2004. MoEC in partnership with UNICEF, World Vision Indonesia, and local activists has introduced life skills and HIV education since 2006 in 256 junior secondary schools (out of 308) in the four most affected districts. World Vision and the local business community have also been raising awareness and building capacity to deal with HIV among youth and children through church leaders in a programme called the Channel of Hope.

Although all of these represent a significant scale up of response in the education sector, a number of problems were identified. A clear mechanism for mainstreaming HIV into the education sector remains absent at national and local levels. There is a lack of technical and expert guidelines in the integration of HIV materials into the school curriculum. Activities were targeted to state/government schools and lacked outreach to non-government schools. In fact, capacity building activities for life skills education and HIV were not conducted evenly across cities and districts.

iii) The Curriculum: HIV, SRH and sexual health

HIV has been included in the school curricula in junior and senior secondary schools through the *minimum standard requirements of subject matter* known as KTSP 2006, providing guidelines for school textbook writers and teachers. But reference to KTSP 2006 in textbooks is not coherent, with varying quality.

School textbooks are an important part of formal education and one of the main sources of information for students. They contain standardized information. HIV information has been integrated into school textbooks. Content on HIV can be found in textbooks for different subject matters at different levels. It is found in Biology, Health and Physical Education, Social Studies and Religion. In primary and junior secondary school, students learn about human development, reproductive organs, changes in the body of girls and boys during puberty from science textbooks (especially biology), but there is no mention of HIV. There is some information on HIV in subjects such as health and physical education, social studies, and religion.

For the SRA, a desk review of elementary (grades IV to VI), junior and senior secondary school textbooks was undertaken of 18 Biology textbooks from grade VIII, X, XI, and XII; one Nature Science from grade VI, two health and sports textbooks from grade VII and X; one religion textbook from grade IX; and three social studies textbooks from grade IV and VIII. In total, 25 textbooks were reviewed.

Biology at Senior Secondary level

In senior secondary schools Biology textbooks, content on HIV is included in the topics of viruses, the blood flow system, body immune and defense systems, and the human reproductive system. In the sections on viruses, HIV is commonly categorized as a virus that is harmful to humans. Within the topic of the blood flow system, body immune and defense systems, and human reproductive system, HIV is discussed as a disease that can be transmitted through blood transfusion and as a disease or abnormality that attacks the reproductive health system, along with other sexually transmitted diseases. In one of the textbooks, HIV is included within the context of the respiratory system since *smoking may increase the likelihood of someone with HIV developing lung problems*.

In a number of Biology textbooks for senior secondary school, the history of HIV is included as a mutation from a virus that usually infects monkeys in Africa. The explanation commonly stops there with no further information. Most textbooks explain how the virus (HIV) is transmitted, but very few textbooks include an explanation on how it is “not” transmitted and common misconceptions are not addressed. The three most common modes of transmission (sex, unsterile syringe and needle, and from mother to unborn baby) are commonly covered in the textbooks. Some books prefer to use *promiscuous sex* and *changing sex partners* rather than *unsafe sex* (without condom) to deal with sexual transmission.

Biology textbooks for senior secondary school include reproductive health issues within the topic of the human reproductive system. Most of the material about human male and female reproductive organs is presented in a very technical manner. The description includes gametogenesis (the forming process of sex cells), menstruation and its cycle, puberty, effects of hormones, fertilization, and pregnancy. Some content on contraception and pregnancy control are found in several textbooks. The most common topics on reproductive health materials are introductions to types of sexually transmitted diseases, including HIV as a form of disorder or abnormality of the reproductive system. The descriptions are usually biological, for example, the physical characteristics of sexually transmitted disease rather than social.

Only one textbook on Biology for senior secondary school (Biology for Grade XI) was found to provide comprehensive information about reproductive health. The descriptions given by this book are clear and helpful, because rather than just giving information about the reproductive system from a biological perspective, the students are also invited to understand their own SRH as something important and reasonable

to discuss so that they have adequate basic knowledge to maintain their own health. However, there is a lack of explanation about prevention methods, about what students should or should not do to prevent them from getting sexually transmitted diseases. Although some textbooks cover issues of birth control, condoms are either not mentioned or explained adequately. Textbooks refer to the importance of staying abstinent by choosing the right friends and not to exposing oneself to adult (pornographic) material.

Junior Secondary level

Discussions about HIV in the Health and Physical Education textbook for junior Secondary School are included within the topic of healthy lifestyle. HIV infection is presented as the consequence of unhealthy lifestyles, one of which is promiscuous sex. STIs and their prevention are also discussed in this topic. One textbook includes an explanation of the different modes of HIV transmission (sex, blood transfusion, tattoo and body piercing, organ implant) and specific body fluids that carry the virus and may cause infection such as sperm, vaginal fluid, blood, and breast milk. It also includes how the virus is sexually transmitted, but the prevention methods presented exclude the use of condoms and emphasis socially and religiously accepted norms and HIV is portrayed as the disease of the perverted.

SRH integration

SRH is often treated as a biological matter. The mental and socio-cultural aspects are rarely discussed except in relation to negative consequences. In such cases, especially in non-biological texts, writers often refer to moral values, stereotypes, or religious teaching. Those engaging in risky sexual behaviours are labeled as perverts, immoral, or lacking in religious understanding or faith. In some junior secondary school biology textbooks students are provided with information on the anatomy of the sexual and reproductive organs and very limited information on personal hygiene to avoid diseases. Some textbooks include a sub-topic on STIs with descriptions of different infections and how they are transmitted. In most cases, however, discussion on how to prevent STIs is absent except to stay abstinent and avoid socially unaccepted behaviors, including pre-marital sex. Guidance for teachers to teach the subject more creatively is not included. Teachers with no pre or in-service training in this topic will likely find it this subject challenging as it contains socially sensitive issues.

In Social Studies textbooks, SRH is part of a section on population and development. Reproductive health is discussed within the context of population growth, birth and mortality. In one of the Social Studies textbooks for junior secondary students, there is a section about social deviation which includes content on male homosexuals, lesbians, and commercial sex workers. It was also found that punishing pre-marital sex by stoning to death was discussed in this section. Similar themes and approach can be found in religious education textbooks. Again, HIV, STI, and adolescent pregnancy are consequences of promiscuous or deviant sex.

All textbooks reviewed in the SRA are missing important components, for example, how information on HIV should be translated into behaviour in daily life and how teachers can deal with the subject matter in a creative manner. In addition, although a number of textbooks include a clear reference or bibliography to the internet, none of the textbooks reviewed mentioned the "HIV/AIDS Prevention Strategy through Education" issued by the MoEC in their references.

Textbooks on religion for junior and senior secondary school approach of sexual

health, HIV and, drug use and abuse from a social pathology perspective. For example, HIV problems are the consequences of lack of self-control and bad social influences; and people become infected with HIV or other STIs because they are engaged in unnatural or immoral sexual acts. HIV learning materials are linked with other topics in certain subjects (for example the topics of *viruses* and *reproductive health* in biology, or *healthy lifestyle habits* in physical health and fitness). Often HIV is just inserted as an example. Sometimes it is included in a class assignment, but without further reference or explanation. This may be appropriate if teachers are well-versed in HIV and students have access to other sources of information such as the internet. This may not be the case especially with teachers in more remote districts.

Given the variations in the depth of explanation and topics related to HIV in the textbooks, it is concluded that there are no guidelines on minimum standards concerning what information that must be included in the books. Textbooks on science and biology provide basic information on HIV but lack sufficient attention to prevention, especially when it comes to safer sex. No information was given on ART as a way to deal with HIV infections.

All textbooks assume that students should be able to abstain from sexual activity. Most of the information deals with moral values and socially acceptable norms, but it is unclear about what to do in everyday life. The way information is presented in the textbooks may actually strengthen existing misconceptions and the stigmatisation of the disease and PLHIV. These textbooks do not give teachers any ideas about more creative teaching-learning strategies.

Drugs Education

Information on drugs can be found in several subject textbooks. For primary and junior secondary schools, content on drug use and abuse can be found in Social Studies and Religion, especially under sections dealing with social problems or juvenile delinquency. In senior secondary school textbooks, content on drugs can be found in Biology and Health and Sport subject matter. Information on drugs at all levels is usually combined with issues of social deviation or social problems, teen delinquency, faulty friendship etc. In all textbooks reviewed, drug abuse is taken to mean the use of drugs without medical supervision. Most textbooks deal with the negative consequences of drug abuse, from biological impact (illnesses, death, and stupidity) to social disruption, discrimination, and isolation. Experimentation and curiosity may lead to addiction. In one junior secondary school textbook for Social Studies, alcoholism is included as a form of addiction. In textbooks on Religion, information about drugs can be found in content on appreciating life by avoiding drug use. What is missing is any content on drug use prevention and the treatment of drug addiction in order to help students deal with real life situations.

Drug abuse is discussed under various topics in different textbooks. In Biology textbooks for senior secondary, drugs are related to issues in the human coordination system (influence of drugs on the central nervous system). This includes the definition of drugs, the classification of drugs (including alcohol), and the effects of the regular use of drugs. In all the textbooks reviewed, very few link the use of drugs and HIV, via the use of unsterilised needles/syringes among people who inject drugs. In religion and social studies, the issue is discussed as part of civic education and growing up as responsible and faithful individual with strong emphasis to avoid experimentation with drugs. Students can easily access basic knowledge of drugs, types, effects, and other related risks. Some textbooks provide case studies to help students understand the influence of drugs on their everyday life. Nonetheless, most

of the information lacks instructional and discussion materials to develop the necessary life-skills.

iv) Implementation findings

Limited available resources for teachers

MoEC has been collaborating with UN Agencies (UNICEF, UNESCO and UNFPA) and NGOs in publishing teachers and training manuals on sexual and reproductive health, HIV, and drug abuse. Due to limited resources, however, distribution and utilisation of these important materials are very limited.

In all provinces, interviewees were not aware of the existence of MoEC booklet on the *HIV/AIDS Prevention Strategy through Education* (2007) and the Life Skills Module for teachers for HIV prevention education.

Varied commitment at the Provincial level

Commitment and responses from the education sector to HIV and related issues across provinces has varied according to local perceptions of the epidemic, the presence of local leadership in the government, school system, and related institutions, as well as the availability of expertise. In most provinces, FGDs suggest that students learn about HIV, sexual and reproductive health, and drug abuse from school textbooks and the mass media. Only in Bali, DKI Jakarta, Kalimantan and Papua are teachers trained in HIV and related issues. In other provinces there was no such opportunity for training although the need to improve teachers' capacity to deal with those issues was recognized. However, local leadership does not see the HIV epidemic and drug abuse priority problems. In most cases, the Provincial AIDS Commission and Provincial or Municipal Narcotic Board do not have significant allocated budget for activities. Activities involving the school were organised intermittently based on requests or offer of the local stakeholders.

In Papua, where there is a generalised HIV epidemic, information on HIV is being mainstreamed within the school curricula from the primary level in select districts. Teachers receive in-service training on HIV and students are trained as peer educators. In Papua and West Papua, prevention of HIV is complicated by level of education, socio-cultural, and geographic factors. These two provinces have the lowest school participation rates in all levels (with many out of school youth at high risk), people speak different languages and live in dispersed geographical areas, and many practice risky behaviors such as having multiple sexual (and commercial) partners. The challenges are very clear. To deal with the generalised epidemic, the Papua Strategic Plan 2007-2011 prioritises expedient mainstreaming of HIV into the school curriculum. With assistance of the UN joint mission, the Dutch Government, and international NGOs, the local government in Papua is engaged in improving the capacity of all stakeholders to deal with HIV. Hundreds of teachers, community leaders, and peer educators have been trained in HIV, sexual and reproductive health, and Life Skills Education. Although progress has been noted, cultural, geographic and language barriers are serious issues that remain to be overcome.

Teacher training and classroom practice

The FGDs showed that HIV, sexual and reproductive health, and drug abuse are subjects of interest to students. Unfortunately, only limited numbers of teachers have received comprehensive in-service training in these subjects in an interesting and

engaging manner. Many students report not being satisfied with what they learned from textbooks and they look for further information in popular media or cyberspace without supervision.

Many education sector stakeholders have mentioned difficulties in discussing sexual health with their children and students. They admitted to a lack of adequate knowledge about HIV and AIDS and appropriate strategies in teaching HIV education. The SRA findings suggest that a lack of correct information about HIV might be common among teachers, parents and community leaders, as well. Findings likewise suggest that misleading information and unhealthy sexuality are being transmitted from stakeholders to students. Further studies are needed to look deeper into these issues.

3.4 Malaysia

3.4.1 The National HIV Response

The National Strategic Plan (NSP) on HIV/AIDS (2006 – 2010) has provided a general framework for a nationally driven and expanded response over the five-year period from year 2006 to 2010. Its development involved a range of consultative processes, including a multi-sectoral consultation. It has also provided the basis for coordinating the work of all partners with a view to successfully achieving UNGASS targets and Millennium Development Goals (MDGs) on HIV/AIDS. The objectives of the NSP were to achieve the following principles of the UNGASS and the MDGs targets and also complement approaches outlined in the National Drug Strategy:

- To reduce the number of young people aged 15–24 who are HIV-infected;
- To reduce the number of adults aged 25–49 who are HIV-infected;
- To reduce the number of HIV infections in injecting drug users;
- To reduce each year the number of HIV-infected infants born to HIV-infected mothers;
- To reduce the number of marginalised populations (sex workers, transsexuals and men who have sex with men) who are HIV infected; and
- To increase the survival and quality of life among people living with HIV.

NSP Strategies

i) Strengthening Leadership and Advocacy

Leadership at the highest level is critical for a successful response to HIV and AIDS. Leadership, at national and state government and community level, is needed to mobilise and co-ordinate actions across sectors and to direct resources and activities to the most urgent priorities.

ii) Training and Capacity Enhancement

The strategy responded to an identified need to upgrade the capacity of the health system and NGOs to increase the coverage and quality of prevention, care and support services as well as using HIV surveillance data to shape policies and programmes. This would determine the quality of the national response to HIV and AIDS. The NSP priorities were: the HIV surveillance system; primary health service delivery, home and community-based care and training for healthcare workers; and VCT services.

HIV and AIDS workplace policies and programmes are to be strengthened and expanded. Malaysia has a *Code of Practice on Prevention and Management of HIV/AIDS at the Workplace* and a programme of seminars and workshops had been initiated jointly by the Ministries of Health and Human Resources to encourage companies to adopt the Code. However, there remained a nation-wide need to develop and implement HIV prevention and care workplace plans, to strengthen measures to provide a supportive workplace environment for PLHIV.

iii) Reducing HIV vulnerability among injecting drug users and their partners

The NSP aimed to reduce HIV infection among people who inject drugs and prevent transmission to their partners by expanding access to harm reduction programmes. Reusing and sharing needles and syringes or other equipment for preparing and injecting drugs is the most efficient mode of HIV and Hepatitis C transmission.

iv) Reducing HIV vulnerability among women, young people and children

For the majority of young people in Malaysia, barriers to access to HIV prevention appear to stem more from cultural and religious values than from limited resources or capacity. Young people, particularly those in marginalised populations, are also deterred from accessing services by concerns about confidentiality and the lack of youth-friendly sexual and reproductive health services. Stigma and discrimination are also issues for PLHIV and youth in marginalised populations.

The peer education program for youth (PROSTAR) is to be implemented which includes more effective ways to educate young people about HIV. In order to reduce the HIV vulnerability of young people and children, the NSP aims to:

- Increase access by young people to life-skills based education;
- Increase access by young people to youth-friendly health and social services;
and
- Create a supportive environment for HIV prevention for youth.

v) Reducing HIV vulnerability among marginalised and vulnerable groups

The NSP focuses on key affected populations: sex workers; men who have sex with men; transgendered people, mobile populations (legal and illegal migrants, displaced persons, refugees, and migrant labourers). The NSP aimed to implement a series of comprehensive campaigns targeting these key population groups in order to:

- Increase their access to accurate HIV, sexual and reproductive health information, education and communication;
- Encourage condom use, provide education in correct use and disposal of condoms among high risk groups;
- Increase their access to community-based, user-friendly VCT, by increasing the number and geographical coverage of VCT services (including mobile units);
- Increase the coverage and quality of outreach programmes, by establishing new programmes, training of staff (including volunteers) and involving target populations in the design, delivery and evaluation of programmes.

vi) Improving access to treatment, care and support

It is estimated (2010) that approximately 10,000 people are living with HIV require anti-retroviral therapy (ART) in the country. The three main approaches are to increase: accessibility to treatment; availability to ARV drugs; and capacity enhancement of support services.

The Government is continuing to support a decentralised approach to health services that includes community-based and primary health care through to hospital-based care. It provides psychosocial support including VCT, palliative care, nutritional support and treatment for common opportunistic infections. Malaysia provides affordable access to clinical care through the public health system, including free or subsidized access to ART. However, the service coverage was falling short of need and demand. The increasing numbers of AIDS cases has the potential to overwhelm the capacity of the health system and available resources. PLHIV in closed settings and those living outside the major cities were particularly affected. The NSP would also improve support to infected and affected children, including orphans.

HIV infected and affected children

To address the specific needs of HIV infected and affected children the NSP emphasised the need for:

- The provision of appropriate counselling and psycho-social support to orphans and other vulnerable children, and to their carers;
- The provision of antiretroviral treatment and care for HIV-infected children;
- Their enrolment in school; ensuring their access to shelter, good nutrition, health and social services on an equal basis with other children;
- Non-discrimination through the promotion of an active and visible policy of de-stigmatisation of children orphaned and made vulnerable by HIV.

3.4.2 The National Drugs Response

The National Anti-Drug Agency (NADA) has been a key organization dealing with drug abuse prevention in Malaysia since 1996 (NADA, 2010). The National Anti-Drugs Agency Act of 2004 formally established NADA's functions and powers in addressing this issue. The objective of NADA is to ensure the implementation of national policies on narcotics and coordinate, monitor and evaluate all activities relating to the control and prevention of drug abuse in order to create a drug-free nation by 2015.

The four core strategies of NADA in eradicating the supply of and demand for narcotics in the country are: 1) Prevention, 2) Treatment and rehabilitation, 3) Law enforcement and 4) International cooperation. Primary prevention programmes involve prevention education in schools and dissemination of information to the public. The activities carried out in 2009 fall into five broad categories:

- Advocacy and Information programmes;
- School-based programmes;
- Community mobilisation programmes;
- Drug prevention programmes for parents; and
- Drug prevention programmes in the workplace.

3.4.3 The Education Sector Response

i) National Policies and Plans

There is a lack of a medium term action plan for school health and the HIV response. Moreover, there is no existing government policy on sexual and reproductive health education. The policy framework that exists for school health comes under the Ministry of Health. There is also a lack of an education sector specific HIV and AIDS workplace policy.

Currently, Malaysia is facing unwanted teenage pregnancy. In response, the CDD-MoE has developed a reproductive health guideline that covers issues for all age groups. This guideline is intended for both NGOs and government organizations to initiate relevant programmes and activities. This guideline will be implemented in the near future.

ii) Curriculum

HIV and Sexual Health Education

School-based SRH education has been implemented as Family Health Education (FHE). FHE has been taught to secondary school students since 1989 and to primary school students since 1994. The FHE curriculum has been incorporated into the subjects of physical and health education, biology, science, ethics and religion as presented in the table below:

Integration of SRH in the curriculum

Subject	Status
Physical and health education	Compulsory, not examinable subject
Science/additional sciences	Compulsory and examinable
Biology	Compulsory and examinable
Moral education (ethics)	Compulsory and examinable for all non-Muslim students
Islamic education	Compulsory and examinable for all Muslim students
Informal NGO activities	Single activity conducted Lack of continuity of the activities conducted

Since its inception from 1989 until 2002, the FHE curriculum has had several changes (in 2000, 2003 and 2005). From 2003, FHE was referred to as *Sexuality Education* until in 2006, the name was changed and it is now called *Reproductive Health and Social Education* (or PEERS which is a Malay language acronym). Under the curriculum transformation in education, which started with Year 1 in 2011, PEERS is to be taught in four 40-minute sessions each month in secondary schools and in a 30-minute session each week in primary schools. Only teachers who have undergone training sessions are eligible to teach this subject in order to ensure the effectiveness of the teaching and learning process. Topics covered in PEERS were modified to fit the current situation that youth are dealing in their daily lives. The

topics are additional/modified topics from those of FHE implemented in the past. However, the CDD-MoE has made plans to review and revise PEERS.

PEERS is to be taught in primary levels 1, 2 and 3. It includes the physical difference between boys and girls, personal hygiene, responding to social situations that would lead to unsafe sexual contact, the importance of preserving one's self-respect and emotional management. PEERS in primary levels 4, 5 and 6 includes conflict management, puberty and physical changes, the reproductive system, skills needed to preserve one's self-respect, risks of premarital sex, the spread of STIs and how to refuse cigarettes, alcohol and narcotics.

PEERS in secondary levels 7, 8 and 9 includes social psychology, life-skills needed to handle high-risk situations, stress management, the transmission of STIs, sexual growth traits, identity and sexual orientation, relationships and the adverse effects of alcohol, cigarettes and narcotics. PEERS in secondary levels 10, 11 and 12 includes social psychology, emotional and mental stability, youth pregnancy, family issues, the spread of STIs and preventative measures against cigarettes and narcotics.

In secondary schools, the prevention of STIs is introduced in the final three years of secondary school In Physical and Health Education, but is most extensively dealt with in the final two years. Sexual relations and practices are taught in the context of the family institution. The biological aspects of human reproduction, disease and growth are extensively covered in Science, Additional Sciences and Biology. Contraception is not introduced until the final year of the secondary school. Condoms are introduced as one a method of contraception not for having safe sex. Health Education is included in Islamic education, this subject and taught in grades 9 and 11. The emphasis is on moral and spiritual virtue and the prevention of illicit behaviours.

During the process of PEERS curriculum development and implementation, the content was designed based on the review and comments made by NGOs and other stakeholders, such as parents, to be more culturally and socially acceptable. According to the National Union of Teaching Profession (NUTP), teachers are more willing to accept the PEERS curriculum because it is a government policy and integrated into the existing core curriculum rather than creating a separate school subject. The CDD-MoE has produced guidance on appropriate terms to be used by the teachers when talking about sexual issues with the students. The terms are deemed culturally appropriate and should minimise controversy among the communities and families.

Drugs education

Preventative drug education in Malaysia has been implemented through curricular, co-curricular activities, teacher trainings, early intervention programs and community-oriented and school-based programs. Elements of drug use prevention education were also included in core school subjects such as physical education, health, ethics, history, languages, home economics, math, science and art.

iii) Co-curricular activities

The co-curricular programme, *PROSTAR*, was and initiated by the Ministry of Health and the UNICEF Malaysia country office and launched in 1996. It was developed to promote youth friendly HIV prevention and life-skills based activities for vulnerable youth. The programme has taught students about HIV and other related risk issues to youth in school. By 2006, more than 64,000 PROSTAR peer-educators had been trained nationwide and 1,009 PROSTAR Clubs established. More than 3,450

PROSTAR activities have been conducted and involved some 667,000 youth (Talib, 2006). An additional module, *I Am in Control*, has been also used for the past four years in secondary schools. This activity-based module was developed by the Ministry of Women, Family and Community Development, the United Nations Population Fund (UNFPA) and other NGOs.

iv) Implementation findings

The curriculum

The subjects in which PEERS content is incorporated are not taken seriously as they are not compulsory for academic exams and progress among teachers and students. To compensate this constraint, some schools have invited NGOs to conduct such activities that aimed to reduce high-risk behaviours, but usually the activities are implemented as a single activity during the school year instead of continuous or a series of activities which are important for effective learning.

Based on the information obtained through FGDs, the topics are not covered fully in the classrooms and are, instead, presented in bits and pieces. This teaching method will clearly weaken the programme aim of preventing high-risk behaviors. In order to build skills and knowledge for student to handle with or prevent their risk taking, serial and sequenced skill building activities are required, rather than a single, one-off activity.

During FGDs, teachers mentioned that the time allocated to teach PEERS was not sufficient to deliver all activities of a skill-based approach. They reported that life skills-based HIV and AIDS education needed more time and continuing training sessions to enable them to use all the manuals with the students. Teachers are uncertain with different guidance on using HIV and AIDS education materials that have been received from different sources. Finally, the NUTP Secretary General and several teachers raised their concerns about the lack of professional training sessions or standardised teaching regarding to this subject

Drugs education

According to available data, the drug prevention education programme has never been fully integrated into the core curriculum. Instead, the most pragmatic approach for reaching all students in schools was to have teachers give a series of 5-minute anti-drug talks at the start of each lesson over a period of five school days. It was believed that by doing it this way, all teachers and students nationwide are involved in drug prevention education immediately.

Drug use prevention in school is taught by health education teachers with the coordination of guidance counselors and NADA staff. NADA approaches schools to conduct its activities and the guidance counselors were to facilitate those activities. A 5-minute talk given by the teachers is still being carried out as an extra activity to reach all students. It was found that most of the drug prevention programmes conducted at public schools are additional activities conducted/assisted by outsiders (e.g. NADA). It has become customary that NADA would organize an event each year at schools. All classes will readjust their timetable in order to participate in the NADA event which included talks on drugs that discussed various types of drugs, how drugs affect the body, families and society and law enforcement.

Co-curricular activities

During interviews and discussions, deputy principals and teachers were asked to clarify the meaning of sexuality education, but no clear answers emerged. In examining the PROSTAR activities, some areas for improvement were identified. It was reported that a single peer-educator training session was conducted and the number of peer-educators was disproportionate compared to the student body. Moreover, peer-educators were not distributed equally across grade levels which would not allow students to convey information effectively if peer-educators were not the same grade as their peers.

The issues taught through PROSTAR tend to focus on lifestyle choices rather than HIV risk behaviors. Some schools had partnered with the state health department to hold training sessions and camps for their peer-educators. The total number of hours taught on HIV is about three hours per year which is not sufficient. The teaching methods used to teach the HIV-related issues have been didactic, rather than participatory.

Education sector drug prevention programmes include the following (NADA, 2010):

1. **Kem INTIM (Kem Kecemerlangan Intelek Murid) (or INTIM Camp):** The objective of this programme which is catered to students in grade 5 (10 – 11 years old) is to enhance their knowledge and life-skills to resist the negative peer pressure to take drugs and other narcotic substances. In 2009, 5,326 students attended a total of 50 camps.
2. **PIP (Program Intervensi Pelajar) (or Student Intervention Programme):** The NADA conducts surprise or random urine screenings for high-risk students so that early intervention actions can be taken. Students identified positive for drug use would be counseled by the school guidance counselor and requested to attend motivational camps/courses to enhance their self-esteem and interpersonal skills. Parents of these students are also invited to participate and share experiences with others on parenting skills. In 2009, a total of 2,610 students from a total of 264 schools were screened and 49 motivational camps were held for the affected students.
3. **SEGAK (Sekolah Gemilang Antidadah) (or Excellent Anti-Drug Schools):** Programmes are implemented in schools which are located in hot spots and students are exposed to drug-related activities. Students' resilience in saying 'No' to drugs is developed through interpersonal skills so that they are able to resist pressure to abuse drugs. 13,527 students from a total of 76 schools took part in this programme in 2009.

Teaching methods

Based on the review of available data and classroom observation, the FHE curriculum focuses on provision of information rather than skills-building. In lesson objectives, it was clearly stated that teachers should conduct a discussion with students but they rather prefer a didactic approach. The curriculum contents have a tendency to mold students' attitudes and values to expected social norms instead of encouraging critical thinking, decision-making and problem solving regarding to particular risk behaviors. Thus, the curriculum has insufficient activities in building skills of students to deal with risky situations and to avoid high-risk behaviors. Only a few lessons identified skill-building objectives such as decision-making and problem-solving skills in the curriculum.

There are some differences about approaches or methods to be used for teaching HIV education. The teacher training sessions conducted by the CDD-MoE, through an NGO named “Focus on the Family” uses its own manual called No Apologies: The Truth About Life, Love and Sex. This is based on the abstinence-only approach to sex while UNICEF Malaysia also held workshops and introduced “Life Skill-Based Education for HIV/AIDS Prevention” which is focused on skills building to handle everyday life situations and giving choices for problem-solving.

Teacher training

The MoE is responsible for organising training sessions to equip teachers with the skills needed to properly implement the PEERS teaching manuals. However, according to information obtained from the teachers, there were several occasions where not all of the teachers involved in PEERS were invited to attend the training sessions. The sharing of the training sessions between trained and untrained teachers is not compulsory so many teachers who are responsible for implementing the PEERS curriculum have inadequate knowledge and skills to implement sessions/activities to meet the needs of students. In order for teachers to gain the skills required to teach their students and for PEERS to be implemented successfully, it is important for all relevant teachers to attend regular training sessions.

During interviews, teachers noted that State Education Department representatives were not involved in most of the training sessions. These would help them coach or mentor the teachers who are implementing the PEERS activities in the classroom. Officers from the CDD-MoE have tried to encourage Health Education teachers to pay attention to the quality of teaching and time allocations for this issue, but with a lack of clarity in policy towards HIV and sexual health education, they tended to give priority to compulsory core subjects instead.

Supervision and support

The CDD-MoE not only acts as the key agency in putting the HIV and sexual health education policy into practice, but also has the key role in developing the curriculum, subject standardisation and conduct of training for teachers throughout the country. However, they were not able to monitor and coach involved teachers. Teachers are key persons in delivering the HIV and sexual health education to the students. Their understanding and proficiency in facilitating the skill-based activities are crucial.

Learning Outcomes

With regard to the adequacy of HIV and AIDS information students received at school. It was found that some students were still not clear if HIV and STIs were related to one another and were sexually transmitted. Some students felt that the information was enough to help them protect themselves from infection while other students (about half of those interviewed) mentioned that the amount of information on these topics did not prepare them to deal with challenges of post-school life when they would not have parental monitoring and guidance.

There is currently no systematic monitoring and evaluation on the impact of the HIV prevention programmes on reduction of risk taking behaviors among youth in the education system. Most of the studies found during the data review process tended to narrate only upon the youth’s knowledge level and the level of youth engagement in high-risk sexual behavior. None of the studies reviewed mentioned the effectiveness of the HIV education program/curriculum implemented on reduction of high-risk sexual behaviors or delay of the average age of first sexual intercourse.

3.5 The Philippines

3.5.1 The national response

The Philippines national HIV response conforms to the principle of "Three Ones," having "one-coordinating authority" through the Philippine National AIDS Council (PNAC) "one strategic plan" embedded in the AMTP, and "one monitoring and evaluation (M&E) framework" through its National HIV and AIDS Monitoring Systems.

The PNAC attached to the DOH, is the highest advisory, planning and policy-making body on AIDS (PNAC, 2010). It is composed of 27 government agencies, NGOs, professional organizations and representatives from PLHIV. It is in charge of planning, coordinating and monitoring the country's national response to HIV, as well as in mobilizing resources and technical assistance. It is responsible for ensuring that all HIV-related projects and initiatives in the country respond to the current AIDS Medium-Term Plan (AMTP) to ensure a nationwide HIV information and education program.

As the lead agency in the national response to AIDS, PNAC develops the Philippine National Strategic AIDS Plan through the AMTP every five years. The goal of AMTP-IV for 2005-2010 was to prevent the further spread of HIV infection and reduce the impact of the disease on individuals, families and communities (PNAC, 2005). Strategy 1 of AMTP-IV was the scaling-up and improvement of the quality of preventive interventions (i.e., preventive education, skills and services) for most at risk populations. Strategy 2 involved institutional (and general public) preventive intervention for children and young people, both in school and out of school (PNAC, 2005).

The strategy for children and the young people in school aimed to: (i) assess the quality and scope of intervention coverage for in-school and out-of-school youth (OSY); (ii) integrate life skills approach in STI/HIV/AIDS modules of DepEd, CHED, TESDA and NGOs with similar activities for children and/or parents; (iii) build capacity in STI/HIV/AIDS life skills education of school-based providers; (iv) expand the implementation of school-based HIV instruction and information; and (v) ensure accessibility of school youths to quality STI counseling and services. The PNAC aimed to tap civil society organizations (CSO) and youth organizations to provide information and education services through the establishment of community outreach and peer education programmes for OSY. This also involved the integration of STI/HIV/AIDS information and services into the local government's programmes and existing community-based programs (PNAC, 2005).

The AMTP-IV Mid-Term Review (MTR) reported significant progress in all the activity areas for children in risky situations; and some progress with the preventive interventions among children and youth, and teachers and guidance counselors in the form of capacity building initiatives; but progress relating to programmes for OSY had been slow (PNAC, 2008a). M&E for OSY had been poor, hence, the scope of achievements in this area had been difficult to gauge. AMTP-IV in 2008 indicated that enforcing the inclusion and mainstreaming of HIV programmes in the mandates of several agencies had not moved and that the education sector response had yet to take off (PNAC, 2010; 2008a).

The goal of the 5th AMTP for 2011-2016 is to maintain an HIV prevalence of less than 66 HIV cases per 100,000 populations. The programmes under the 5th AMTP are strongly focused on most at risk populations to achieve impact and to be cost effective. Behaviour change communication activities for key affected populations are

to be delivered through outreach education in communities, while those for the youth are to be delivered within institutions. The general youth population will be reached by HIV-related awareness messages through integration of HIV education into existing programmes at low or no cost.

3.5.2 The Education sector response

Policy and strategy

Republic Act 8504, the Philippine AIDS Prevention and Control Act of 1998, directs DepEd, CHED and TESDA to integrate instruction on the causes, modes of transmission and ways of preventing HIV and other STI in subjects taught in both public and private schools in all levels, including non-formal and indigenous learning systems (Article I, Sec. 4). The provisions on education and information dissemination in RA 8504 also require health providers to allow public access to information necessary to control the spread of HIV and to correct misconceptions about the disease. The Law guides the education sector in its response. It mandates the integration of HIV education in the elementary, secondary, tertiary, and technical-vocational education. HIV education should be integrated in, but not limited to, the following subjects: Science and Health, Home Economics and Livelihood Education (HELE), Civics and Culture, Good Manners and Right Conduct (GMRC) and Filipino for the Elementary level, and for the Secondary level, HIV education, integration in Science and Technology, Social Studies, Music, Arts, Physical Education and Health (MAPEH), and Values Education. At the tertiary level HIV education is integrated in General Education courses: Natural/Biological Sciences, General Psychology, and General Sociology, as well as, in specific courses in Dentistry, Nutrition and Dietetics, Respiratory Therapy, and Nursing. The Law directs TESDA to integrate instruction on the causes, modes of transmission and ways of preventing HIV-related diseases and other STIs in subjects taught.

The Health Education Reform Order of 2006 (EO No. 595) likewise orders the DepEd, CHED and TESDA to ensure an effective and efficient public health awareness campaign for the prevention of common diseases through the educational system, covering the health education curriculum of primary, secondary and collegiate levels all over the country. All public and private elementary and high schools were directed to refocus the existing health curriculum from curative to preventive aspects of diseases and other top causes of mortality and morbidity in the country or in the locality.

The Research Agenda 2006-2011 guides policy makers, researchers, programme planners, implementers, and other stakeholders in decision-making on the allocation of resources for research. The utilization of research data for policy formulation and program planning requires access to data of all stakeholders. Hence, accessibility of research findings, completed as well as ongoing, has been through the M&E system, which serves as the repository and referral center of information. DepEd, CHED and TESDA are likewise expected to submit research studies to the M&E Unit to guide programme planning.

All schools have policies and rules on student discipline related to HIV, drugs and sexual health education, but not all have them printed in student handbooks for students and parents' information. Student handbooks from private schools shown to the Research Team had provisions about dress code to avoid "temptations." Other prohibited behaviours include intimate and suggestive actions, like holding hands, kissing, public display of affection, smoking, and possession of cigarettes and other

paraphernalia within and outside the school premises, when wearing the school uniform.

ii) Management

The membership of the Education Committee in PNAC shows representatives not only of the three education sections responsible for the levels of education—DepEd for elementary and secondary, CHED for tertiary and TESDA for technical-vocational—but other agencies as well, including representatives from the PLHIV community. It is chaired by the Health Action Information Network (HAIN) and vice-chaired by the Department of Labor and Employment (DOLE). The Committee is mandated to undertake an aggressive education campaign, with emphasis on harm reduction, promotion of a healthy sexual health behavior, safer sex practices, and a broad focus on the determinants of health as critical support for a successful HIV preventive programme. The Education Committee is developing a basic manual for HIV education and anticipates the use of this “mother module” by the different sectors in the development of their own age-specific and sector-specific module.

The leadership and management of HIV-related programmes are taken on by the DepEd, CHED and TESDA. They are expected to monitor and assess their performance and report to the PNAC’s M&E unit. The DepEd’s School Health and Nutrition Center (SHNC) coordinates all its HIV-related activities with PNAC. Its key programme, the School-based AIDS Education Programme (SAEP) developed instructional materials on HIV integrated in appropriate subject areas in basic education. Now renamed the School-Based HIV and AIDS Preventive Education Programme, its modules cannot yet be updated due to the curricular reform that basic education is currently undertaking. The Feminine Hygiene Educational Program (FHEP) and the National Drug Education Programme have been integrated in the SAEP (DepEd, 2010). The CHED and TESDA are the management and implementing arms of PNAC in tertiary and technical education, respectively. PNAC coordinates the HDSE activities of DepEd and TESDA, as they are active members of the Education Committee and their activities are planned and shared during their meetings. A focal person from the DHSNC has been appointed to coordinate the integration of HIV and AIDS in DepEd’s planning, putting in place a monitoring mechanism and undertaking activities to promote HIV and AIDS education.

iii) The curriculum.

Republic Act 8504 mandates the integration of HIV and AIDS in specific subjects in the curriculum of basic and tertiary education while Republic Act No. 9165 of 2002 mandates different government agencies, including DepEd and CHED to formulate, develop and establish a comprehensive, integrated, unified and balanced national drug use prevention and control strategy.

The SRA content analysis of the curricula in basic education shows that:

- HIV education is not explicitly integrated in the curriculum, although there are many topics in different learning areas that relate indirectly to sexuality and HIV;
- At the elementary level, sexual health is integrated in Science and Health, Filipino, Social Studies, HELE and GMRC; HIV, drugs and sexual health are not integrated in English, Mathematics and in MAPE; and the historical development of the role of women and women’s rights are extensively taken up in Social Studies;

- At the high school level, HIV education is integrated only in P.E. and Health, indirectly integrated in other learning areas, but not in Social Studies; sexual health is integrated in English, Filipino, Technology and Home Economics (THE); Social Studies; Arts, Physical Education (P.E.) and Health (part of MAPE); and Values Education; drugs education is integrated in Values Education and P.E. and Health; HIV is not integrated in Science and Technology, Mathematics, and Music.

A content analysis of public school textbooks (Grades 1-6 in English, Science and Health) by Galvez Tan, et al., (2005) found that:

- There is gender bias in the treatment of the physical changes that happen during puberty, for example, menstruation is taken up, but not nocturnal emission;
- There are instances where unfair generalisations are made, for example, “Did you know that the rapid growth of population is one of the reasons why AIDS and other communicable diseases spread easily?”
- There are inaccuracies, for example, AIDS is mentioned as a disorder of the circulatory system.

iv) Resources for teachers

The DepEd and CHED have developed numerous instructional materials with funding assistance from UN and development partners. See the box below for examples of resources for HIV and sexual health education:

Resources for HIV and sexual health education

- In 1994 DepEd created the Technical Committee on School AIDS Education to prepare high school supplementary teachers’ guides and self-instructional students’ modules integrating AIDS education written in Filipino in PEHM (P.E. Health and Music 1st and 2nd year), Values Education (1st and 4th year), and in Filipino (3rd year): *HIV and AIDS: This is the Truth*, with support from UNESCO and WHO;
- In 2002 DepEd developed resource materials on HIV and AIDS for Teachers with assistance from Control of STI,AIDS/STD Partnership in Asia Region (CHASPAR), Southeast Asian Ministers of Education Organization (SEAMEO), Tropical Medicine and Public Health (TROPMED) and the German Agency for Technical Cooperation (GTZ);
- In 2002 Training of Trainers Manual on AIDS education was developed with assistance from SEAMEO and the University of the Philippines (UP);
- In 2002 the Faculty Handbook on HIV and AIDS Education in Higher Education, a resource book for faculty members, especially those handling subjects identified in RA 8504 and other appropriate subjects was jointly published by CHED and PNAC;
- In 2007 a teacher education manual on AIDS prevention and response in the Philippines was published with support from UNESCO Jakarta;
- In 2008 the book for Filipino teachers already in service was published with assistance from UNESCO Bangkok;
- In 2008 the BALS developed a teachers’ guide on ARH focusing on life skills for OSY and a facilitator’s guide on peer education with funding from AusAID and UNFPA;
- In 2009 Galvez Tan, J. et al. wrote a resource book published by the UNESCO National Commission; In 2010 UE and the UP-Manila National Institute of Health, with support from UNESCO National Commission organized a seminar to train health educators on the use of the above resource books;
- Support instructional materials have been developed and are integrated in appropriate subject areas in basic education for the School-Based AIDS Education Project. (DepEd, n.d.)

The instructional materials that are found helpful by the students and stakeholders who participated in the FGDs are Modules on Sexuality and pamphlets by DDB & PDEA; Complete courtship, complete marriage “Church Goals”; DepEd’s *Where Did They Come From?*; Books and pamphlets, for example, DDA Manual on courtship and marriage.

In 2005, the DepEd developed instructional materials on ARH, but during pilot testing, many negative reactions came out from the media, religious groups, parents, and other stakeholders, Due to a lack of consensus about the content of the curriculum, the materials are still under review.

iv) Implementation

Policy

Republic Act 8504 has been enacted since 1998, but previous and current consultations reveal that the Law has not been well-disseminated and fully understood by the LAC members and other stakeholders, including their roles and responsibilities (UNESCO Natcom, 2011; PNAC, 2005, 2008a, 2008b). This challenge has been raised in the UNGASS Report, 2006-2007 and remains unanswered. In addition, the budget appropriation for the PNAC as stated in the law is no longer adequate to support the operation of its Secretariat and its programmes and activities.

Although the Act prioritises Education and Information, there is as yet no budget appropriation for the activities of the three agencies of the education sector. The budget appropriation of Php 20 M is allotted only to the operation of PNAC, through the DoH. As such, the budget for HIV-related programs of the education sector is sourced from its own funds. With other programs in the education sector to compete with, HIV education is given low priority. Overall, the domestic priority of HIV in the country is very low at only 0.69 per cent in 2009 (UNAIDS, 2010). The absence of a budget appropriation in the law for the HIV and AIDS programmes of the DepEd, CHED and TESDA undervalues the role and function of the education sector in preventing HIV and in building its capacity to respond to the problem.

Teacher training

Teachers are not yet well-trained in life skills education, although the 10 life skills to be emphasised in basic education have been identified as early as 2000. An analysis of the curriculum in basic education shows that at the elementary level, the development of life skills is integrated in Filipino and is very evident in GMRC; in high school, only the teaching of P.E. and Health is explicitly life skills-based.

DepEd, CHED and TESDA have conducted occasional training courses on HIV, drugs and sexual health education, in cooperation with different agencies. They include:

- Regional Workshop on Youth and Teachers’ Participation in STI and AIDS Initiatives in collaboration with SEAMEO, TROPMED and GTZ in 2003;
- Training of Trainers on the integration of AIDS Education in the Basic Education Curriculum, in cooperation with UNAIDS, PNAC and the Health Education Association of the Philippines (HEAP) in 2003;

- National Work Conference on AIDS Education on supported by UN organizations in 2005;
- Seminar-Workshop on HIV Preventive Education for in-service and pre-service teachers on the use of the Philippine adaptations of the Teacher Education Manuals (UNESCO Jakarta, n.d.) to commemorate WAD, organized by UE and UNESCO NatCom. It focused on the development of innovative teaching strategies to integrate HIV preventive education in high school MAPEH, Bachelor of Secondary Education, major in MAPEH, and General Education courses in Biology, Psychology, Sociology, and National Service Training Programme (NSTP).

Teaching methods and classroom practice

DepEd has launched an interactive approach to HIV education for high school students through “The Power of You” campaign, making use of an interactive video in partnership with UNICEF. The project orients young people on risky behaviours, HIV, AIDS, and STI, and equips them with knowledge and important life skills that will enable them to adopt positive attitudes and behaviors, as well as empower them to exert individual rights. Results of FGDs show that teaching strategies on drug and HIV preventive education preferred by students are open-interactive discussion, group discussion, seminar, and use of pictures and illustrations. Students likewise prefer learner-centered teaching strategies in an informal setting so that they can “bare their hearts and minds” and express their feelings freely.

Results of FGDs showed the appreciation of the students for the gender equality experienced in the classroom. The Philippines, though traditionally a patriarchal society, ranks 9th among 134 countries that continue to demonstrate the greatest equality between men and women (World Economic Forum, 2010). The school setting mirrors the same situation, where female students are given equal opportunities as male students in all aspects of the decision-making process.

Extra-curricular activities

Department Memoranda have been issued since 2006 encouraging all schools to commemorate World AIDS Day (WAD), with varying themes and activities. Unfortunately, the issuance of the memoranda is not regular although WAD is celebrated annually. The last memorandum issued was in 2008. The suggested activities that schools could undertake during WAD are almost the same every year: bulletin board display; symposia and panel discussions; posters, essays, or slogan contests; use of the AIDS ribbon; films; radio and TV plugs; community assembly; and integrating HIV in lessons; streamers; and mobilization of school health personnel to teach about HIV; and advocacy activities, with the cooperation of the LGU and CSOs.

Unfortunately, the monitoring and evaluation of the activities have not been reported, if done at all. A probable reason for this is that the activities were supposed to be coordinated by the School Health and Nutrition personnel, which in many schools are non-existent, since there are not enough physicians and nurses to service more than 40,000 public schools in 7,107 islands in the Philippines.

Learning Outcomes

Teachers make use of objective and subjective tests as well as alternative assessment tools to evaluate skills and values-based instruction on HIV, drugs and sexual health education.

3.6 Timor-Leste

3.6.1 The national response

High levels of poverty and social disruption that resulted from the conflict surrounding the independence, combined with the presence of several thousand peacekeepers and other international personnel (many from countries with high HIV prevalence), led the country to develop a national AIDS strategy early on. At the time the National AIDS Strategy was developed in 2002, no hard data were available to guide programme choices and help prioritize strategies. Significant advancements have been made since those early days.

National Strategic Plans for AIDS

The 2002-2005 National Strategic Plan for a comprehensive and multi-sectoral response to HIV and AIDS acknowledged the challenges HIV poses for nation-building and HIV prevention as a national priority. The plan was introduced during the country's first National AIDS Conference in June 2002 and was adopted formally in September 2002.

The 2006-2010 National HIV/AIDS and STI National Strategy of Timor-Leste was adopted in the context where the country had low levels of HIV infection and a relatively steady pattern of economic growth and social development. The reference point for strategic priorities on HIV and AIDS referred to the Asian Epidemic model which prioritises containment of infection among most at risk populations (particularly FSWs and their clients, MSM and people who use drugs).

Significant political, economic and social changes took place in Timor-Leste upon the adoption of 2006-2010 current strategy which were not expected. These included:

- Political and social upheavals resulting in high level of social conflict and population movements;
- The weakening of traditional sources of social authority (e.g. church, family) and increased exposure to competing social influences; and
- One of the fastest economic growth rates in the world, resulting in the emergence of a growing population group with significant disposable income.

The combination of these factors is believed to have increased the risk of HIV transmission and is being considered as Timor-Leste looks forward in the next phase of its response. Population movements expose people to different risk situations and the presence of an international population expose the local population to varying degrees of different exposures to risk behaviours. Despite these challenges, Timor-Leste can claim the following achievements:

- Significant prevention programme coverage of most at risk populations, reflected in the continuing low levels of HIV transmission;
- Access to anti-retroviral therapy (ART) for those diagnosed with HIV and eligible for treatment;
- Extensive coverage of syndromic STI management;
- Implementation of an effective sentinel surveillance system;
- The establishment of a significant programme infrastructure;
- Strong endorsement at the political level for addressing HIV;
- The development of strong leadership within the NGO sector; and

- Effective partnerships between government and community sectors in programme implementation.

In 2010, Timor-Leste faces new challenges in confronting the threat of HIV and other STIs. The country is experiencing rapid economic growth which combined with the social dislocation of recent years has created new patterns of risk and vulnerability to HIV/STI infection. The strategic priorities outlined in the draft strategy for 2011-2015 are:

- Establishing an enabling environment through a coalition for gender equality, sexual and reproductive health;
- Access to a basic service package including HIV and STI knowledge, clinical services and availability of condoms for the general population;
- Targeted prevention programs targeting individuals with multiple partners outside of key populations;
- Strengthening intensive prevention programmes targeted at most at risk populations (sex workers, clients of sex workers, MSM, Uniformed Services);
- Scaling up services in border districts;
- Ensuring universal coverage of life skills-based sex education for young people
- Achieving universal access to treatment for those who are infected by increasing coverage of testing and counselling;
- Strengthening the capacity of the health system to respond to increased need for HIV treatment services; and
- Strengthening community sector systems to enhance quality of service delivery.

Civil society organizations and the Church play a major role in the national response to HIV in Timor-Leste. In fact, non-government organizations, the church and other civil society were a large provider of health services during the early years of the country's independence, until the health system was strengthened.

3.6.2 The education sector response

i) Policy and strategy

Timor-Leste has placed education and training at the very core of its development strategy as explicitly expressed in the Timor-Leste's Strategic Development Plan for 2011-2030. Timor-Leste's Constitution expresses that the State recognizes and guarantees that every Timorese has the right to education and culture, being responsible for the creation under the law of a public basic education system that is universal, compulsory and, as far as possible, free. In 2008, reforms in the education sector has been initiated with the creation of the Education Organic Law (2008), the Education Policy (March 2008) and the Basic Law on Education (October 2009) which established the necessary framework for a new system. The beginning of the year 2010 marked the implementation of a Free and Universal Education System with nine (9) years of compulsory education. None of these policies explicitly addresses HIV, and there is no specific policy for the sector on HIV and AIDS.

ii) Management

MoE engagement or involvement in the implementation of programmes to address HIV, drugs and related issues was recognized to be very limited. The majority recognized that teaching materials on the issue including reference materials on drugs and sexual health education are sparse and there has not really been an

ongoing process to train teachers on HIV and AIDS to-date. Overall, support and commitment was felt to be provided by the sector leadership once initiatives are undertaken though and the general response of the MoE officials was noted to be always positive.

There is no established unit within the current structure to coordinate and manage the Ministry's contribution to the national HIV response. MoE staff indicated during the interviews, that prior to the establishment of the current organizational structure, the Focal Point for HIV and AIDS was the Director for the National Directorate on School Management and Accreditation which was also responsible for school health programmes of the Ministry. Currently, the HIV and AIDS Focal Point of the Ministry of Education is also the School Health Coordinator at the national level responsible for overseeing the school health programme who sits within the National Directorate for Curriculum and Materials Evaluation. This will eventually change altogether again with the new Ministry structure being approved effective 2011 under its reform process.

The School Health Coordinator/Focal Point at the national level is responsible for coordinating and linking with the Ministry of Health on a range of issues. The wide breadth of issues covered by School Health Coordinator (one individual) likely means that not all receive adequate attention. The current key activities that the Coordinator is reportedly undertaking include the finalization of the child-to-child module (healthy children module) and teachers' training and workshop on the module. As the structure is not explicitly defined, the function of responding to the issues in programmatic terms from the national level down to the lower level automatically falls on the lap of the Regional Director at the regional level, District School Directors/Managers at the district level and sub-district coordinators at the sub-district level and down to the school heads and principals at the village levels.

ii) The curriculum on HIV, drugs and sexual health

The MoE has only recently developed the national pre-secondary curriculum while the national secondary curriculum is still under development. Textbooks and learning materials are reportedly limited. HIV, drugs and sexual health are included in the main subjects of health, science and in civic education, and religion and moral education curriculum.

Primary education. The primary level curriculum within the current basic education structure uses the same curriculum developed in the early years following independence, and the MoE has a plan to revisit and revise the curriculum within the framework of the 9-year basic, compulsory education. The current textbook being used for the primary education which integrates an HIV-AIDS topic is the "Estudo do Meio" book. This is a book which talks about science both natural/physical sciences and social sciences including the environment. HIV and AIDS as a topic is specifically included in Grade 6 level but only on the basic definitions of HIV and AIDS. (See Annex 6: Topics/Chapters on "Estudo do Meio" Book for Primary Level).

Pre-secondary education. At the pre-secondary level, HIV is integrated in the Physical and Natural Science subject. It is not an independent topic, but rather discussed in the adolescent reproductive health topic which also addresses drugs and sexual health. HIV and AIDS can be part of the civic and religious and moral education subjects as well in the pre-secondary level, but this is arbitrary, depending on the teacher and also dependent on the availability of materials.

Secondary education. The MoE has started the process of developing the new secondary curriculum in partnership with a Portuguese University and is scheduled to be implemented for 2012. Life skills education is integrated in the curriculum. The old Bahasa Indonesia curriculum for secondary is still being used pending on the implementation of the new secondary curriculum which is currently under development. The topic of HIV and AIDS is covered in substantial detail both at the curriculum and textbook levels. New textbooks are not yet available for the secondary level, the old Bahasa Indonesia textbooks are still being used by almost all teachers. However, availability is very limited.

A review of the reference textbooks for secondary level, found that HIV and AIDS are integrated into the subject of Biology. Most of the schools are basically using this reference material for lack of new materials/textbooks from the Ministry of Education. HIV Education is taught or discussed in the subject of Physical Sports and Education as well as Religious and Moral Education which include the topic of drugs and sexuality as well as smoking or tobacco control education.

iv) Teaching and learning materials

The teaching and learning materials either for HIV, drugs or reproductive health and sexuality are very limited as well aside from the textbooks mentioned above. There are curriculum guides for teachers at all levels and, at the pre-secondary and secondary level, teaching modules are specifically developed on all subject areas either both at the public or private high schools. The new textbooks for primary level are all in Portuguese for which teachers are challenged to teach at the same time learn and master the Portuguese language.

At the primary level, prior to the production of the Portuguese textbooks, the main reference material for teaching was the Lafaek magazine for which most teachers rely upon. The topic of HIV and AIDS was included under the science and health subject. The magazine which is produced by CARE in Timor-Leste however, will cease to be produced soon as the Ministry of Education will take over the production of these materials.

The pre-secondary level reference textbooks are in Portuguese and include the topic of HIV and AIDS specifically within the Biology subject. Aside from that, materials guides for teachers are also developed on specific subjects such as civic education, physical education and religious and moral education. (See *Annex 4: Pre-Secondary High School Level-Reference Material Guide for Teachers-Canossa Pre-Secondary School*).

Reference textbooks have also been made available in secondary school that addresses HIV, AIDS and related issues. (See *Annex 7 Secondary High School Level Reference Textbook with Inclusion of HIV-AIDS Topic*).

v) Implementation

A low priority

Most of the officials interviewed acknowledged that HIV is an important issue but seemed not to be an urgent concern due to the lack of a deeper understanding of the issue; limited information on the impact it has on children/students and young people and in the education sector in general; competing priorities in the sector; and the fact that Timor-Leste remains a low HIV prevalence country. Moreover, it remains a distant problem. The majority of those met reportedly not being aware of the HIV

cases in the country, apart from those reported in the news or information that are issued by authorities.

HIV and the workplace

There has not been an effort either to address the vulnerability of MoE personnel to HIV and AIDS. Likewise, there is no data or figures at all regarding learner/student and teacher mortality or number of students and teachers infected and affected by the disease. This includes students and teachers in the non-formal sector. With this, it lacked yet the effort to either respond or mitigate the impact of AIDS, if at all there is any, on the education system. With the absence of data, stigma and discrimination against students and teachers with HIV infection has not been observed given that there have not been reported cases yet among students or teachers.

The MoE is however, implementing the concept of child-friendly schools ensuring that schools are safe and healthy places for students. Pilots have been undertaken in relation to implementing the concepts, which are also supported by NGOs working in the sector. Similarly, to address gender-related vulnerabilities, there have been recent reforms at the structural level in the MoE including the appointment of a Gender Focal Point to oversee implementation of the gender equality initiatives and reforms. The Director for Policy and Planning is designated as the Focal Point at the national level supported with staff dedicated for gender mainstreaming in the Ministry. Further, the MoE has initiated a study on girls' education and disparities this year which is a positive undertaking to address issues of vulnerability.

Teaching and the classroom

During interviews, it became apparent that some teachers would teach the topics in the areas of physical education, civic education and religious and moral education to complement/reinforce the subject. Based on interviews with Catholic schools, HIV and AIDS are usually discussed in the religious and moral education subjects apart from the topics in the Biology subject.

Teacher training

Based on interviews with MoE officials, there used to be some training provided to teachers on HIV, specifically on the teaching of life-skills education, with support from UNICEF. According to those interviewed, there have been very limited opportunities for training and inputs regarding HIV with the MoE officials and staff. Materials as well are very limited and not widely accessible, and there is little guidance on HIV available for all teachers and educators all over the country.

Monitoring and evaluation

Presently, there is no monitoring of the HIV and AIDS activities yet within the education sector mainly due to a very limited programmatic response. No research has been carried out to date either in relation to HIV and AIDS in the education sector, much less, programme evaluation.

The Education Management Information System (EMIS) of the Ministry of Education provides basic data on the health and sanitation conditions of schools, but is very limited on data on the health status of children. The EMIS system of the Ministry of Education is not linked with the Health Management Information System (HMIS) of the Ministry of Health to get a picture of the risks and vulnerability status of children and young people. It is felt that information on the health status and risks of children and young people is very low or no information at all.

Partnerships

HIV and AIDS and education partnerships have yet to be established. There are however, PLHIV groups but the education sector is not involved at with them, though NGOs are supporting such networks. Parent-Teachers' Associations (PTAs) are organized in the whole territory under the community-based school management approach; however, there is no partnership on HIV education in these associations yet nor are there any student groups on HIV.

Section 4. Discussion

Education sector responses to HIV, sexual health and drugs vary across the five countries. The country responses are summarised in terms of the important components of an education sector response.

4.1 National Responses

All five countries in this study have put in place national responses to HIV and AIDS as well as national responses to drug abuse. These responses while ostensibly multi-sectoral are dominated by the health sector, a trend that has been strengthened by steps to expand access to treatment and care. The focus of HIV prevention efforts has generally been to provide targeted services to key affected populations. The education sector response as a component of the multi-sectoral HIV strategy has become a lower priority as the general population is considered to be at low risk or in the case of children at school, no risk.

In Brunei, the emphasis is on health promotion and the achievement of a healthy lifestyle. Interventions to prevent HIV, other STIs, unwanted pregnancy and drug abuse are largely delivered through NGOs. There are strong penalties under the law (civil and Shari'a law) for drug consumption and supply as well as for sexual crimes (e.g. close proximity and forbidden sexual intercourse). Indonesia has focused on HIV prevention and Behaviour Change Communication (BCC) with key affected populations in successive National HIV and AIDS Plans. Harm reduction programmes have been introduced for injecting drug users. Malaysia has a similar approach though there appears to be a stronger emphasis on meeting the needs of HIV infected and affected children in the National HIV/AIDS Plan. Philippines also now focuses on BCC for key affected populations, but in the previous plan (2005-2010) had included strategies for children in school. Timor Leste similarly prioritises key affected populations in its National HIV and AIDS Plan.

It is very clear that the education sector response to HIV is becoming marginal to National HIV and AIDS Plans in the five countries. However, this strategic approach risks neglecting the needs of young people in terms of the knowledge and skills they will need to become healthy adults. As is evidenced in the situation analyses in the previous section, young people do need education about sexuality, drugs and STIs. In order to provide an enabling environment for preventing HIV and drug abuse, it is important to have an educated population, one that does not hold misconceptions or is discriminatory towards key affected populations, including people living with HIV. This is where education can play an important complementary role with health sector interventions.

4.2 Education Sector Responses

Policy and strategy

The countries have put in place a variety of policy responses for HIV, drugs and sexuality education. Only Indonesia has a specific education sector policy or strategy on HIV, sexuality and drugs education. It also appears that some countries lack specific policies on school health (e.g. Timor Leste). The Philippines has a national law on HIV prevention which prescribes policy for education (Republic Act 8504, 1998), including the specification of curriculum content. In practice, the curriculum is the main policy document on HIV, sexuality and drugs. Only Indonesia includes a strategy for HIV and drugs education in its Education Sector Strategy. No country

has a sector specific strategy for developing HIV and drugs education or school health.

Indonesia has put in place policy through the *HIV/AIDS Prevention Strategy through Education* to integrate HIV into school curricula and guide how teachers should be informed and trained to carry out the mandate. Although this policy document was disseminated nationally, it appears to be neglected. The SRA found that many in the field were unaware of it. In 2008 MoNE Decree No. 39 on *Guidance and Supervision of Student Activities (Pembinaan Kesiswaan)* was enacted in which HIV and Drug Abuse prevention are mandatory activities. In the current Education Sector Plan (2010-2014), life skills education is the strategy for preventing HIV and drug abuse.

The Philippines has had national legislation in place on HIV education since 1998 that mandates the education sector to integrate HIV preventive education in formal and non-formal education from the elementary through the tertiary level and in technical education. However, the law has not been well-disseminated and implementation is not strong. This was also observed to be case in Indonesia. In the Philippines, all schools have policies and rules on student discipline related to HIV, drugs and sexuality education, but not all have them printed in student handbooks for students and parents' information.

Managing the Response

Policies require implementation arrangements, including dissemination mechanisms in order to be effective. This can require the establishment of specific institutional capacity to take this forward or adding the responsibility to existing arrangements. In large education systems, it is important to decentralize implementation to provincial or state levels. In all education systems, it is important to build implementation capacity in the school itself and the community.

The five countries are implementing a range of management responses. In practice, the school health framework appears to be critical for implementation. In Brunei Darussalam, capacity to implement HIV and drugs education has been established in the Health Promotion Centre of the MoH and in key NGOs (BDAC and BASMIDA). Indonesia had appointed a focal point for HIV in the Ministry of Nation Education (Director of the National Centre for Physical Quality Development). With the exception of the Papuan provinces there has been limited capacity building in Provincial Education Offices. Malaysia has not put in place any specific management arrangements for HIV and drugs education. The MoH is responsible for school health. The Philippines has established a complex set of arrangements for coordination and management of the HIV response. This includes an Education Committee in the National AIDS Commission (PNAC), mainstreaming responsibilities in existing bodies such as Department of Education (DeEd), CHED and TESDA. The School Health and Nutrition Centre of DepEd plays the key coordination role as includes the focal point on HIV and AIDS. Timor-Leste has appointed a focal point for HIV who is also the School Health Coordinator within the National Directorate for Curriculum and Materials Evaluation. Otherwise management arrangements are recognised to be very limited.

The Curriculum

The strategy that has been adopted by the five countries is curriculum integration to enable teaching and learning to take place on HIV, sexuality and drugs. Content for these topics has been integrated into the curricula of all five countries. With the exception of Timor-Leste, which includes it in Science/Social Sciences at grade 6, HIV is generally introduced in secondary education. Often information HIV is strongly

bio-medical in approach and not related to actual contexts in which students live. HIV is included in Biology (Indonesia and Timor Leste), Social Studies (Indonesia), Physical Education and Health (Indonesia, the Philippines, and Timor Leste) and Religion (Indonesia and Timor Leste). Similarly sexuality issues including SRH are usually covered in Biology or Science during secondary education (e.g. Brunei Darussalam, Indonesia and Malaysia). Drugs education is included in secondary curriculum in subjects such as Physical Health (Brunei Darussalam and Malaysia), Biology and Science (Brunei Darussalam, Indonesia, and Malaysia), Social Studies (Indonesia) and Religion (Indonesia, and Malaysia). The link between injecting drugs use and HIV is not always made (Indonesian textbooks). Life-skills based HIV education is being introduced in Indonesia, Malaysia, the Philippines and Timor-Leste.

In general, curricular content on HIV tends to be superficial. Moreover, the integration of HIV, sexuality and drug issues in multiple subjects risks the fragmentation of learning and the loss of a logic model in prevention. In the Philippines, HIV education is not explicitly integrated in the curriculum, although there are many topics in different learning areas that relate indirectly to sexuality and HIV. Content on HIV may be incomplete and not comprehensive. For example in Indonesia most textbooks address how HIV is transmitted but do not include myths and misconceptions. Some content on HIV is prejudicial, for example HIV can be portrayed as an affliction of the promiscuous, perverted or depraved (in some Indonesian textbooks). There are also inaccuracies e.g. AIDS is a disorder of the circulatory system (Philippines).

HIV prevention methods including condoms are given limited attention (e.g. Indonesia). Sexual abstinence is the preferred method until marriage in all 5 countries. With drug abuse education, methods for prevention and helping students to deal with real life situations tend to be lacking.

In Indonesia, HIV has been included in the school curricula in junior and senior secondary schools through the *minimum standard requirements of subject matter* known as KTSP 2006, providing guidelines for school textbook writers and teachers. But reference to KTSP 2006 in textbooks is not coherent, with varying quality.

Health education is an important vehicle for HIV, sexuality and drugs education. It is particularly important in Malaysia, the Philippines and Timor-Leste. In the Philippines, at the high school level, HIV education is integrated only in P.E. and Health. Brunei Darussalam emphasizes the importance of moral and values education through religious education and the Malay Islamic Monarchy syllabus. Across all countries religious values are important in education and in HIV, sexuality and drugs education.

It was found that HIV, sexuality and reproductive health, and drug abuse are subjects of interest to students in Indonesia and Malaysia. However, many students are not satisfied with what they learned from textbooks and they look for further information in popular media or cyberspace without supervision.

Co-curricular activities

Co-curricular activities can very usefully complement a curriculum-based approach. All five countries have some co- or extra-curricula activities that may be supported by NGOs or CBOs in some schools which includes HIV sexuality and drugs education. There is a lack of data on the coverage of these programmes. These appear to be important in that they allow for a more participatory student-centred form of learning experience. Brunei Darussalam provides a range of activities including youth-led a HIV awareness programme (HAPPY) and life skills (LESTARI). Peer education and

life skills-based HIV education are implemented in Malaysia through the PROSTAR programme. Targeted activities are implemented in high-risk contexts for drug abuse through the Excellent Anti-Drug school initiative (SEGAK). Camps for life skills development are held in Malaysia for students who have been identified as taking drugs through random screening tests (The Student Intervention Programme). In Philippines, attention is given to the annual World AIDS Day commemoration as a means of raising awareness.

A risk of reliance on NGO-implemented programmes is that they can lead to a fragmented programme of learning activities that are disconnected from the curriculum. They can also fall outside any accountability framework in the school. It is important therefore that capacity is built in schools to ensure that such co-curricular activities are coordinated with the curriculum as far as possible.

Teacher training and classroom practice

Effective teachers are critically important to the success of school-based HIV, sexuality and drugs education. This entails the provision of quality teacher training, teaching and learning materials, guidance for teaching, professional supervision and support. It is clear that insufficient attention has been given to enabling teachers to be effective in the classroom with the curricula that have been developed.

The five countries have generally not developed teacher training curricula and materials for teachers in pre-service training. Such training as has been given tends to be delivered as in-service training and on an ad hoc basis. It appears that only limited numbers of teachers have received comprehensive in-service training in HIV, sexuality and drugs education subjects in an interesting and engaging manner. Brunei Darussalam has trained school counselors on HIV and related issues. In the Philippines, HIV education is included in the annual training of School Health personnel.

In general, there are very limited resources available for teachers. In Timor-Leste teaching and learning materials either for HIV, drugs or reproductive health and sexuality are very limited. Teacher training materials have been developed in a number of countries. In Indonesia MoEC has been collaborating with UN Agencies (UNICEF, UNESCO and UNFPA) and NGOs in publishing teachers and training manuals on sexual and reproductive health, HIV, and drug abuse. Due to limited resources, however, distribution and utilization of these materials are very limited.

Little is known about actual classroom practice. It is likely that at some of the teaching is conducted in a didactic manner emphasising the mastery of facts rather than practicing skills and engaging in participatory learning activities. This is being addressed through various life-skills education based initiatives. Textbooks give little support to the teacher in developing creative teaching and learning strategies (Indonesia). Where the HIV, sexuality and drugs education is not compulsory, it risks not being taught by teachers who focus on the core curriculum (e.g. Malaysia). Other implementation problems that were reported by teachers in Malaysia include lack of time to deliver the curriculum; lack of adequate training on life skills education/HIV education; confusion about differing guidance on HIV education and training is not compulsory. Limited training, guidance and materials are also an issue in Timor-Leste.

In Indonesia, many education sector stakeholders have mentioned difficulties in discussing sexual health with their children and students. They admitted to a lack of adequate knowledge about HIV and AIDS and appropriate strategies in teaching HIV

education. The SRA findings suggest that a lack of correct information about HIV might be common among teachers, parents and community leaders, as well. Findings likewise suggest that misleading information and unhealthy sexuality are being transmitted from stakeholders to students.

Supervision and support

There appears to be very limited professional supervision and support available to teachers who teach HIV, sexuality and drugs education. This is an area that needs further attention at school level in particular.

Learning outcomes

The most important result of HIV, sexuality and drugs education is the learning achieved, whether in terms of knowledge, values and attitudes or skills. Little is known about the learning outcomes of HIV, drugs and sexuality education in the five countries. It was not possible to undertake any assessment in the SRAs and this represents a very significant gap in our data. Little is known about assessment methods in the five countries in this area. In Philippines, teachers make use of objective and subjective tests as well as alternative assessment tools to evaluate skills and values-based instruction on HIV, drugs and sexuality education. FGDs in Malaysia revealed that students had limited knowledge about HIV and STIs.

Monitoring and evaluation

No country has put in place an M&E framework for HIV, sexuality and drugs education.

4.3. Conclusions

All five countries are delivering HIV, sexuality and drugs education through the national curriculum and with co-curricular activities. The curricular content has been prepared in line with local culture and religious beliefs. Content is not comprehensive, nor does it closely match the sexual risk factors or reflect the everyday lives of the learner. It tends to be theoretical and bio-medical in nature. There is therefore scope for reform in order to bring the subject more to life for the learner and to make the content more comprehensive (e.g. to include more on means of prevention, access to services, treatment education etc).

All five countries place a strong emphasis on the importance of values in preventing HIV and drug abuse. This appears to be an important contribution to reducing risk behaviours. In the Philippines, the importance of the value of gender equality in practice in the classroom is mentioned as a positive factor by learners in FGDs. It is less clear that values and attitudes towards PLHIV and most at risk populations are being positively addressed.

Teachers need more support if they are to teach the curricula effectively. This involves the development of pre-service training, in-service training and supervision/support mechanisms at school level. There needs to be a stronger emphasis on building capacity at the school level. Importantly, there needs to be some attention to learning outcomes. The experience of SAQMEQ in southern Africa in developing a standardized regional HIV test in order to assess learning outcomes may be of interest to the five countries and to ASEAN more generally.

School health arrangements appear to be critically important in implementing HIV, sexuality and drugs education. There seems to be a need to develop comprehensive school health policies to reflect this as well as strengthen school health implementing

arrangements at central and decentralised levels down to the school. Such policies should be supported by the preparation of school health strategic plans for effective implementation. These would include a framework for M&E.

Finally, each country appears to have developed its own response individually. There seems to have been little cross-country sharing and learning. This should be addressed.

4.4. Recommendations to countries and to UNESCO

The Situation

- a) Invest in obtaining better strategic information about adolescents/young people concerning sexuality, drug use and HIV risk and vulnerability
- b) Consider commissioning comprehensive studies on the Situation of Young People, which include comprehensive consultations with young people to better reflect their interests, assets, vulnerabilities/risks, needs and aspirations;
- c) Examine the documentary good practices concerning Situation Analyses of Young People e.g. Zambia and Viet Nam.

The Response

- d) Consider developing comprehensive school health policies and strategies in part to reflect current practices in HIV, sexuality and drugs education and in part to help strengthen the effectiveness of the implementation of current approaches. Existing policies should; be reviewed as part of that process. Clarify criteria and arrangements for NGOs working with schools to develop a better enabling environment for effective programmes;
- e) Strengthen management arrangements to implement policies on school health, HIV, sexuality and drugs education at central (e.g. a Task Force), decentralised and school/community levels. Strengthen community participation and parental education;
- f) Strengthen curriculum development practices for HIV, sexuality and drugs education. Review current curricula in the light of the IATT criteria for effective curriculum-based HIV programmes, EDUCAIDS and UNESCO sexuality guidelines. Consider addressing issues of gender more centrally, including masculinities and GBV;
- g) Strengthen curriculum implementation at school level through school-based management. Ensure that teachers in HIV, sexuality and drugs education are adequately trained, supervised and supported and that adequate teaching and learning resources are available in all schools;
- h) Identify key gaps in current provision such as stigma and discrimination and address these in the curriculum and co-curricular activities;
- i) Continue to strengthen values education ensuring that positive values are promoted concerning HIV prevention and PLHIV;
- j) Focus more strongly on assessing learning outcomes in relation to HIV/SRH and drugs issues. Consider developing a standardized test for the five countries similar to that constructed by SAQMEQ in Southern Africa;

- k) Promote cross-country learning across the 5 countries. Establish a network of School Health/Sexuality and Drugs Education focal points and create a website for the purpose of sharing information and promising or innovative practices;
- l) Develop EDUCAIDS country snap shots of the HIV/Sexuality and drugs education responses for all five countries.

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