Need and Significance of HIV/AIDS Preventive Education in Pakistan

Curriculum Wing, Ministry of Education
in collaboration with
UNESCO Office, Islamabad
September 2006
Need and Significance of HIV/AIDS Preventive Education in Pakistan

Curriculum Wing, Ministry of Education in collaboration with UNESCO Office, Islamabad September 2006
Contributors

Written by:

1. Prof. Dr. Zafar Iqbal
2. Prof. Abdul Kabir Hashmi
3. Dr. (Mrs.) Firdous Zahra Bashir
4. Dr. Sultana Bakhsh
5. Dr. Haroona Jatoi

Reviewed by:

1. Dr. Haroona Jatoi
2. Qamar-ul-Islam Siddiqui
3. Ms. Jehan Ara Mueen
4. Prof. Dr. Zafar Iqbal
5. Mr. Aurangzeb Rehman
6. Mr. Arshad Saeed Khan

Coordination:

Mr. Arshad Saeed Khan

All Rights are Reserved

First Edition - December, 2003
Second Edition - July, 2005
Quantity - 500
Printed by - Orient Printers, Islamabad
Published by (i) Curriculum Wing
Ministry of Education
Government of Pakistan
Islamabad

(ii) UNESCO Islamabad
## List of Contents

<table>
<thead>
<tr>
<th>Chapter/Module</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS: Threats and Basic Facts</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Global, Regional and National Scenario of HIV/AIDS Epidemic</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>Factors of HIV/AIDS Infection and Impact on Socio-Economic Development</td>
<td>28</td>
</tr>
<tr>
<td>4</td>
<td>Role of Education for HIV/AIDS Prevention</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
<td>HIV/AIDS: A Challenge for Educational Planners</td>
<td>50</td>
</tr>
<tr>
<td>6</td>
<td>Teacher Training for HIV/AIDS Preventive Education</td>
<td>62</td>
</tr>
</tbody>
</table>
PREFACE

Pakistan is a developing country. Like every developing country it has a host of challenges with comparatively less resources to overcome these. However, the Government of Pakistan is trying its level best to put the country on the track of the development and to provide better facilities in education, health and other social sectors. Education is an important base for economic and social development. The fast changing world of today demands a lot from the educational system to respond and to bring the desired changes especially positive attitudinal changes.

The world of today is threatened with the fast growing menace of HIV/AIDS. Most of the people fall victims to this deadly infection because of ignorance about the means of transmission of this infection. The new generation has to be informed about its challenges and the preventive measures to be adopted. It is through education that the youth and our future generation can be informed as well as equipped for adopting safe behaviour, so as to protect themselves from the deadly infection. It is through education, both through formal and non-formal ways, that this message can reach every one.

The Ministry of Education, taking cognizance of the teaching of our religion, the prevalent cultural values and efforts made by different countries/organizations of the world, has decided to highlight the importance of preventive education against HIV/AIDS through system of education in the country. Efforts are being made to introduce these concepts in the curriculum as well as in the teaching materials. It is imperative that the policy makers, curriculum developers, administrators, teacher educators and teachers are apprised of this menace and also about the effects of this deadly virus.

The present book has been developed by the Ministry of Education with support from UNESCO. In the recent past, UNESCO has also contributed in the development of a teacher training manual on Preventive Education at primary level, which has already been circulated to the teacher training institutes of the country. The present book gives a comprehensive view about the threats of the fast spreading disease. The global, regional and national scenario as well as the impact of HIV/AIDS, on socio economic development has been explained in detail. It also throws light on the important role and the challenges being faced by education sector for prevention from this epidemic. The training of teacher is an important aspect being dealt through this effort.

The Ministry of Education while conveying its appreciation to UNESCO, Islamabad is indebted to all the educational and technical experts who have contributed in the development of this important publication. The Ministry is confident that the Provincial Education Departments and others related organizations will find this material quite important and responsive to the present needs. Thanks are due to all the experts, colleagues in the Ministry of Education, and experts from UNESCO, UNAIDS, UNICEF, and National AIDS Control Programme. The development of material is an on going creative effort and cannot be the ultimate one. There is always room for improvement. We will welcome all comments and suggestions for its next edition.

Dr. Haroona Jatoi
Joint Educational Adviser
Ministry of Education
Curriculum Wing
Islamabad
15th December, 2003
Chapter 1

HIV/AIDS – THREATS AND BASIC FACTS

The fact that HIV/AIDS is a fatal disease with no remedy at all, is well established. The only remedy is prevention / precaution. Foreseeing the danger and consequences likely to affect the youth in schools / colleges and its spread in the network of related institutions and ultimately in the community, awareness through education system will certainly contribute in reducing the rising graph of HIV/AIDS.

Unlike other diseases HIV/AIDS does not discriminate between rich and the poor. However apathy and ignorance appears to facilitate the spread of this infection and aggravate its impact.

WHAT IS HIV?

HIV stands for Human Immunodeficiency virus. This is a virus that people can become infected with and that they can then pass on to other people. The virus attacks the body’s immune system and over a period of time destroys it. This leaves the body defenseless against infections and other diseases.

HOW IS A PERSON INFECTED BY HIV?

When someone becomes infected with HIV it begins to attack the immune system, which is the body’s defense against illness. This process is invisible.

A person infected with HIV may look and feel perfectly well for many years, without knowing that he /she is infected. Then as the persons’ immune system weakens, he/she becomes vulnerable to illnesses, many of which, in normal conditions could be easily fought off.

WHAT IS AIDS?

When a person is infected with HIV he/she is likely, as time goes by, to be ill more and more often. A person is said to have AIDS (Acquired Immune Deficiency Syndrome) when, usually several years after first becoming infected with HIV, one or a number of particularly severe infections are developed.

HOW HIV IS TRANSMITTED?

HIV is present in the sexual fluids and blood of infected people. It can also be present in the breast milk of infected women.
HIV is transmitted when infected blood, semen, vaginal secretions or breast milk get into another person's body. In other words HIV infection occurs after the virus enters and establishes infection in the body. HIV may take many (2-10) years to transform into AIDS. A series of blood tests can identify the infection in the early stages. The blood test identifies antibodies that are produced as a result of the infection i.e. virus. These antibodies weaken the defense mechanism of human body and the individual becomes prone to conditions like:

- persistent diarrhea
- severe weight loss
- fever
- fatigue
- cough
- skin rash
- loss of appetite
- enlarged lymph glands

STAGES OF HIV INFECTION:

Stage 1: Window Period

Once a person is infected with HIV, that person does not immediately become “HIV Positive”. In other words the body takes time to produce measurable amount of antibodies after infection (HIV), the period is usually 2-12 weeks; in some cases it may even be longer. This is called the “Window Period”. If an HIV antibody test is taken during the window period, it will be negative, since antibodies are not yet at a detectable level. The infected person may, however transmit HIV to others during this period.

Stage 2: Asymptomatic Period

After the HIV infection is acquired, there is apparently no change in the person’s health for many years. Most people infected with HIV are still healthy and can live for years with no signs of being sick—“asymptomatic.” This period is around 8-12 years. At times, a person may begin to show signs of infection as early as 5 years after the infection.

Stage 3: Symptomatic Period

When the deterioration of the immune system reaches a particular degree, the infected person begins to feel fatigued and unwell. He/She begins to suffer from successive attacks of illness e.g. influenza, diarrhea etc. which normally can be cured through medicines. However in case of HIV infection these diseases are not cured through medicines and the defense system becomes so weak that opportunities become available to ordinary infections to establish themselves. These are referred to as **Opportunistic Infections**. These opportunistic
infections attack the individual frequently, who is now said to be suffering from AIDS. Thus HIV leads to AIDS and the opportunistic infections then prove fatal. Most may die within eight to ten years or even sooner after they become infected with HIV.

An individual infected with HIV is infected for life. There is presently no treatment for elimination of this virus. However costly research is being carried out for its prevention and cure.

WHAT IS SYNDROME?

 Syndrome is a group of symptoms and illnesses. In other words it is a combination of symptoms and conditions that, taken together, makes it possible for the diagnosis of AIDS. For example the immunodeficiency syndrome constitutes the essential features of AIDS. It can also occur in other diseases, such as tumors, T.B, Hepatitis etc.

DOES AGE OR SEX FACTOR MAKE A DIFFERENCE?

Majority of the AIDS cases are found in adults between the ages of 20-50 years. Differences however exist between male and females in this regard i.e., 30-39 years for males and 20-29 years for females. This means that AIDS strikes hardest at those, man and women, who are in their most productive years.

In countries of high prevalence, a significant number of AIDS cases exist among the children below the age of 5 years. These children may have received the infection from their parents including MTCT (Mother to Child transmission). Almost all such children die very soon. The school going children in the 5-14 years age groups are referred to as the “window of hope” because if they escape the fatal infection they constitute a hope for the future.

PRESENT SITUATION OF AIDS/ HIV:

- It is among the top five fatal diseases and is the leading cause of death, particularly in Africa;
- It threatens the socio-economic setup, health and security of all countries;
- It is spreading very rapidly in many developing countries;
- It manifests a widening gap between the rich and poor countries;
- It is greatly affecting the young people with more than half of those before the age of 25;
- It is damaging the social and family life, leaving in its wake a large number of widows and orphans;
- It is causing adverse effects on developing economies and institutions.
HOW IS HIV TRANSMITTED?:

Following are four major modes of transmission of HIV, which ultimately lead to AIDS:

- Sexual relationship;
- Transfusion of contaminated blood and blood products, tissues and organs;
- Use of contaminated needles, syringes and other piercing instruments and
- Mother/Parent to child transmission.

a) Sexual Relationship

HIV can be transmitted through unprotected sexual intercourse in other words unsafe sex (Men to women, women to women and men to men) is the main cause of HIV transmission. HIV is spread when body fluids (blood, semen) from HIV infected person enter into the body of an uninfected person. An HIV infected individual is most likely to infect one or more sex partners, particularly if the later is already infected due to an injury, ulcer and STI's (sexually transmitted infection, e.g. Gonorrhea, syphilis etc). Individual having unprotected sex relations with several partners and especially with sex workers are more likely to get infected with HIV/AIDS. Young girls are physiologically more vulnerable.

b) Contaminated blood or blood products, tissues and organs

Blood transfusion saves millions of lives each year, but in places where a safe blood supply is not guaranteed, those receiving transfused blood have an increased risk of being infected with HIV.

Transfusion of blood of an HIV infected person to another would directly transmit HIV into the blood of the recipient. It is therefore always recommended that blood donated by voluntary donors should be screened before transfusion. Besides the blood offered by professional donors in lieu of money should not be accepted and used for transfusion. To prevent transmission by tissue and organ donation for transplant, including sperm for artificial insemination, the HIV infection status of the donor should be carefully examined.

c) Contaminated syringes, needles or other piercing instruments

HIV can be transmitted through the use of HIV-contaminated needles or other invasive instruments. The sharing of syringes and needles by injecting drug users is responsible for the very rapid rise in HIV infection among persons in many parts of the world.

A risk is also attached to non-medical procedures if the instruments used are not properly sterilized. Such procedures include ear, nose and body piercing,
tattooing, acupuncture, circumcision and traditional scarification. The actual risk depends on the local prevalence of HIV infection.

HIV transmission by means of injection equipment can also occur in healthcare settings where syringes, needles and other instruments, such as dental equipment, are not properly sterilizes, or through injury by needles.

Sharp instruments like razors, blades, and knives can be a source of HIV/AIDS. Barbers may use one blade for shaving more than one client. While shaving, the client may receive a small cut or bruise and the contaminated blade may do the damage and infect the person with HIV.

d) Mother/Parent-to-child transmission (MTCT)

Mother-to-child transmission (MTCT) is the overwhelming source of HIV infection in young children. The virus may be passed onto the unborn child, during pregnancy, labour, delivery or after the child’s birth through breast-feeding. In environments where there are limited means of health care such chances are ever greater.

WHAT IS “RISKY ACTIVITY?”

A risky activity is any activity that makes it possible for the virus to pass from one person to another. This is why sexual intercourse without a condom could be risky, because the virus, which is present in an infected person’s sexual fluids, can pass directly into the body of the partner.

Contact with an infected person’s blood is risky, if it allows the virus to pass into another person’s body, through cuts and grazes in the skin. This is why it can be risky being pricked by, or injected with a needle or a syringe already used by some one else.

HIGH RISK BEHAVIOUR

High-risk behaviour is defined in the context of HIV/AIDS as a person’s likelihood of becoming infected with HIV, due to his or her own unsafe actions. It is believed that there are two major high-risk behaviours, which are facilitating the spread of HIV/AIDS in Pakistan. One is unsafe sex and the other is injecting drug use.

AIDS education covers effective prevention, care and support of people with HIV/AIDS. Education of this kind helps young people to avoid high-risk behaviour.
Risk Related To Injecting Drug Use

The second high-risk behaviour, which may greatly influence the course of Pakistan's HIV/AIDS epidemic, is injecting drug use. Users often share needles and syringes, which is highly efficient mode of transmission for HIV and other blood-borne infections. Recent studies indicate that the frequency of unsafe injecting drug abuse is increasing throughout the country.

In addition to the risk associated with needle and syringe, infected injecting drug users can pass a risk to others through sexual transmission. In the early stages of drug addiction, drug dependents often remain sexually active. In the later stage while sexual activity may not be so frequent, a decrease in concerns about high-risk behaviour is often also noted. This behaviour can pass the risk of transmission of HIV infection to their sexual partners. The present estimation of the number of drug dependent persons in Pakistan is approximately four million. An additional concern is that many injecting drug users are thought to sell their blood for money to support their drug habits. There is every possibility of triggering of a more generalized HIV epidemic, as a result of secondary transmission through sexual activity, or through transmission by blood transfusion.

Risk Related To Unsafe Sex

Unsafe sex accounts for up to 70% of Pakistan's reported HIV infections. Unsafe sexual activity refers to unprotected sexual activity between people, who may or may not be aware of each other's infection status. This includes not only prostitutes (sex workers) and their clients, but also anyone who has unprotected sex with multiple partners and men who have sex with men (MSM). Even when male homosexuality has been prohibited, there are well-developed homosexual networks and sub-cultures, which maintain their confidentiality of identities due to legal and social intolerance.

As in other parts of the world, truck drivers are considered to be at high-risk for acquiring and transmitting HIV. Other research has suggested that sexual activity among men is widely practiced among long distance truck drivers, jail inmates, male hostels, workshops, etc. in Pakistan as well.

As blood transfusion and the use of blood products accounted for approximately 18% of HIV infection in Pakistan, blood collection and transfusion are reported to be major areas of concern regarding prevention of HIV infection.
HIV/AIDS is a continuing threat to young people. The future projections of the global HIV/AIDS epidemic depends on whether the world can protect young people everywhere against the epidemic and its aftermath.

In countries and communities where the prevalence of HIV is very high, the epidemic already constitutes a major crisis. Millions have died. If current trend continue, millions more will suffer the same fate.

**Estimated Adult and Child Deaths Due to HIV/AIDS During 2002**

<table>
<thead>
<tr>
<th>Region</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>South and South East Asia</td>
<td>440,000</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>45,000</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>25,000</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>2,400,000</td>
</tr>
<tr>
<td>North Africa and Middle East</td>
<td>37,000</td>
</tr>
<tr>
<td>Western Europe</td>
<td>8,000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>42,000</td>
</tr>
<tr>
<td>North America</td>
<td>15,000</td>
</tr>
<tr>
<td>Latin America</td>
<td>60,000</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
<td>&lt; 100</td>
</tr>
</tbody>
</table>

**Total 3.1 Million**


**HOW HIV IS NOT TRANSMITTED:**

Family, friends and co-workers should not fear becoming infected with HIV through casual contact with an HIV-infected person at home, at workplace, or socially. Such misconceptions and prejudices can be warded off if proper information about the disease is provided.

**These activities will not transmit the virus:**

HIV/AIDS will not affect any one through air, food, water, handshake, or Every day contact with infected people. Unlike many other diseases, talking to an infected person, HIV is caused through the penetration of body fluid like blood, semen or other secretion coming through sexual activity.

- Other body fluids like sweat, urine, and saliva are generally not likely to cause infection;
• mosquito bite. Unlike the malarial parasite, HIV does not survive inside the mosquito;
• sitting close to the infected person, who is coughing and sneezing;
• swimming with an HIV/AIDS infected individual in the same pool;
• serving or taking care of an infected person;
• eating food prepared by someone who has HIV;
• sharing food, eating or drinking utensils;
• using drinking fountains;
• using toilets or showers;
• using a phone booth;
• shaking hands, hugging or kissing.

AIDS and work

For the vast majority of occupations, the workplace does not pose a risk of acquiring HIV. The exceptions include laboratory workers, health care workers, and persons dealing with hospital waste products, emergency medical response personnel and any other occupation where there is possibility of exposure to blood. Though the risk is low, the treat is real. Among the hazards to which these persons may be exposed are needle-prick injuries and other skin piercing accidents and blood splashing into the eyes while they are administering treatment or otherwise performing duty.

Mouth-to-mouth resuscitation is a life-saving procedure that should not be withheld because of an unsubstantiated fear of contracting HIV or other infection. No case of HIV transmission via this route has been reported. A theoretical risk, however, exists if the person resuscitated is bleeding from the mouth. In this case it is advisable to use a clean cloth to wipe away any blood from the persons mouth.

A person who is bleeding needs immediate attention. Care should be taken to avoid blood contact with the eyes, mouth and any broken skin. Open cuts and wounds should be covered before giving first aid. Hand should always be washed with soap and water as soon as possible after giving first aid.

AIDS and sports

There are no documented cases of HIV being transmitted during participation in sports activity. The very low risk of transmission during participation in sports would involve those that bring direct body contact, in which bleeding might be expected to occur.

It is theoretically possible for the virus to be transmitted if an HIV-infected athlete had a bleeding wound or skin lesion with fluids that may come in contact with another athlete’s skin lesion, cut or exposed mucous membrane. Even in such an unlikely event, risk of transmission would be very low. However, in sports
involving direct body contact or combative sports where bleeding might occur, it is sensible to cleanse the effected skin lesion with antiseptic and cover it securely.

TREATMENT OF HIV/AIDS

There is no known therapy for restoring the HIV/AIDS free status of an affected person. Individuals once infected with HIV/AIDS are infected for life. The opportunistic infections can be treated at moderate cost. However, Highly Active Antiretroviral Therapy (HAART) may suppress viral activity in the body and thereby prolong the time for the patient to survive. This virus is not eliminated but suppressed for some time. In other words anti-retroviral treatment is not an absolute cure.

The onslaught of HIV/AIDS can be checked by the provision of appropriate information and education at all levels of society, thereby creating an enabling environment for behavior change. Preventive measures through education system remain a cornerstone of HIV/AIDS control particularly for youth.

STIGMA AND DISCRIMINATION

Stigma, discrimination, blame and collective denial make it very difficult to effectively tackle the epidemic at its various stages HIV/AIDS-related stigmatization and discrimination make prevention difficult by forcing the epidemic out of sight and underground.

What is Stigma?

Stigma and discrimination associated with HIV and AIDS are the greatest barriers to preventing further infections, providing adequate care, support and treatment. HIV/AIDS-related stigma and discrimination are universal, occurring in every country and region of the world.

Stigma has been described as a quality that “significantly discredits” an individual in the eyes of others. People with HIV/AIDS are often believed to be promiscuous and deserve what has happened to them. Often these are linked to sex or to undesirable and socially unacceptable activities, such as injecting drugs. Men who become infected may be seen as homosexual, bisexual or having sex with prostitutes. Women with HIV/AIDS are viewed as having been "promiscuous'.
Self Stigmatization

Self-stigmatization is a shame that people living with HIV/AIDS experience when they are discriminated by others. Self-stigmatization can lead to depression, withdrawal and feeling of worthlessness. It saps the strength of the individual, and causes them to blame themselves for their misery.

What is Discrimination?

Discrimination occurs when a distinction is made against an HIV/AIDS infected person and is treated unfairly and unjustly. Hospitals, for example, may not offer health services to a person with HIV/AIDS, employers may terminate the worker’s employment, or schools refuse admission to a student on the grounds of his or her actual or presumed HIV-positive status.

Reasons for Stigma and Discrimination

People may lack the information and education to understand that HIV/AIDS cannot be transmitted through everyday contact, and they may not be aware that infection may be avoided by taking simple precautions. This leads people to stigmatize and discriminate against those infected, or presumed to be infected with HIV/AIDS.

The reasons are many and include:

- lack of understanding of the disease;
- myths about HIV transmission;
- prejudice;
- HIV/AIDS being incurable;
- lack of treatment available;
- irresponsible media reporting;
- fears about sexuality;
- fears about illness and death;
- fears about illicit drugs use and injecting drugs.

Places where stigma and discrimination can take place:

a) Work

In many countries including Pakistan, employers have fired employees detected or suspected with the disease, although they might not pose any risk to the others.
b) Education

School going children are forced to leave school if found HIV positive or came from a family of an infected person.

c) Health care

Health care workers have known to have refused services to HIV/AIDS patients. The doctors and the medical staff, who are generally more informed about the disease, have in certain incidents refused to attend to patients with HIV/AIDS.

d) Community

Non-availability of a viable remedy for HIV/AIDS may result in the death of the infected person leaving behind a widow and orphans to further suffer from the discrimination and apathy of the society and community. Not only the persons living with HIV/AIDS but the spouses and children also experience the stigma and discrimination at the hands of friends, neighbours, and working colleagues. The infected person is sure to lose employment, whereas the children may be expelled from the schools. The rejection by friends and society, leads to isolation, which causes emotional disorders, agony and dejection. The infected one is greatly depressed due to the absence of a cure and fears of fast approaching death. The household economy breaks down completely and access to day-to-day needs becomes impossible. Such adverse circumstances badly affect the family life. The fear of infection creates a loss of affection among the family members.

Summary:

Aids is an incurable disease, which can be passed on by sexual intercourse, by infected blood transfusion, and by infected mothers to their unborn and new born children.

Safe sex means being sure that neither partners is infected, remaining mutually faithful and using condoms if in doubt.

Any injection with used or unsterilised needle or syringe is dangerous.

Women suffering from HIV/AIDS should avoid becoming pregnant.

All parents should educate their teenaged children about the disease and to avoid risky behavior.
Chapter 2

Global, Regional and National Scenario of HIV/AIDS epidemic

The AIDS epidemic claimed more than 3 million lives in 2002, and an estimated 5 million people acquired Human Immunodeficiency Virus (HIV) in 2002 – bringing to 42 million the number of people globally living with the virus1.

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS in combination with other crises, is driving ever larger parts of nations towards destitution.

The world has stood by as HIV/AIDS swept through these countries. It cannot be allowed to turn a blind eye to an epidemic that continues to expand in some of the most populous regions and countries of the world.

The global spread of HIV/AIDS has greatly exceeded the most pessimistic projections of a few years ago. Today almost, every country is threatened by HIV/AIDS. It is a pandemic where in both children and adults are afflicted and have died. In the absence of a cure or freely available therapy these will die before the end of this decade. The same sources say that if the spread of AIDS continue unchecked, the number of cases is likely to reach uncontrollable proportion.

In several countries experiencing the early stages of the epidemic, significant economic and social changes are giving rise to conditions and trends that favour the rapid spread of HIV—for example, wide spread social disparities, limited access to basic services and increased migration.

Best current projections suggest that an additional 45 million people will become infected with HIV in 126 low middle-income countries between 2002-2010----unless the world succeeds in mounting a drastically expanded, global prevention effort. More than 40% of those infections are likely to occur only in Asia and Pacific second after the Sub-Saharan Africa.

**GLOBAL SUMMARY OF THE HIV/AIDS EPIDEMIC**

**DECEMBER 2003**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV/AIDS</td>
<td>40 million</td>
<td>(34 - 46 million)</td>
</tr>
<tr>
<td>People newly infected with HIV in 2003</td>
<td>5 million</td>
<td>(4.2 - 5.8 million)</td>
</tr>
<tr>
<td>AIDS deaths in 2003</td>
<td>3 million</td>
<td>(2.5 - 3.5 million)</td>
</tr>
</tbody>
</table>

Source: UNAIDS, AIDS Epidemic Update, 2003

---

**Situation in Asia**

- In Asia, 2,700 people get infected every day.
- Around 25 million people could be infected in Asia by 2010 if prevention is not scaled up.
- The epidemic can be curbed if appropriate prevention programmes are put into place.

*UNESCO and UNAIDS Advocacy Kit*

---

**High Risk**

The Asia-Pacific region is seriously affected, with the potential for rapid spread if action is not taken.

*UNESCO and UNAIDS Advocacy Kit*
Global Scenario Of HIV/AIDS Epidemic December 2002

| Number of People living with HIV/AIDS | Adults          | 38.6 million |
|                                       | Women           | 19.2 million |
|                                       | **Children under age 15** | 3.2 million |
| **Total:**                             |                 | **42 million** |

| People newly infected with HIV/AIDS in 2002 | Adults          | 4.2 million |
|                                            | Women           | 2 million   |
|                                            | **Children under age 15** | 800,000 |
| **Total:**                                 |                 | **5 million** |

| Deaths due to HIV/AIDS in 2002 | Adults          | 2.5 million |
|                               | Women           | 1.2 million |
|                               | **Children under age 15** | 610,000 |
| **Total:**                    |                 | **3.1 million** |

<table>
<thead>
<tr>
<th>Asia and Pacific by 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of People living with HIV/AIDS</td>
</tr>
<tr>
<td>Deaths due to HIV/AIDS</td>
</tr>
<tr>
<td>Almost young people are living (aged 15-24) with HIV</td>
</tr>
</tbody>
</table>

(Ref: AIDS Epidemic Update, December 2002, UNAIDS/WHO, Switzerland, Page 2, 7)
### REGIONAL AND NATIONAL HIV/AIDS STATISTICS AND FEATURES END OF 2002

<table>
<thead>
<tr>
<th>Region</th>
<th>Sub-Saharan Africa</th>
<th>North Africa &amp; Middle East</th>
<th>South &amp; South East Asia</th>
<th>East Asia and Pacific</th>
<th>Latin America</th>
<th>Caribbean</th>
<th>Eastern Europe &amp; Central Asia</th>
<th>Western Europe</th>
<th>North America</th>
<th>North Australia and New Zealand</th>
<th>Pakistan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemic stated</td>
<td>Late 70s Early 80s</td>
<td>Late 80s</td>
<td>Late 80s</td>
<td>Late 70s Early 80s</td>
<td>Early 90s</td>
<td>Early 90s</td>
<td>Early 70s Early 80s</td>
<td>Early 90s</td>
<td>Late 70s Early 80s</td>
<td>Late 70s Early 80s</td>
<td>Early 80s</td>
<td></td>
</tr>
<tr>
<td>Adults &amp; Children living with HIV/AIDS</td>
<td>29.4 million</td>
<td>550.000</td>
<td>6.0 million</td>
<td>1.2 million</td>
<td>1.5 million</td>
<td>440.000</td>
<td>1.2 million</td>
<td>570.000</td>
<td>980.000</td>
<td>15.000</td>
<td>233</td>
<td>42 million</td>
</tr>
<tr>
<td>Adults &amp; Children newly infected with HIV</td>
<td>3500.00</td>
<td>83.000</td>
<td>700.000</td>
<td>270.000</td>
<td>150.000</td>
<td>60.000</td>
<td>250.000</td>
<td>30.000</td>
<td>45.000</td>
<td>500</td>
<td>1765</td>
<td>5 million</td>
</tr>
<tr>
<td>Adults Prevalence Rate % (●)</td>
<td>8.8 %</td>
<td>0.3 %</td>
<td>0.6 %</td>
<td>0.1 %</td>
<td>0.5 %</td>
<td>2.4 %</td>
<td>0.6 %</td>
<td>0.3 %</td>
<td>0.6 %</td>
<td>0.1 %</td>
<td>-</td>
<td>1.2 %</td>
</tr>
<tr>
<td>% HIV Positive Adults who are women</td>
<td>58 %</td>
<td>55 %</td>
<td>36 %</td>
<td>24 %</td>
<td>30 %</td>
<td>50 %</td>
<td>27 %</td>
<td>25 %</td>
<td>20 %</td>
<td>7 %</td>
<td>13.2</td>
<td>50 %</td>
</tr>
<tr>
<td>Main Mode of Transmission for adults living with HIV/AIDS (❖)</td>
<td>Hetero</td>
<td>Hetero IDU</td>
<td>Hetero IDU</td>
<td>IDU Hetero MSM</td>
<td>MSM Hetero IDU</td>
<td>Hetero MSM</td>
<td>IDU</td>
<td>MSM IDU</td>
<td>MSM IDU</td>
<td>MSM Hetero IDU</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

(❖) Hetero (Hetero Sexual Transmission), IDU (Transmission through intravenous drug use), MSM (Sexual transmission among men who have sex with men)

HIV/AIDS epidemic has left no part of the world untouched. Notwithstanding the catastrophic effects that are already being experienced, the full consequences of the pandemic are still to be felt. The storm has been gathering for two decades. While some countries have begun to experience its impact, there are many where it has yet to break with full force. The bleak prospect is that “over the next decade, AIDS will kill more people in Sub-Saharan Africa than the total number of casualties lost in all wars of the 20th century combined”. Across the continent, and in all other severely affected areas, AIDS is already taking a devastating toll in human suffering and death. It is causing untold physical, psychological and emotional sufferings. It is carrying off the most productive members of the society, those in the 15-49 age range. It is disrupting social systems, exacerbating poverty, reducing productivity, wiping out hard won human capacity, and reversing development gains. Although it has only begun to make its way into many communities and economies, its ravages increase by every minute. World-wide, there are 16,000 new HIV infections every day about eleven every minute, or one every four seconds (World Bank, 1999).

**SUB-SAHARAN AFRICA**

By far the worst effected region, sub-Saharan Africa is now home to, 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the past year. Today in Sub-Saharan Africa, 10 million young people (aged 15-24) and about 3 million under 15 years are living with HIV infection.

According to a report of four southern countries of sub-sahara, the national adult HIV prevalence rate has been higher than was expected i.e. exceeding 30%: Botswana (38.8%), Lesotho (31%), Swaziland (33.4%) and Zimbabwe (33.7%). The food crises faced in the later three countries are linked to the toll of their longstanding HIV/AIDS epidemic, especially on the lives of young productive adults.

HIV prevalence is estimated to exceed 5% in eight other countries of West and Central Africa, including Cameroon (11.8%), Central African Republic (12.9%) and Nigeria (5.8%). Massive efforts from the world at large are needed to bring treatment and care to the millions of Africans in need, and cushion the epidemic’s impact.

*The annual number of new infections has remained steady, but it hides dynamic trends. In some countries, the epidemic is still growing, despite its severity. Others face a growing danger of explosive growth.*

Yet there are new, hopeful signs that the epidemic could eventually be brought under control. Positive trends seem to be taking hold among younger people in a number of countries. (All figures taken from UNAIDS/WHO, 2002).
Nineteen African countries have set up national HIV/AIDS councils or commissions at senior levels of government, and local responses are growing in number and vigor. Across the region 40 countries have completed national strategic AIDS plans as evidence of their determination to reach the targets outlined in the Declaration of Commitment on HIV/AIDS. Also encouraging is the active involvement of regional bodies, such as the Economic Commission for Africa, the Africa Union, and the Southern African Development Community, in taking HIV/AIDS as a development issue.

**LATIN AMERICA AND THE CARIBBEAN**

The epidemic in Latin America and the Caribbean are well established. There is a danger that epidemic could spread both more quickly and more widely in the absence of any strengthened responses. As estimated 1.9 million adults and children are living with HIV in the region – a figure that includes the estimated 210,000 people who acquired the virus in 2002.

Twelve countries in this region (including Dominican Republic of Haiti, Several Central American countries, such as Belize, Honduras, Guyana and Suriname) have an estimated HIV prevalence of 1% or more among pregnant women. In several Caribbean countries, adult HIV prevalence rates are surpassed only by the rates experienced in Sub-Saharan Africa – making this the second most affected region in the world. HIV/AIDS is now a leading cause of death in some of these countries. Haiti remains worst affected (with an estimated national adult HIV prevalence of over 6 %) along with Bahamas (where prevalence is 3.5 %).

It should be noted, however, that the quality of surveillance systems varies across the region, making it possible that serious, localized epidemics in other parts of the region might be escaping detection.

Unsafe sex and MSM is rife across the entire region. Most countries of the region have mounted prevention programmes oriented towards men who have sex with men. However quality of their programmes varies, and often depends on countries’ legal contexts and the extent to which a wide range of social sectors is involved in prevention efforts. However many such initiatives are impeded by discriminatory Laws on homosexuality.

The spread of HIV through the drug sharing equipment is of growing concern in several countries, notably Argentina, Brazil, Chile, Paraguay and Uruguay (in South America) the northern parts of Mexico and Bermuda and Puerto Rico (in the Caribbean). Injecting drug use accounts for an estimated 40% of reported new infections in Argentina and 28% in Uruguay. In both countries an increasing number of women with HIV are either themselves injecting drug users or happen to be sexual partners of male drug users.
New light is being cast on a hitherto hidden dimension of the epidemic: HIV infection among prisoners. A study in three urban prisons in Honduras has revealed an HIV prevalence of almost 7% among male prisoners in general, and almost 5% among those 16-20 years of age. Despite a clear need for focused HIV prevention work among prisoner inmates, institutional barriers impede the development and evaluation of such programmes.

At the same time, though, countries' determination to stem the epidemic and limit its impact is more evident than ever---most obviously through their efforts to provide antiretroviral drugs to patients HIV/AIDS-related illnesses. Countries such as Argentina, Costa Rica, Cuba and Uruguay now guarantee free and universal access to these drugs through the public sector, while sharp price reductions have recently been secured in Honduras and Panama. In mid-2002 the Pan Caribbean Partnership against HIV/AIDS signed an agreement with six pharmaceutical companies in a bid to improve access to cheaper antiretroviral drugs.

THE MIDDLE EAST AND NORTH AFRICA

Available data points to increasing HIV infections rates, with an estimated 83,000 people having acquired the virus in 2002. Today this brings the estimated number to 550,000, people living with HIV/AIDS. The epidemic claimed about 37,000 lives in 2002.

However, systematic surveillance remains inadequate, making it very difficult to deduce accurate trends. It is possible that hidden epidemics could be spreading in this region. Better surveillance systems (such as those introduced in Iran, Jordan, Lebanon and Syria) will enable more countries to accurately track the development of the epidemic and mount effective responses.

Significant outbreaks of HIV infection among injecting drug users have occurred in about half the countries in the region, notably in North Africa and in the Islamic Republic of Iran.

In Iran, most HIV transmission is occurring among the country's estimated 200,000 – 300,000 injecting drug users, about 1% of whom are believed to be living with HIV. High-risk behaviour is widespread in this largely male population. About half of the users share injecting equipment, and as many are believed to have extramarital sexual relations. According to some estimates, a significant percentage (more than 30%) of them is married. Yet Condom use is very rare. In addition about 10% of prisoners are believed to inject drug and more than 95% of them shares needles. HIV prevalence among imprisoned drug injection was 12% in 2001. (UNAIDS/WHO – AIDS Epidemic estimated 2002, page 24).
Other infected groups include men who have sex with men, sex workers and their clients. In Morocco, the National AIDS Programme has noted the relatively high prevalence of other sexually transmitted infections – a sign that unsafe sex is more common than routinely assumed.

Overall, recognition of the need for more effective and far reaching prevention efforts has grown in this region. Some countries are fashioning potentially potent responses. Examples include the mobilization of non-governmental organizations around prevention programmes in Lebanon, and harm-reduction work among injecting drug users in the Islamic Republic of Iran.

But appropriate surveillance data on HIV infection and behaviours are in short supply, capacities are still limited, and HIV/AIDS responses are still concentrated almost exclusively in the health sector. In the absence of greater candor, political commitment and improved prevention programmes, wider HIV/AIDS spread can be anticipated.

**EASTERN EUROPE AND CENTRAL ASIA**

The unfortunate distinction of having the world’s fastest growing HIV/AIDS epidemic still belongs to Eastern Europe and Central Asia in 2002, there were an estimated 250,000 new infections, bringing to 1.2 million the number of people living with HIV/AIDS.

In recent years, the Russian Federation has experienced an exceptionally steep rise in reported HIV infections. In less than eight years, HIV/AIDS epidemics have been discovered in more than thirty cities and 86 of the country’s 89 regions. Up to 90% of the registered infections have been attributed officially to injecting drug use, reflecting the fact that young people face high risk of HIV infection as occasional or regular drug injectors. Indeed almost 80% of registered new infections in the Common Wealth of Independent States between 1997 to 2000 were among people younger than 29. In the Russian Federal, the total number of reported HIV infections climbed to over 200,000 by mid-2002.

The epidemic is growing in Kazakhstan, where a total of 1926 HIV infections had been reported by June 2001. More substantial spread of HIV is now also evident in Azerbaijan, Georgia, Kyrgyz Stan, Tajikistan and Uzbekistan. In the later two Republics, recent evidence of rising heroin use heightens concerns that they could be on the brink of larger HIV/AIDS epidemics. Already a steep rise is reported that HIV infections have been noted in Uzbekistan, where 620 new infections were registered in the first six months of 2002---- six times the number of new infections registered in the first six months of 2001.
Reported HIV incidence is rising sharply elsewhere. Estonia now has the highest rate of new HIV infections in this region (12 in 1999 to 1474 in 2001).

Though often overlooked, role of prisoners in the spread of HIV infection in many countries of the region is now obvious. The other Baltic State Lithuania, is experiencing a major HIV outbreak in one of its prisons, where 284 inmates (15% of total) were diagnosed HIV Positive between May and August 2002. This confirms the important, though often overlooked, role of prisons in the spread of HIV in many countries of the region. The concentration of large numbers of young people in over crowded prisons or juvenile justice facilities, often marked by an abundance of drugs but scarcity of information on HIV, clean needles and condoms, provides fertile ground for the rapid spread of HIV among inmates and, upon their release, into the wider population.

While injecting drug use among young people remains the predominant mode of HIV transmission in the Russian Federation and other countries of the region, heterosexual intercourse has now become a prominent mode of transmission in Belarus and Ukraine, accounted for 28% of all new cases reported in the first six months of 2002.

In some cities of Russian Federation and Ukraine, 30% of female injecting drug users are also involved in commercial sex work. In Belarus and Ukraine, HIV/AIDS is steadily spreading into the wider population.

There is evidence that young people in several countries are becoming sexually active at an earlier age and that premarital sex is increasing. Yet, awareness and knowledge of HIV/AIDS remain dismal at many places. In Azerbaijan and Uzbekistan, for example, one third of young women (aged 15-24) had never heard of AIDS, according to a 2001 survey.

**HIGH-INCOME COUNTRIES**

Approximately 76,000 people became infected with HIV in high-income countries in 2002. A total of about 1.6 million people are now living with the virus in these countries, where an estimated 23,000 people died of AIDS in 2002.

Several salient changes have emerged in recent years. The introduction of antiretroviral therapy since 1995/96 has dramatically reduced HIV/AIDS-related mortality, although this trend has begun to level off in the past two years. Longer survival of people living with HIV/AIDS had led to a steady increase in the number of people living with the virus in high-income countries. About 500,000 people were receiving these drugs at the end of 2001. Both counseling and
prevention services need to be stepped up if an increase in HIV transmission is to be avoided.

A large proportion of new HIV diagnosed (59% more overall between 1997 and 2001) in several Western European countries is occurring through heterosexual intercourse. More than half of the 4279 new HIV infections diagnosed in the UK in 2001 resulted from heterosexual sex, compared to 33% of new infections in 1998. In Ireland, a similar trend is visible, with the number of heterosexually transmitted HIV infections increasing fourfold between 1998 and 2001. Although injecting drug use remains the main mode of transmission in Spain, about one-quarter of all HIV infections have been heterosexually transmitted.

In the United Kingdom, as in some other European countries, a large share of heterosexually transmitted HIV infections are being diagnosed in persons who originate from, or who have lived in or visited, areas where HIV prevalence is high. Prevention, treatment and care activities need to become more culturally appropriate and socially relevant if they are to reach and benefit such diverse communities.

Most high-income countries are contending also with concentrated HIV epidemics, including in the United States of America where injecting drug use is a prominent route of HIV infection (accounting for 14% of all reported HIV diagnosis). Reported HIV prevalence among injecting drug users in Spain in 2000 was 20-30% nation wide, while, in France, prevalence ranged between 10% and 23%. Portugal's serious epidemic among injecting drug users accounted for more than half newly diagnosed HIV infections in both 2000 and 2001.

Latest available data show that the epidemic's shift into poorer and marginalized sections of society is continuing. African Americans accounted for an estimated 54% of new HIV infections in 2000 but constitute only 13% of the population of the United States. According to a 2002 CDC report, AIDS-related illness remained the leading cause of death for African-American men aged 25-44 and the third leading cause of death for Hispanic men in the same age group. (In Canada, meanwhile, aboriginal persons accounted for 9% of new HIV infections in 1999, although they constituted less than 3% of the general population).

In Japan, where a record 621 people (most of the males) acquired HIV in 2001, the virus is spreading increasingly among young people. A reportedly growing trend of casual sex with multiple partners (known as sukusutomo or "sex friends"), along with falling condom sales, suggests new patterns of HIV spread could widen significantly.

Nearly 40% of new HIV infections in 2001 were among people in their teens and twenties—a development that seems to match reports of increased rates of sexually transmitted infection among Japanese men (up to 21% between 1998 and 2000) and women (upto14%) under 24.
ASIA AND THE PACIFIC

Almost 1 million people in Asia and the Pacific acquired HIV infection in 2002, bringing to an estimated 7.2 million the number of people now living with the virus – a 10% increase since 2001. A further 490,000 people are estimated to have died of AIDS in the past year. About 2.1 million young people (aged 15-24) are living with HIV.

With the exception of Cambodia, Myanmar and Thailand national HIV prevalence levels remain comparatively low in most countries of Asia and Pacific. That, though, offers no cause for comfort. In vast populated countries such as China, India and Indonesia, low national prevalence rates somewhat blur the picture of the epidemic. China and India, for example, are experiencing serious localized epidemics, that are affecting many millions of peoples.

India has announced a significant increase in HIV/AIDS Cases – 4.58 million at the end of 2002, up from 3.97 million people affected with HIV/AIDS at the end of 2001 – the second highest figure in the world, after South Africa. UN warns India on AIDS problem as new figure was released.

In China, it is estimated as one million people were living with HIV virus in mid 2002. Unless effective responses rapidly took hold, a total number of 10 million Chinese would have acquired HIV by the end of this decade.

Several epidemics are being observed among certain population groups in various parts of this vast region. Serious localized HIV epidemics are occurring among injecting drug users in nine provinces, as well as in Beijing Municipality.

The most recent reported outbreaks of HIV among injecting drug users in the Hunan and Guizhou province (where sentinel surveillance among users has revealed HIV prevalence rate of 8% and 14% respectively).

There are also signs of heterosexually transmitted HIV epidemics spreading in at least three provinces (Yannan, Guangxi and Guangdong) where HIV prevalence in 2000 was as high as 11% among sex workers population.

The onward sexual transmission of HIV by people who become infected when they sold their blood to collecting centers that ignored basic blood-donation safety procedures poses a massive challenge, as does the need to provide them with treatment and care. Signaling the gravity of the situation, one 2001 survey in rural eastern China found alarmingly high HIV prevalence—12.5%—among people who had donated plasma. Most of the country’s estimated 3 million paid blood donors live in poor rural communities, and those now living with HIV/AIDS.
face limited access to health-care services while having to endure severe stigma, shame and discrimination.

There is a clear need for urgent action and the five-year AIDS action plan promulgated in mid-2001 signaled a growing commitment to take up that challenge, as did the recent moves towards negotiating affordable antiretroviral treatment with pharmaceutical companies.

A dangerous new trend in Indonesia is a sharp rise in injecting drug use and with it the risk of rapidly increasing HIV spread. Official estimates suggest that between 124,000 and 196,000 Indonesians are now injecting drugs. This data is revealed from the largest drug treatment center in Jakarta.

National estimates indicate that some 43,000 injecting drug users are already infected with HIV, with needle sharing being the norm. Throughout the region injecting drug use offers the epidemic a huge scope for its growth. Upwards of 50% of injecting drug users already have acquired the virus in parts of Malaysia, Myanmar, Nepal, Thailand and in Manipur in India, while HIV infection among Indonesia’s growing population of injecting drug users is soaring. Very high rates of needles sharing have been documented among users in Bangladesh and Vietnam, along with evidence that a considerable proportion of street-based sex workers in Vietnam also inject drugs.

Male to male sex occurs in all countries of region and significantly features in the growth of the epidemic. Countries that have measured HIV prevalence among men, who have sex with men, have found it to be high – 14% in Cambodia in 2002, and roughly the same level among male Thai sex workers. Homophobia or dominant cultural norms mean that many men who have sex with men, hide that aspect of their sexuality. Many might marry or have sexual relationship with women.

Among the pacific Island countries and territories Papua New Guinea as reported the highest HIV infection rate was 7% in 2001 and the rate of sexually transmitted infection ranged as high as 30%. (UNAIDS/WHO, P-7-12).

Focused efforts that protect vulnerable populations against HIV/AIDS are important and cost-effective. Alone, though, they cannot halt the epidemic. It is vital that AIDS responses everywhere extend also into wider populations, imparting the knowledge and providing the services that people need to protect themselves and each other against HIV/AIDS.
CURRENT SITUATION IN PAKISTAN

The HIV/AIDS situation in Pakistan, as in some other Asian countries is at dangerous cross roads. While the number of reported and estimated cases is still relatively low, Pakistan’s growing population continues to be vulnerable to an epidemic of HIV/AIDS in a number of ways.

Reported HIV Infection and AIDS Cases:

Pakistan is at present a low prevalence and high-risk country for HIV/AIDS infections. Since 1987, the number of reported HIV infections and AIDS cases has been steadily on the rise. The total cases reported by December 2002 from all geographical regions of the country are 1972 with 1765 HIV positive and 233 AIDS cases. However, the WHO/UNAIDS forecast model estimates the number of HIV positive persons to be approximately 70,000 to 80,000 i.e. 0.1% of the adult population. The heterosexual transmission accounts for majority of reported cases i.e. (63.52%) being most common mode of transmission of HIV infection in Pakistan. Other modes of transmission include: infection through contaminated blood or blood products (7.30%), homosexual or bisexual (5.60%), injecting drug abuse (0.86%), and mother to child transmission (3 %). Mode of transmission in 19.70% of reported HIV infection is unknown. The unknown cases are assumed to be mostly through sexual transmission. 161 persons (69.10%) of the total AIDS cases acquired the disease through sexual contact.

Limited available research indicates that prevalence of HIV infection is 1-2% in vulnerable/high risk population groups. These include, commercial sex workers, migrant workers, injecting drug users, men who have sex with men, long distance truckers (drivers and attendants), blood and blood product recipients, patients suffering from sexually transmitted infections, professional blood donors, jail inmates and seamen.

Over 86.8 % of the reported HIV positive cases in the country have been detected in men. Most of whom (51.88 %) fall within the age range of 20-40 years. 24.59 % of the reported cases are unknown, 13.20 % females infected with HIV positive, 45.10 % of the total HIV carriers acquired the disease through sexual contact.

HIV/AIDS cases have been reported from all provinces of the country. Primarily the easy and continuous migration between rural and urban areas makes infection levels likely to rise as time goes on. The table given below shows the figures area-wise distribution of HIV/AIDS.
EPIDEMIOLOGICAL SITUATION OF HIV/AIDS IN PAKISTAN

Total tests carried out during 1986-2002 (uptil 31 December) = 3,648,550 million tests (on recommended categories *)

Area-wise Distribution of HIV/AIDS

HIV Positive (1765) + AIDS (233) = Total 1998 Cases at Islamabad, Karachi, Lahore, Rawalpindi and FANA.

NUMBER OF AIDS CASES IN PAKISTAN BY YEAR 1986 – 2002

(Total: 233)

Chapter 3

Factors of HIV/AIDS Infection and Impact on Socio-Economic Development

AIDS has emerged as one of the most serious diseases facing the developing world, with consequences that reach far beyond the health sector. In many societies, it is becoming clear that HIV and AIDS have substantial economic and social impact on individuals, on families and households, on communities and groups and on society as a whole.

HIV/AIDS, since its outbreak, has caused the deaths of more than 20 million people. Around 3.1 million deaths occurred worldwide due to HIV/AIDS epidemic and an estimated 5 million people acquired the virus. It has shattered families and left them destitute. It has orphaned more than 14 million children, a number that is expected to more than triple by 2010. More than 42 million people have been infected with the HIV/AIDS so far. In developing and poor countries where resources for health care are scarce, and even clean water can be hard to come by, the means to battle the virus through prevention and awareness programs are often unavailable. Because of low literacy rate, majority of population of developing countries in general and Pakistan in particular, have poor information about HIV/AIDS as a disease. Consequently, the impact of HIV/AIDS and the potential for future damage to societies and economies in the developing world is particularly devastating.

Pakistan being placed among ‘Low prevalence but High Risk Areas’ with regards to AIDS, needs a comprehensive approach to address all contributing factors for spreading of the virus. Apart from the focus on “direct factors” “indirect and circumstantial factors” are more crucial in country like Pakistan and susceptible to the spread of HIV/AIDS. People have to be sensitized about the contributing factors, which majority of the population of Pakistan face or may come across in one-way or the other.

FACTORS THAT CONTRIBUTE TO HIV/AIDS

Following are the factors contributing to the spread of HIV/AIDS in countries where poor socio-economic conditions prevail and no sources of information about this fatal disease are readily available.

1. Ignorance & Lack of Awareness

The world community has come to recognize that HIV/AIDS is not just a health problem. HIV/AIDS reduces life expectancy; increases child mortality; leaves large numbers of children without adult care; places intolerable strains on health-care systems; undermines economic
But HIV/AIDS does not discriminate

Everybody is vulnerable. The virus is not restricted to any age group, race, social class, gender, or religion. In many countries of Asia and the Pacific HIV/AIDS has spread to the general population.

No country is immune to the epidemic

- The HIV/AIDS epidemic can spread very quickly
- Low HIV prevalence rates in the general population of a country can conceal serious epidemics in smaller, high-risk groups or in certain areas
- The epidemic can quickly cross over from high-risk groups to the general population.

AIDS and Development

“AIDS is turning back the clock on development. In too many countries the gains of life expectancy won are being wiped out. In too many countries more teachers are dying each week than can be trained”.

UNESCO & UNAIDS Advocacy Kit
development through increased labor costs and the decreased availability of skilled human resources; and impoverishes households.

People, with little or no access to information, education and health services are susceptible to HIV/AIDS infection. Studies have shown that infection rates have been lowered by:

- screening blood for transfusion;
- frank information about spread of HIV/AIDS;
- clear prevention messages urging abstinence, fidelity or safer sex;
- needle exchange programs for drug users;
- encouraging and enabling people to get prompt care for sexually transmitted diseases (STDs).

In Pakistan only a small percentage of people have adequate information about HIV/AIDS. Those who have no access to the education and media, have little chance of being informed or even having an understanding about the ravages of this fatal disease.

Effective communication and social mobilization efforts are needed to broaden HIV/AIDS awareness and promote healthy lifestyles. Lack of open debate and denial has led to increase in HIV/AIDS cases in our country.

The social stigma that continues to surround the diagnosis of HIV/AIDS among homosexual men or drug users, causes many people to refrain from telling their family members or friends about their illness. The stigma is due to the reluctance to acknowledge the existence of the disease at the personal level and the fear of scorn from the near ones. People may recognize that the epidemic poses major problem for human life, but the infected individuals conceal the fact from fear of discrimination and shame. This may lead to further endangering the lives of other people.

2. Inadequate Access to Support Mechanisms

An infected person faces many challenges i.e., choosing the best course of treatment, paying for health care, and providing for the needs of children in the family while ill. This is mainly because of the following problems:

- insufficient funds;
- lack of testing facilities;
- lack of healthcare facilities;
- lack of adequate information;
- lack of awareness.
3. **Non-observance of Norms, Values and Religion**

Norms, values and religion play an important role in regulating human behavior. This not only encourages congenial atmosphere in the society but also protects the members from indulging into socially unacceptable behaviors.

   a. Sexual contacts
      
      i. homosexuality (gays and lesbians);
      ii. extramarital sex (adultery and fornication);
      iii. commercial sex (prostitution).

   b. Norcotics
      
      All types of drugs injected intravenously.

4. **AIDS and Poverty**

Unlike other infectious diseases, HIV/AIDS does not respect social barriers. It affects rich and poor alike. Nevertheless, poverty seems to facilitate the spread of the disease and worsen its impact. One reason for this is that where poverty prevails, responding to immediate short-term needs e.g., food and shelter, assume greater importance than dealing with an infection that appears to lie dormant for several years.

Moreover other poverty creates situations of vulnerability to HIV infection, which put people at high risk may be;

- lower nutritional status of poor people;
- lack of access to adequate health services;
- smaller likelihood of treatment of sexually transmitted diseases;
- overcrowded living conditions;
- survival needs which force poor women and girls to be exploited sexually;
- economic needs which force young men from poor families to leave home and migrate to high-risk environment in search of work;
- lack of access to information and the means of protecting themselves in sexual encounters;
- professional blood donors who may be infected.

5. **Circumstantial and Situational Factors**

The following factors contribute to the spread of HIV/AIDS:

- drug trafficking;
- child abuse;
- prisoners in jails;
- truck drivers and small road side hotels;
- hostels and madrassas;
- beauty parlors and auto work shops;
- migrant workers;
- trafficking of Women.

IMPACT OF HIV/AIDS ON SOCIO-ECONOMIC DEVELOPMENT

Unlike other infections HIV/AIDS brings along with it miseries like stigma, shame, isolation, deprivation, agony, fear of death, estranged relations and economic break down. Among many, some of its socio-economic aspects are as under:

1. Impact on Individuals

Learning that he/she is infected with HIV/AIDS, the individual receives the greatest shock of his/her life, provided the awareness about the ultimate consequence is there. The affected individual isolates himself from all friends and relatives for fear of stigma and shame, discrimination and apprehension about infecting others. The loss of affection and love of dear ones causes further distress and agony resulting in anger, violence and emotional disorder aggravates due to non-existence of a cure or remedy. In the initial stages of infection the individual tends to conceal the sickness for fear of losing job, love of friends and relatives. However, when it is no longer possible to keep quiet, the job is lost and more miseries set in as the household economy collapses due to loss of employment and heavy expenditure on treatment.

2. Impact on Children

The children of affected families are subjected to extreme mental stress and grief due to rejection by other children and their friends. They have to face the fear of expulsions from schools and the indifference of community. Even within the family, the parents after having learnt about their own HIV/AIDS status keep their children at a distance for fear of infecting them. Most often the parents do not disclose their infection to the children for fear of rejection by them. The misfortune of the children, left helpless due to the death of both father and mother, is unimaginable. Particularly in the less developed and poor countries, there are no arrangements or institutional set ups by the Government or NGOs for taking care of the orphans. Such children are likely to become beggars or subjected to sexual abuse. Yoktri finds a link between disruption of education of especially girls and the increased likelihood of their entry into sex work (Yoktri 1999, 7).
3. YOUTH More Susceptible to HIV/AIDS

Generally, the school children at this stage where they start to be sexually active, eager for adventure, and under the influence of peer pressure, are more susceptible to be the victims given the proliferation of inducements catering to worldly pleasures and consumerism. Young people are prone to regard these as the “in-thing” to do. Sex, drugs, imitating movies, idols, playing rich and famous, as these condone irresponsible behaviour leading to situations which render them vulnerable to HIV infection.

Pakistan has an unusual young overall population, which in some ways can make it even more vulnerable to an epidemic. Sixty three percent of the country’s population is below the age of 25 years. It is especially important to consider that nearly half the population is of reproductive age and that sexual transmission is believed to be the principal cause of HIV infection in Pakistan today.

HIV/AIDS epidemic in Pakistan could, therefore, have a serious impact on the productive work force, thereby diminishing the economic vitality of the country.

In other instances children are sold for prostitution and/or subject to abuse by their peers or elders. Ignorance, fear and cultural taboos prevent these children from getting justice and proper care. If not AIDS victims themselves, children are orphaned early in life by AIDS Parents thereupon, deprived of material and moral support when they need them most.

Special Vulnerability of Young People in Pakistan

Children and adolescents are at no less risk from HIV/AIDS than are adults in Pakistan. Adolescence is a time when young people may be curious about sex and drugs, they are forming their habits and values, and are heavily influenced by their peers. In addition, unemployment, the relatively easily available drugs and economic frustration can all influence young people to engage in unsafe sexual behaviour which may put them in situation with increased risk of infection.
The special vulnerability of Pakistani young people is, at least in part, related to a lack of information and awareness about reproductive health in general and about HIV/AIDS and other sexual transmitted infections, in particular. While this lack of information and awareness is common to most segments of Pakistani society, it is even more pronounced among the young people. It is also because social taboos related to sexuality inhibit the open discussion of issues related to sex and reproductive health. Opportunities to gain accurate information about such issues and for learning skills with which to protect oneself from infection are quite limited for the vast majority of Pakistani youth.

In addition to the general vulnerability of Pakistani youth, poverty pushes young boys and teenagers to look for work, who are employed as assistants to truck drivers and are often expected to provide sexual service to the latter. They can also be found working as male prostitutes at roadside truck stands and in hotels.

Finally, in addition to the vulnerabilities faced by all women in Pakistan, young women may be at special risk. Marriages for many young women occur when they are between the ages of 15 and 19 years. These women being relatively young and inexperienced become extremely vulnerable to exploitation by their husbands or members of their in-laws families. Women are also exposed to sexual harassment and assault.

UNAIDS estimates suggest that over half of new infections with HIV are occurring among young people (15-24 years of age) or 7000 new infections a day worldwide (UNAIDS, 2001). The impact on young people and children is growing. The UNAIDS/UNICEF reports, “that there are 1.8 million children orphaned by AIDS at the end of 2001. This number is expected to rise to over 3 millions in 2005”.


4. Impact on family

The individual infected from HIV/AIDS is not the only one to suffer. All other family members equally bear the agony and perpetual distress. On the one hand the family members undergo psychological stress caused by grief and on the
other frustration overtakes due to non-availability of a remedy. The household economy collapses under the burden of increasing needs of the patient. The urgent requirements of other family members remain unfulfilled. Costly treatment aggravates the situation, thereby causing anger and frustration among the family members. When the nature of ailment gets to be known, attitudes of relatives and friends change from love to rejection and neglect.

This is again a source of great shock and disappointment for the family members. The employment of the patient is terminated. Due to discrimination and apprehensions the employment of other family members is also at stake. As a result of these developments serious economic problems emerge adding to the miseries of the family. On the one hand the financial resources diminish and on the other expenditure on needs and costly treatment continues to increase. In order to cope with the problems, even consumption of the bare necessities has to be cut down, borrowings increase and with the exhaustion of savings, assets like property, vehicle, ornaments etc. are sold.

The school-going children have to discontinue their education and forced to take up petty jobs in order to supplement the family income. Despite all these efforts the death of HIV/AIDS infected patient is inevitable. There is no one to look after and take care of orphans left behind. They are left to take care of themselves and that of other family members as well. Death of relatively young people due to HIV/AIDS or any other calamity brings along many misfortunes and sufferings for the bereaved family. In the absence of welfare institutions and NGOs there is no one to arrange for the rehabilitation and education of such orphans.

5. Impact on Society

HIV/AIDS badly damages social cohesion, social integrity and warm relationships. The infected one loses the warmth and affection of friends and relatives. On the other hand the dear ones isolate the patient through rejection and indifference. It is quite possible that the members of society may breed contempt and hatred for a person suffering from HIV/AIDS. Total apathy, fears, apprehensions and indifference against the infected person may lead to social conflict, which seriously affects the value structure of the community and is a threat to the harmonious relationships.

6. Impact on Economic Development

HIV/AIDS pandemic confronts us with a full range of development issues:

- issues of poverty,
- entitlement and access to food
- medical care and income
- the relationship between men and women
• the relative abilities of states to provide security and services for their people
• the relations between the rich and the poor within society and between rich and poor societies
• the viability of different forms of rural production and
• the survival strategies of different types of household and community
all impinge upon the socio-economic structure societies.

The world community is quite conscious of the fact that HIV/AIDS is not just a health problem. It is rather a development crisis of unprecedented proportions. In the face of the epidemic, the hopes of achieving development goals in the areas of human and economic prosperity are not likely to materialize. Evidence to this effect of HIV/AIDS on the development of communities and nations is beginning to appear. At present many developing countries are facing problems of sick economy because of recession, foreign debt, war and natural disasters. Such countries are simply unable to cope with the routine demands of development, let alone assess the impact of HIV/AIDS and respond effectively to it.

The situation is further aggravated by the succession of one crisis by another. As such economic difficulties encourage the transmission and spread of HIV/AIDS in two ways. The population risk increases directly through greater urban migration, poverty, poor status of female and prostitution or indirectly due to economic constraints decreasing out-lays on health care, education etc.

6.1 Micro Level Impact

At the micro level of society, the impact on individuals and families is quiet damaging. Infected individuals lose jobs and income. The families have to incur heavy expenditure on treatment thereby sustaining further loss of income. This results in the spending of savings with adding burden of borrowings. The death toll takes away professionals and specialists e.g., doctors, engineers, scientists, agriculturists, entrepreneurs etc. This badly affects agricultural, industrial and other specialized sectors of economy.

Research studies in Tanzania show that women spend up to 60% less time doing farm work when their husbands are seriously indisposed. With the death of the husband, the widow may be deprived of credit facilities for agricultural inputs etc. and may even lose the right of inheritance to land and property. The illness and subsequent death of an adult female may threaten the security and survival of the family. Survey undertaken in two districts of Zimbabwe reveals that two third of the households that had lost a working female had disintegrated and dispersed. All of this micro level impact add up, at the macro level, to a significant reduction of national productivity and output.
6.2. **Macro Level Impact**

Developed economies have the capacity to absorb shocks of recession and depression but the underdeveloped economies, already suffering from pressure of population, foreign debt, growing unemployment etc., cannot survive, particularly if an epidemic as HIV/AIDS spreads at a larger scale.

Under developed economies, where GDP (Gross Domestic Product) is low, necessary savings for further investment not forthcoming, and population growing at a fast rate, will have to face the problems of poverty, unemployment, vulnerable governments, law and order, etc. Under such conditions, sufficient government revenue would not accrue for spending on health care, education and other social services.

To add further, illness and death at a higher rate and scarcity of trained professionals leads to high cost of recruitment, training and a demand for higher salaries. Thus a reduction in both quantity and quality of available labour has an impact on production and services.

As a result it can be safely assumed that AIDS will reduce the rate of GDP growth and per capita income in countries largely affected. "In many countries, in Africa negative growth rates in GDP capita will be lowered even more as a result of the HIV/AIDS epidemic (African Development Bank Group: b 18-19)". One of the most pernicious aspects of HIV/AIDS is how it may reverse the process of development, particularly in regard to child survival, basic education, and reduction in poverty, communications, housing and other sectors of economy.

**Economic Impacts of HIV/AIDS**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Individual</th>
<th>Community</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Increased Expenditure</td>
<td>Increased Expenditure</td>
<td>Need to Expand Health Infra Structure</td>
</tr>
<tr>
<td>Education</td>
<td>Absenteeism</td>
<td>Decreased Value of Future Human Resources</td>
<td>Loss of Trained People</td>
</tr>
<tr>
<td>Trade &amp; Industry</td>
<td>Loss of Productivity</td>
<td>Increased Emigration</td>
<td>Effects on Tourism</td>
</tr>
<tr>
<td>Agriculture</td>
<td>Loss of Productivity</td>
<td>Reduction in Cultivated Land</td>
<td>Threat to Food Security</td>
</tr>
</tbody>
</table>
## Costs and Stages of HIV/AIDS Infection

<table>
<thead>
<tr>
<th>Cost</th>
<th>Before Infection</th>
<th>Infection</th>
<th>Illness</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Control &amp; Preventive Measures</td>
<td>Testing &amp; Outpatient Care</td>
<td>Inpatient Care</td>
<td>Funeral &amp; Associated Expenses</td>
</tr>
<tr>
<td>Indirect</td>
<td>Precautionary Savings</td>
<td>Lower Productivity of Sick Members</td>
<td>Lower Productivity &amp; Loss of Income</td>
<td>Income Foregone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction in Consumption &amp; Investment</td>
<td>Reduction in Consumption &amp; Investment</td>
<td>Drop in Family Income</td>
</tr>
<tr>
<td></td>
<td>Insurance</td>
<td>Opportunity Cost of Looking After Sick Member</td>
<td>Opportunity Cost of Looking After the infected Member</td>
<td>Poor Health of Surviving Members</td>
</tr>
<tr>
<td></td>
<td>Acceptance Of Less Risky, But Less Well-Paid Jobs</td>
<td>Psychological Cost to Sick &amp; Other Family Members Costs to Others Unwillingly infected by the infected Member</td>
<td>Psychological Cost</td>
<td></td>
</tr>
</tbody>
</table>

Source: UNAIDS
SOCIO-ECONOMIC IMPACT OF HIV/AIDS

- Stigma/Shame
- Rejection from Friends/Relatives
- Isolation
- Termination
- Costly Treatment
- Discontinuity of Children's Education

- Breakdown Household Economy
  - Depletion of Savings
  - Borrowings
  - Sale of Property
Chapter 4

Role of Education For HIV/AIDS Prevention

Let us not forget the alarming facts that:

- Already over 25 million people have died of AIDS worldwide, with 3.1 million deaths in 2002.
- Nearly 42 million are presently living with HIV/AIDS.
- Every day, six thousand young people under 24 are infected with HIV.
- Every day, sixteen hundred children die of AIDS and more than six thousand children are left orphans by AIDS, and a third of them under 5 years.

Possibly the most significant outcome of the AIDS epidemic, from an international perspective, is the way it has galvanized the world concern. It has alerted the international community to the need to address a major health, development and human crisis. In a very fundamental way, it has highlighted to address the root causes of the vulnerability, and to make goal of sustainable human development more attainable.

Within this global vision, attention is being increasingly focused on education as the cornerstone of poverty reduction efforts. Because education brings positive results in areas like disempowerment, lack of knowledge, health care and gender equity, the international community sees it as contributing simultaneously to poverty reduction and HIV/AIDS control.

Because HIV/AIDS is "so people intensive," the education sector is particularly affected by this epidemic. Teachers are dying, orphaned children may not be able to attend school, pupils are prevented from going to school to take care of dying ones, quality of education is deteriorating- and all this threatens the ability of countries to achieve universal education.

Yet, education lies at the heart of development. It is one of the most powerful instruments and, one of the best preventive responses to HIV. It is part of the solution to the pandemic. It is education only, especially --if it encompasses broad life skills—that has the capacity to protect children from HIV and allow them to grow up into HIV-free adults.

2. Education Generates Hope

In the absence of any cure and very expensive drugs, that can only delay and slow down the attack of the HIV virus, the only hope lies through developing appropriate standards of behaviour, that promote a healthy state of mind, body and spirit. (Siame,1998). In this and in other AIDS-related areas, education can
be a powerful ally in forestalling the tragedy and helping those suffering from the ravages of the disease, to begin again. Education shows that there is hope.

**Why education can combat HIV/AIDS**

The education system has the advantage of reaching out to many children and young people early, at a time when few are infected and before they engage in behaviour that may put them at risk of getting HIV. It can help prevent infection among young people, in both the long term and the short term.

As the long, arduous and costly research for HIV cure must continue, it is imperative that the structures of education are exploited to the full. By the very fact of sending a child to school, parents expect the school to work the magic of transforming the young from being a child into being an adult. The entire education sector, can work the wonder of slowing down the spread of HIV/AIDS, transforming young people into individuals who are temperamentally immune against infection. It may take years before the vaccine is developed and becomes easily and cheaply available. But every educators should have the conviction that through education, children and young people can be "immunized". Through education, they can be safeguarded, Education can equip them intellectually, effectively, morally, so that they can make sound decisions, deal with pressures, keep themselves free of HIV infection, and extend compassion, solidarity, and care to all who are affected by the disease.

3. **Why to Focus on Youth/Adolescents ?**

Many young people cannot talk about AIDS either at home or in the community. Nor can they talk about the risky behaviours that can lead to HIV infection. Young people generally find it difficult to reach services where they can discuss questions related to sexual health or sexuality. They are reluctant to talk about sex to doctors, either out of embarrassment or because they are scared that confidentiality will not be respected. Counseling is rarely available and they may feel equally uncomfortable talking to their parents, and their parents in turn may also be embarrassed or simply lack the confidence to discuss the subject with their children.

Young people have great energy and commitment. Since they have had less time to develop prejudices, young people can also learn to adopt non-discriminatory behaviour and attitudes towards people with HIV/AIDS, far more easily than adults.
Young People and Preventive Education

studies from around the world show that young people provided with correct information, knowledge, and skills will not only delay starting their sexual activity, but once they start having sex, they will also be more likely to protect themselves against sexually transmitted infections, including HIV/AIDS.

Every child attends, or is meant to attend, school for six or seven years, and school is the crucial entry point where these topics can be addressed. The potential strengths of the school setting are that children there have a curriculum, teachers, and a peer group. The School can teach them not only information, but also skills and above all help to shape attitudes.

It is worth mentioning the many reasons for taking special steps to stand by young people, whether in or out of school, in the formal school system or in any other types of educational undertakings:

- They are numerous-------- the school going children
- They are vulnerable to HIV/AIDS-------UNAIDS estimates that in 1998 alone. 590,000 children and adolescents under the age of 15 became infected.
- They are crying out for help as they suffer from the experiences of HIV/AIDS, some in their own persons, some in their families and among their friends, many as orphans.
- They are young, idealistic, optimistic, hopeful. They want to make a world for themselves and they want that world to be a better place than that which they have inherited from their fathers.
- They are passing through a change and growth in their bodies, and hence are at a period of sexual awakening, learning and experimentation, and need extensive help and support from the schools and parents.
- Most important, they are the window of hope for the future.

This is where the hope for the future really lies. The challenge that formal and non-formal education faces is to engage the student's effectively, thereby contributing to the development of a set of personally held principles and guidelines that will help the students make the right choices.
Concerns of Youth

Children and young people highlighted the HIV/AIDS related concerns and issues in their countries in the South Asia Regional Forum for Young People on HIV/AIDS---Kathmandu 15-19 Dec 2002. Increased public awareness through media and focused attention to adolescent needs and adolescent potential were the suggestions made by the young people.

“A lot of listening has to be done, and this also applies to our government, which to date has not allowed adolescents and children to express their views on issues that concern them. All the decision making has been done by adults, with no great results.”

It is only through understanding that we can prevent our children and ourselves from the scourge of HIV and AIDS. We must educate ourselves on the implications of AIDS; we must work on our behaviour, attitude and practices - our behaviour towards people living with HIV, towards vulnerable groups, and towards children and young people. Let us believe it is our problem not theirs alone.

Emmen Saeed, 17, Pakistan

“The hardest thing for me is that in my country nobody wants to talk about it. It’s not just older people, but young people too. The cultural barriers are so strong that everybody is scared, embarrassed, or he thinks that talking about HIV/AIDS and spreading information is just talking about sex.

I am most worried about the people who are affected by HIV/AIDS. These are the people who are left alone in the world after the infected one has died. They don’t have the disease but are still treated badly by their community. It must be very traumatic and depressing for them. They did nothing wrong: only lack of education makes people treat them like this.”

South Asia Regional Forum for Young People on HIV/AIDS. KATHMASNDU, 15-18 Dec 2002. Save the Children - unicef

We must commit ourselves to understanding the impact of HIV/AIDS in the world. Although Pakistan so far is a low-prevalence country, yet this is no time for being complacent. The high prevalence rate of HIV positive people in Uganda, Thailand and India should remind us, what can happen to us in the future. We should not be lured by the fact that we are out of danger, as we are citizens of a Muslim country. We have brothels, open or disguised, we have STDs, we have addicts and professional blood donors and we also have a culture of silence. Our position is more vulnerable than that of many people of other countries. Our
ignorance and lack of knowledge will speed up the HIV/AIDS prevalence rate in no time. It is due to these features and norms of our society, that Pakistan is considered a "Low-Prevalence but High Risk country. This means that although at present there are less number of HIV/AIDS cases in the country, but these can multiply rapidly and infection rate might explode in the near future, if precautionary measures are not taken.

4. INTERNATIONAL POLICIES ON HIV/AIDS AND EDUCATION:

A number of UN agencies of international organizations have joined their hands in the fight against HIV/AIDS. These include UNAIDS, UNESCO, World Health Organization, UNODC, UNDP, UNFPA, and UNICEF. UN has organized a number of international forums to mobilize support for the fight against HIV/AIDS. In April 2000, at Dakar (Senegal), about 160 nations and their Education Ministers gathered and resolved their commitment for Dakar Framework of Action for EFA. This Dakar Framework of Action explicitly supported HIV/AIDS Preventive Education. The government organizations (including Pakistan) pledged to:

"Implement as a matter of urgency education, programmes and actions to combat the HIV/AIDS pandemic".

In June 2001, heads of states and representatives of Governments met at the United Nations General Assembly Special Session (UNGASS), dedicated to HIV and AIDS. UNGASS highlighted that, in only 20 years, HIV and AIDS pandemic has destroyed entire communities, slashed life expectancy, undone development gains, and that it is now seriously threatening whole continents.

UNGASS set in place a framework for national and international accountability. At the meeting, heads of states and representatives of Governments issued the Declaration of Commitment on HIV/AIDS. Targets related to education that were agreed upon include:

- **Reduction:** reducing HIV infection among 15-24 year old by 25% in the most affected countries by 2005 and, globally, by 2010;

- **National Strategies:** developing by 2003, and implementing by 2005, national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS;

- **Access to Information:** ensuring that by 2005 at least 90%, and by 2010 at least 95% of young men and women aged 15-24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection;
- **Vulnerability**: having in place strategies by 2003, to address vulnerability to HIV infection, including under-development, economic insecurity, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self protection, and all types of sexual exploitation of women, girls and boys

- **Life Skills**: Promotion of life skills and peer education with children and young people, and among teachers themselves. Efforts should be made to encourage learning in ways that maximize participation and the application of relevant knowledge; that promote positive attitudes; and that provide opportunities for individuals to develop skills in decision making, cooperation, coping and stress management, and critical and creative thinking.

- **Role Models**: Involvement of people with HIV/AIDS. People living with, or affected by, HIV/AIDS have an important role to play in education for HIV/AIDS prevention. They may serve as role models but may also provide access to perspectives and experiences that help reduce risk.

*(From HIV/AIDS and Education: A Strategic Approach, 2002, UNAIDS IATT on Education)*

5. **UNGASS Declaration**

“To stop the spread of the epidemic, all countries must emphasize prevention in education, nutrition, information and health care services.”

*(Paragraph 18, UNGASS declaration of Commitment on HIV/AIDS, 2001)*

6. **HOW EDUCATION CAN CHALLENGE HIV?**

**Reducing Risk**

Most of the people fall victim of HIV/AIDS infection, due to their ignorance about the means of transmission of this deadly disease from one person to another.

It is through education system that children and youth, our future generations, can be informed and warned about the acts and attitudes which lead to HIV/AIDS infection. Such an education or information, will enable the youth to adopt safer behaviour and protect themselves from HIV/AIDS infection. In this way, the risk of their being infected will be reduced. The following strategies have been suggested:
Actions for reducing risk:

- **National Policies:** The development of clear national policies to support education for HIV/AIDS prevention. Within schools and education authorities, clear policy frameworks need to be in place. These should specify the knowledge young people should have access to, and the services and resources (including condoms) needed to protect against the infection.

- **Health Education:** School-based risk reduction education specifically targeting HIV/AIDS. Preparation and distribution of scientifically accurate, good-quality teaching and learning materials on HIV/AIDS, communication and life skills.

- **Life Skills:** Promotion of life skills and peer education with children and young people, and among teachers themselves. Efforts should be made to encourage learning in ways that maximize participation and the application of relevant knowledge; that promote positive attitudes; and that provide opportunities for individuals to develop skills in decision making, cooperation, coping and stress management, and critical and creative thinking.

- **Teacher education and training:** Teachers must be well prepared and supported in. Teachers require ongoing support in introducing the enquiry based, rights oriented types of education about HIV/AIDS that are known to work best. Many of these approaches encourage active participation and skills development.

- **Links to health services:** Wherever possible, links should be made between the education for HIV/AIDS prevention undertaken in schools and youth friendly health services.

- **Non-formal and community education:** Non-formal and community based education is important in reaching those not accessible through schools. Action should be taken to ensure that school and community HIV/AIDS prevention programmes are coordinated in the messages they provide. The active involvement of parents and community leaders is to be encouraged.

(Source: HIV/AIDS and Education: A Strategic Approach, 2002, UNAIDS IATT on Education)
All young people have a right to know

Young people have a right to know how they can protect themselves and others and how to mitigate the impact of HIV/AIDS. They need to:

- Know about their own body
- Know about gender stereotypes
- Know about sex and sexuality
- Know about basic facts on HIV/AIDS and other STIs and the necessary skills to protect themselves
- Know their HIV status and where to find testing facilities
- Know where to get medical, emotional, and psychological support if they are living with HIV/AIDS
- Know how to shield their families and peers from HIV/AIDS
- Know how to protect those in their communities who are living with HIV/AIDS
- Know about HIV/AIDS education programmes and their rights
- Know how to involve their peers in campaigning against HIV/AIDS

7. Education and HIV/AIDS Prevention: The need for a radical approach

A successful education response to HIV and AIDS requires maintaining and strengthening education by addressing all aspects of HIV and AIDS on all policies and development plans. This has implications for the curriculum, for the nature and location of schooling, for the teacher and the education sector workforce, etc. The potential impact of HIV and AIDS needs to be considered as part of a larger-scale educational reform effort in Pakistan.

HIV prevention is complex. It requires tackling individual risk-taking as well as societal vulnerability. Crucial in both agendas is sustained political support at the highest national level. A critical task for policy makers and planners in education, therefore, is to identify the potential areas of impact and to design appropriate responses. Some interventions may be designed in reaction to circumstances that have actually been experienced. There is a need to be proactive, anticipating what might possibly happen, forestalling undesirable situations, and managing the impact with two objectives in view: (1) enabling the education system to pursue and attain its essential objectives: and (2) using the sector's potential to slow down the rate of new infections, (3) help its infected members to cope, and support those among them who have been touched by HIV/AIDS.

One impact of HIV/AIDS, therefore, is to push the education system, at all levels, into more open and frank discussion of these issue related topics in the school
and community, in the system itself, and in society at large. Among other things, this requires schools to have greater cultural sensitivity to, and intimacy with, the community.

Education must therefore, undergo a radical transformation in Pakistan to be able to respond to the effects of the HIV/AIDS epidemic. There is a need to re-examine education goals and find most effective implementation strategies. This requires open-mindedness, questioning of prevalent complacency in attitudes and the willingness to bring about changes, which must essentially involve changes in social norms and values. This needs the creation of an environment, which creates the possibility of open and honest dialogue and discussion on this emerging threat and its dangerous effects.

The policy-makers and the practitioners alike need to be alert to the ways in which HIV/AIDS can impact on education, to conceive potential solutions, and to design interventions that can either offset or forestall the negative impacts of the disease. Incorporating the reality of HIV/AIDS necessitates, mainstreaming the AIDS perspective in all aspects of policy, planning and action. It demands the openness to see and recognize the threat posed by HIV/AIDS and to consider new and untried solutions and modalities. It calls for vision, flexibility, and a courageous readiness to depart from the status quo.

<table>
<thead>
<tr>
<th>Why preventive education works</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ If used appropriately, preventive education is a powerful tool. Young people need to know how to protect themselves and mitigate the impact of HIV/AIDS.</td>
</tr>
<tr>
<td>➢ A general basic education has an important preventive impact. It can equip people to make healthy decisions concerning their own lives, bring about long-term healthy behaviours, and give people the opportunity for economic independence and hope.</td>
</tr>
<tr>
<td>➢ Education is among the most powerful tools for reducing girls' vulnerability. Girls' education helps to slow and reverse the spread of HIV/AIDS by contributing to economic independence, delayed marriage, and family planning.</td>
</tr>
<tr>
<td>➢ Schooling offers an appropriate infrastructure for delivering HIV/AIDS prevention efforts to large numbers of the uninfected population – school children – as well as to youth, who are the age group at most risk in many countries.</td>
</tr>
<tr>
<td>➢ Education is highly cost-effective since the investment in prevention is many times smaller than the cost of caring for the sick.</td>
</tr>
</tbody>
</table>
The following diagram needs attention and remedial actions by the educational planners, curriculum developers and teacher educators:

**FIGURE 1: THE IMPACT OF HIV/AIDS ON EDUCATION**

**Demand**
- Decreased fertility
- Increased infant and child mortality
- Increased demand for child labour
- Reduced family income
- Orphans
- Stigma and ostracism

**Uptake**
- Projected number fall
- Decreased uptake of educational laces (females esp. vulnerable)

**Resources**
- Staff
  - Absenteeism
  - Increased mortality
  - Increased benefits
- Money
  - More calls on government budget (health and welfare)
  - Household and community resources constrained

**Response**
- Fewer less experienced teachers

**Output:** educated and trained citizens

This figure shows that the challenge is to maintain and improve the output in the face of new pressures resulting from HIV/AIDS.
Chapter 5

HIV/AIDS: A CHALLENGE FOR EDUCATIONAL PLANNERS

The education system is intrinsically oriented to the future. Its core business is to equip children and young people with the information and skills that they will need for a productive life. But because of HIV/AIDS there would be no future for many young people. We are also aware that an education system responds creatively and flexibly to HIV/AIDS, only, when it continues to provide meaningful, relevant educational services of acceptable quality to learners in and out of the formal system, in complex and demanding circumstances. This creative response will require a policy and management framework that can make things happen.

1. Barriers to HIV/AIDS Preventive Education

Despite the evident urgency of providing AIDS education to students, there are various obstacles standing in the way:

The subject is considered too controversial. The policy makers, teachers and parents may object to the introduction of school HIV-prevention programmes, on the grounds that the topic is too sensitive for children, or controversial for the society.

Overcrowded curriculum. Finding a slot for HIV/AIDS education in an already overcrowded school curriculum, especially when there are many issues competing for space, may be difficult.

Incomplete coverage. In the absence of a clear policy on HIV/AIDS education and at what level it should be taught, if at all taught, this important message may not get the attention it requires, to arrest the danger the disease poses to our young people. AIDS education – where it exists at all – is usually taught at the secondary school level. Because of high drop-out rates in many schools, children – and particularly girls – who frequently leave school before secondary school age, do not get AIDS education.

Information is taught, but not skills. In some countries, HIV/AIDS education may be provided in schools, but it may deal only with medical and biological facts only and not with the real life situations that young people find themselves in only if life skills are taught, and matters such as relationships. Sexuality and the risk of drugs are discussed, will young people be able to handle situations where they might be at risk of HIV infection.
Poor quality of curriculum. Even if HIV/AIDS Education is allowed in certain countries, its impact may still be inadequate due to following deficiencies in the curriculum:

i. AIDS education is not meaningfully integrated into the curriculum and its links with other health and social issues are not brought out

ii. Learning materials may be inadequate

iii. Materials for teachers may not exist

iv. Teachers may not be properly trained to organize classroom activities on sensitive issues

v. There is no provision of assessing how well students have learnt

vi. No education is provided on referral services, such as further information and skills training, counseling, and youth friendly STD services.


The National Education Policy (1998-2010) clearly envisaged to introduce and integrate AIDS Education into the curricula:

"Emerging key issues such as, computer literacy, population and environmental education, health education, AIDS Education and Values Education, etc. shall be introduced and integrated in curricula"

(Para 5.5.4-iv – page 32, National Education Policy (1998-2010)

3. Policy Planning for HIV/AIDS Education: Possible Strategies

Introduction and integration of HIV/AIDS Preventive Education in school education can not take place without a policy level initiative from the high level. To start this process and effectively achieve the objective of Introduction of HIV/AIDS Preventive Education at school/college level, we have to take action on the following directions:

- Policy formulation
- Building partnership with other stakeholders and local community
- Curriculum reforms/changes
- Sensitization and training of teachers

Experiences and Trends in other countries with respect to HIV/AIDS Preventive Education should also be taken into consideration for future planning. The educational approaches followed in India, Bangladesh, Thailand, Iran, China, etc. may also be studied and considered for adoption/adaptation in Pakistan.
3.1 Policy Formulation

Federal Ministry of Education has to take the lead and coordinate with the teaching and research institutions and develop clear guidelines for use of schools and other educational institutions like mosques, madrassas, etc, in connection with HIV/AIDS education.

It is desirable that Federal Ministry of Education should do the following:

- Formulate its policy on HIV/AIDS Preventive Education.
- Establish coordinate and communicate this policy with wider national HIV/AIDS control Program.
- Have a commitment to well-coordinated multi-sectoral intervention and to work in close cooperation with communities, religious organizations, NGOs, district Nazims, Union Councils and other segments of society.
- Introduce health education in educational institutions and throughout the country.
- Design its strategies for personnel and human resources support and replacement.

The successfullness of above mentioned endeavors of Ministry of Education will mainly depend upon:

- Guidelines for use of concrete situations in schools, colleges and at lower levels in the system.
- Its commitment to the development of information base to guide policy and planning.
- Its concern that gender sensitivity be manifested in all HIV/AIDS interventions.
- How it proposes to monitor the impact of disease on student and to measure the success of its interventions.

3.2 Building Partnerships and Increasing Coordination

A particularly important task of educational planners, would require to coordinate and share with other ministries, for example, labor, health, population and welfare, women, culture and youth affairs regarding initiatives and interventions for HIV/AIDS prevention. They will have to bridge their gaps and build partnerships so that every one takes the responsibility and the ownership for an AIDS free society in Pakistan.

The policy makers, teachers, parents, religious leaders need to make an alliance through their concerted efforts, in determining the kind of AIDS education to be
Change in the content and role of education regarding HIV/AIDS is required in order to meet student needs, focus more on life skills and adapt curricula to marginalized groups. Although there is an increasing consensus for the need of HIV/AIDS education for young people, curriculum design and delivery of HIV/AIDS education will remain a serious cause of concern, unless interventions are designed by taking into account cultural, religious and ethical norms and values while dealing with sensitive issues.

In the absence of appropriate training for teachers for HIV/AIDS Education and over-crowded and examination driven curriculum, the “integration and Infusion” and multiple-disciplinary approaches can be introduced where HIV/AIDS topics are included in the carrier subjects.

**HIV/AIDS Education**

HIV/AIDS education is part of health education. Health education is a shared responsibility among school, neighbourhood, community, school division, health district, and provincial levels.

It is important that teachers and students recognize that health-related information in general, and AIDS-related information in particular, is dynamic and accurate because misinformation about HIV/AIDS is available, often through the mass media.

**HIV/AIDS Education places an emphasis on enabling people**

- To make healthy decisions that affirms personal standards.
- Study HIV/AIDS information with a focus on committing themselves to a lifestyle free from HIV infection.
- Encouraging students to support their peers as they demonstrate effective communication skills with parents/caregivers.

HIV/AIDS is a real threat to the education sector, and thus potentially to human resource-based development. The implication of the HIV/AIDS epidemic is that these goals of EFA become more difficult to achieve. Furthermore the education sector has a considerable responsibility for addressing HIV/AIDS, as it is the most appropriate and cost-effective place for education to take place.

The issues facing the education sector will occur, at all levels, from primary to tertiary, including the inspectorate, planning cadres and teacher training.
Guidelines for preventive education

The purpose of preventive education is to promote a healthy lifestyle and responsible behaviour and to prevent disease.

Strategy
This is achieved by providing the knowledge, attitudes, skills, and means to encourage and sustain behaviour that reduces risk of infection, by providing social support and care and by reducing stigma and discrimination.

Early Action
It is important to start early, that is before children/adolescents become sexually active or drop out of school.

Multi-dimensional
An effective preventive education approach must be comprehensive, multisectoral, open, and flexible; and it must address all factors that increase vulnerability to HIV/AIDS.

Communication Skills
Education Personnel must be equipped with communication skills including a capacity to listen and to learn and an ability to effectively address sensitive issues.

Cultural Context
Best practices from other countries and regions can be borrowed and adapted, but the unique cultural contexts of your country needs to be taken into account.

Beyond School
HIV/AIDS education does not stop in the classroom. HIV/AIDS should be integrated both into the curriculum and into extracurricular activities within the school setting such as youth camps, peer education, theatre, study tours, exhibitions, contests, sports, etc.

In addition HIV/AIDS Preventive Education efforts should be undertaken through Non-formal Education system also, including through religious education institutions, or Madrassas.

5. HIV/AIDS EDUCATION AND THE SCHOOL CURRICULUM

Schools share responsibilities for HIV/AIDS education with parents, madrassas and mosques, community organizations and social agencies.

The first phase of the battle against HIV/AIDS focused mainly on epidemiological action and research concerning the disease itself. However, scientific progress has revealed that a long period of time (5 to 10 years) can lapse between the first infection and the manifestation of the disease. Thus greater attention needs to be paid, not only to the medical, but also to the educational management of prevention and the post-infection intermediary phase. Strategic guidelines and culturally appropriate prototype educational materials for curriculum planners, teachers, young people (Both in and out-of-school) girls and women, would have to be researched and designed, in order to make them accessible to the specific target groups.
Change in the content and role of education regarding HIV/AIDS is required in order to meet student needs, focus more on life skills and adapt curricula to marginalized groups. Although there is an increasing consensus for the need of HIV/AIDS education for young people, curriculum design and delivery of HIV/AIDS education will remain a serious cause of concern, unless interventions are designed by taking into account cultural, religious and ethical norms and values while dealing with sensitive issues.

In the absence of appropriate training for teachers for HIV/AIDS Education and over-crowded and examination driven curriculum, the "integration and Infusion" and multiple-disciplinary approaches can be introduced where HIV/AIDS topics are included in the carrier subjects.

**HIV/AIDS Education**

HIV/AIDS education is part of health education. Health education is a shared responsibility among school, neighbourhood, community, school division, health district, and provincial levels.

It is important that teachers and students recognize that health-related information in general, and AIDS-related information in particular, is dynamic and accurate because misinformation about HIV/AIDS is available, often through the mass media.

**HIV/AIDS Education places an emphasis on enabling people**

- To make healthy decisions that affirms personal standards.
- Study HIV/AIDS information with a focus on committing themselves to a lifestyle free from HIV infection.
- Encouraging students to support their peers as they demonstrate effective communication skills with parents/caregivers.

HIV/AIDS is a real threat to the education sector, and thus potentially to human resource-based development. The implication of the HIV/AIDS epidemic is that these goals of EFA become more difficult to achieve. Furthermore the education sector has a considerable responsibility for addressing HIV/AIDS, as it is the most appropriate and cost-effective place for education to take place.

The issues facing the education sector will occur, at all levels, from primary to tertiary, including the inspectorate, planning cadres and teacher training.
Sensitive Issues

HIV/AIDS education deals with the personal and sometimes sensitive issues of interpersonal relationships, drugs, and death. Students come to classrooms from diverse backgrounds and bring with them a range of values and ideas about these issues. Students may live in traditional families or non-traditional families. Some may be hesitant to share ideas and join discussions. It is important to respect the diversity of students' backgrounds, needs, and interests.

The topic of homosexuality may arise during discussions about HIV/AIDS. In accordance with learning for development of Personal and Social Values and Skills, health educators must remind students that all people deserve respect, and that discussions should be free of stereotyping and prejudice. Within HIV/AIDS education, it is best to focus on prevention, transmission, support, and treatment rather than focusing on particular groups of people. Emphasizing on behaviour change, decisions, and actions will benefit students throughout this unit of study and the future.

Some students may have friends or family members who are HIV positive, are dying, or have died of AIDS. For those students, information on supporting friends or family who are living with AIDS, and dying may be of importance. Appropriate resource people and community agencies can support both teachers and students.

School as the Focal Point of HIV/AIDS Activities

The schools would have to take up additional and changing role. School is an important institution of the society which can play an effective role in bringing about a social change. It seems logical, therefore, that the school should be the focal point for all HIV/AIDS control activities. This would necessitate suitable communication and new counseling roles for teachers, who would be called upon to counsel their students and help them with the stress arising from HIV/AIDS in their families. In other words, in addition to the traditional concern with intellectual development, schools have to be prepared to play a more active role in pupil psychological support and counseling.

The rational use of resources for dealing with HIV/AIDS epidemic requires radical break from stereotyped compartmentalized approach to human development. This break could be achieved by converting the schools into multipurpose development and welfare institutions that can deliver more than formal school education as traditionally understood in the country.

The principal and the district management may be sensitized about their role and responsibilities about HIV/AIDS, for better implementation. This would help in the dissemination of information at the grass root level and decentralization of resources for a behavior change.
In addition to facing different set of clients, the school and its personnel may also need to take on some new roles. Some of these will appear within the school itself. Even at the primary level, as more and more of its pupils drop out of school or are unable to continue to a higher level, schools may need to pay greater attention, in the curriculum and outside of the class hours.

Policy makers and planners should also be concerned about such issues designing convincing and effective programs for students, which will be acceptable to not only the students but also their parents and the other community members.

**Flexibility of School Programs**

Formal educational provision tends to be quite inflexible. The daily schedule for beginning and ending classes, the time table for each day's learning and co-curricular activities, the calendar for the school year, the basic organization of the teaching and learning process, the content of what is studied throughout the country, contribute to the effective delivery of the message of HIV/AIDS. Non-formal and formal education approaches, open learning and media may be extensively used for HIV/AIDS education. Thus creating awareness and sensitizing maximum number of the clientele.

**Make a situational assessment and design a good curriculum.**

Steps are recommended in designing a good curriculum for AIDS education, the first of which is to make a proper situation assessment. This involves studying students' patterns of behaviour relating to:

- risk of HIV
- drug consumption
- at what age they tend to leave school
- common forms of sexual behaviours

The results of the situation assessment have a direct bearing on the curriculum design:

- nature and scope of the programme (including the age at which it is introduced).
- selecting objectives of the programme
- making a curriculum plan
- planning for materials development
- developing teacher guides
- developing students activities
- planning teachers training and
- validating the curriculum
planning orientation sessions for school administrators to gain their continuing support.
Designing programme evaluation.

Ensure an effective AIDS education programme

Effective programmes are those that have a positive influence on behaviour as regards sex, drug use and non-discrimination and not simply increased knowledge and changed the attitudes of students.

Effective programmes do the following:

- Focus on life skills—particularly relating to decision making, negotiation and communication.
- Concentrate on personalizing risk through appropriate role playing and discussions.
- Explain where to turn for help and support among peers, school staff and outside facilities.
- Stress the skills useful for self protection from HIV, abuse of drugs including tobacco and alcohol and also help build confidence.
- Reinforce values, norms and peer group support for practicing and sustaining safe behaviour and resisting unsafe behaviour, both at school and in the community.
- Provide sufficient time for classroom work and interactive teaching methods such as role play and group discussions.

Three other elements have been shown to be important for effective AIDS education in schools:

1. Teaching primary and secondary students to analyse and respond to social norms in order to understand which ones act in a potentially harmful direction and which ones protect their health and well-being.

2. Effective training, both for the teacher themselves and for peer educators, specially selected to educate their friends about HIV/AIDS.

3. The third vital factor is that of age. Effectively, this means that age appropriate programmes should start before sexual activity does, thus preparing the students to cope with future risk activities.

6. Approaches and Interventions for HIV/AIDS Education

For any effective programme that has to deal with issues like HIV/AIDS education a number of approaches and interventions need to be devised as the
education system can no longer deliver a strictly health based message about HIV/AIDS in a traditional and conventional manner.

Five possible approaches for interventions of HIV/AIDS in curriculum may be:

1. **The separate subject approach**: where HIV/AIDS and reproductive health are designed as a freestanding separate subject. This mode ensures that subject is clearly identifiable and manageable. It can also ensure that it receives sufficient emphasis. There is the further advantage that this allows HIV/AIDS to be given a high profile as an examinable subject, thereby capitalizing on the power of examination to drive the desired learning.

2. **The carrier subject approach**: wherein HIV/AIDS and reproductive health become an integral part of an existing carrier subject (such as General Science, Biology, Social Studies, Urdu, Islamiyat, English etc.). The difficulty with this approach is that the new areas will receive only as much emphasis, from learners and teachers, as attached to the carrier subject, there is also some possibility that the HIV/AIDS concept might lose their identity within the carrier subject.

3. **Unit approach** may be much helpful in HIV/AIDS education. This simply demands developing 2 or 3 units specifically on different aspects of the curriculum. The information included in the units must be to the level of students.

4. **Infusion Approach** in which the concepts of HIV/AIDS are not placed in a separate chapter or book but they are infused in different subjects in appropriate places. For example in the text-book of Islamiyat, the versions of the Holy Quran and sayings of the Holy Prophet regarding sick people, poverty, cleanliness, rights of individuals etc, are discussed and it is for the teacher to know as to how he/she can handle that concept while teaching Islamiyat so that the students are properly educated about the HIV/AIDS and its effects. Similarly infusion in other subjects is possible but in this type of approach the responsibility lies with the teacher, to give proper emphasis to HIV/AIDS related concepts but not at the cost of the subject he/she is teaching.

5. **The integration approach** where HIV/AIDS is taken to be crosscutting issues to be in all subject areas and become examinable as a part of those subjects. In this approach also there is some risk that the concept about HIV/AIDS would lose their identity. There is a further risk that being part of every subject, they would receive adequate treatment from none and would not go beyond knowledge and information.
In our education system there is a hope, from past experiences that the Integration Approach is comparatively possible for the purpose of teaching about HIV/AIDS.

7. Preferred Subjects for Interventions

At the school level, the curriculum for social sciences, Islamiyat, General Science, languages and other disciplines that deal with human rights needs to be extended to include HIV/AIDS applications. This can also find expression in efforts to bring HIV/AIDS out in to the open, to contribute to break the silence, the secrecy, the stigma, the shame that are associated with HIV/AIDS. HIV/AIDS in itself is a calamity and trauma for an individual, the family and the community. It doesn’t need an inhuman response of aggravating it through stigma, silence and shame.

---

**Education is the only way**

- There are no cures or vaccines for HIV/AIDS. Currently education is the only way to prevent infection.
- Preventive education also means preventing stigma, denial, and discrimination.
- HIV/AIDS is associated with sex, disease, and death, and with behaviours that may be illegal, forbidden or taboo, such as pre- and extramarital sex, sex work, sex between men, and injecting drug use. Education can help to break these barriers.

---

**Incorporating HIV/AIDS prevention and care in the national curriculum**

- **Integrate** HIV/AIDS issues in a broader health education approach, also including malaria, tuberculosis, reproductive health, substance abuse, and sexually transmitted infections
- **Train** teachers on how to deal with HIV-positive students and colleagues and how to teach about HIV/AIDS, life skills, and related issues, and integrate this content into the teacher training curriculum
- **Develop** adequate teaching and learning materials related to HIV/AIDS knowledge and skills based on a life skills approach and with supporting materials for use outside the school setting
This Figure provides a proposed flow diagram of HIV/AIDS concepts in different subjects as carriers.

- Knowledge of how HIV/AIDS is transmitted.
- Risk behaviours of HIV/AIDS spread.
- Environmental pollution.
- Ways of protection.
- Drug abuse.
- Contaminated needles.
- Susceptible host.
- HIV/AIDS positive mothers & other persons

- HIV/AIDS basic question.
- Looking into HIV/AIDS.
- Specific preventive measures.

- HIV/AIDS chain of infection.
- Causes of HIV/AIDS.
- Blood transfusion.
- What happens with HIV/AIDS infection?
- Portal of entry
- Vulnerable groups.
- Blood Circulatory System

---

ENGLISH

URDU/REGIONAL LANGUAGES

SCIENCE

SOCIAL STUDIES

ISLAMIAT OR ETHICS

MATHEMATICS

  - (Up to Higher Secondary Level)

- Factors that do not cause HIV/AIDS infection.
- Effects of HIV/AIDS on global & national level.
- Social effects of HIV/AIDS.
- Ethical Religious Aspect.
- Working together for prevention of epidemic.
- Social and economic issues.
- Unsafe sexual practice
Chapter 6
TEACHER TRAINING FOR HIV/AIDS PREVENTIVE EDUCATION

In this fast moving age of technology and scientific discoveries, the role of the teacher has become all the more challenging and demanding. The rapidly changing society needs to put a premium on people to be able and willing to learn; throughout their lives. Since most of the learning takes place inside the school in the country, pupils need to be equipped with a range of skills and qualities. The teacher therefore cannot rely just on the information skills. The teacher needs to develop them in life skills, for example thinking skills, problem-solving, creativity and generating new ideas. It also includes attitudes, values, and develop competencies to enable the pupils learn about new themes like HIV/AIDS, human rights etc, embedded in the curriculum. In fact, learning to learn is very close to learning to be. In order to develop skills and qualities in the young, the teachers also need to be clearer about the competencies they themselves need, to make effective classrooms and schools.

2. Importance of Teacher Training

No educational system can be better than the quality of its teachers. The competence and enthusiasm of teachers determine the heights to which a programme like HIV/AIDS can rise. We may put in any effort to improve our objectives, policies, programmes, curricula, equipment and administrative structure, but it is only the teachers who put life into this skeleton.

Entrusted to the teacher is the body, mind, heart and the soul of the child which is more susceptible and malleable than the potter’s clay, more valuable than the miser’s gold and more powerful than the scientist’s atomic bomb. The job of the teacher is, therefore, a very crucial one. It is usually remarked that the programme is precisely worth the teacher’s worth and for this reason training the teacher is the first priority in any programme of HIV/AIDS education to be a success.

3. Teachers as Learners:

Just when teachers think they have their jobs all figured out, the curriculum springs something new on them. Although such demands are often necessary and eventually enhances student learning, they require teachers to become students---if only briefly—as they learn about the required changes and determine how best to implement them.

Changes in the school policy, technology, teaching strategies, and so on, require more from teachers than simply memorizing information and promptly forgetting it. In their own classrooms, teachers know that they cannot simply accept rote memorization as a valid product of learning, nor can they force pupils to
understand and apply knowledge. Teachers are aware that for a change to be lasting, pupils must be motivated to learn. Educators or administrators responsible for staff development must motivate teachers to want to learn and apply new knowledge.

Teacher training is therefore a crucial component, particularly in the case of HIV/AIDS education, as the issues involved are extremely sensitive. In this respect it is important that teachers are made to understand what is known about HIV/AIDS specifically about its spread and sensitization in youth so that they can give reliable information about it to students; They also have to confront their own feelings, specially of fear of the disease, and about people with HIV/AIDS; they have to feel comfortable with the issues raised in the program, particularly those related to sexual behavior as enunciated by Islam; and finally, they have to design and try out the classroom activities described in this regard.

It is necessary to assess the accuracy of teacher’s knowledge, their attitudes and levels of comfort with sensitive topics, before designing a training program. An instrument has to be developed to carry out the need assessment- needs analysis for the teacher training program that will have to be adapted to the country’s religious and cultural need.

Presently there are three streams of teacher training: conventional or formal training, non-formal training systems and distance education through the Open University. In private sector Aga Khan Education Foundation and the Ali Institute are major contributors. In the conventional or formal training system, the programs include:

1. Existing pre-service and in-service training
2. Project related training programs mostly supported by international agencies.

In the non-formal education there are several variations in the provinces including field-based training, mobile training and crash training programs. The Allama Iqbal Open University (AIOU) provides distance education. Virtual university is another avenue of distance learning, which may be approached for in-service training of teachers about HIV/AIDS through its study centers, which may prove partially effective for sensitization.

Any teacher-training program designed for this purpose should

1. Increase know-how of theoretical knowledge about HIV/AIDS and its impact on human behavior.
2. Display for attitudes that foster for prevention from the epidemic and effect of HIV/AIDS on genuine human relationship.
3. Provide knowledge in the subject matter, about the spread of HIV/AIDS and statistics of epidemic.

4. Impart technical skills of teaching that facilitates students learning.

These trainings should enhance the existing teaching skills of the teacher and also encourage them to devise innovative methodologies for teaching about HIV/AIDS in the classroom. Teachers should be involved in designing lesson plans for different levels encouraging positive attitudes in the pupils in terms of prevention of HIV/AIDS and understanding about the needs of the infected people. One very important aspect that is mostly ignored by teachers is the objectives of the lesson. Teachers need to be trained to identify goals that are explicit and specific, achievable realistic, attainable, measurable and time framed. Only then they will be in a position to evaluate their programme.

### Planning and managing HIV/AIDS education

- **Ensure** strategic, operational, and anticipatory planning processes which lead to early warning of impact and realistic and realisable operational plans and policies
- **Reserve** adequate budgetary provision with streamlined access to resources
- **Appoint** full-time mandated HIV-and-education officers within major institutions and make sure that their responsibilities regarding HIV/AIDS are clearly laid out in their job descriptions

Remember that the Education Ministry/Department is responsible for incorporating preventive education in the curriculum and facilitating implementation

### Methods of Teaching for HIV/AIDS

The instructional methods used in teaching may vary, according to the viewpoints of the teaching community. Some experts emphasize child centered as against teachers directed approach and methods, some stress that the teachers' role should not be limited to knowledge transmission only, but should be that of a facilitator. Others recommend that teachers should encourage children to take more active part in developing their own knowledge, Independent, self-paced learning through activities, mixed ability groups and multi-grade teaching, team teaching, and non-formal groups are also some of the teaching methodologies, in practice.

For teaching to be effective, teachers have to use a variety of approaches, instructional strategies and techniques, depending on the nature of the context. Teachers must be able to recognize the needs and their own ability to teach to suit various situations. Good teachers must use instructional strategies and techniques that foster a concern and motivation for learning about the issue and
provide supportive environment. Furthermore, all students have the right to be taught by the teachers who are knowledgeable, skilled and committed to achieve the goal of sensitization about HIV/AIDS.

Having clearly identified **what we want to teach** and **why we want to teach**, our next important concern is **how we can teach effectively**. The "how" of teaching the concepts "HIV/AIDS" comes after the "what" and "why". "Teaching strategies" is the third main component, which completes the triangle of an effective teaching of HIV/AIDS. The following triangle shows these components.

![Diagram showing the triangle of an effective teaching of HIV/AIDS]

The teacher, while preparing for daily teaching, first selects concepts and content: then formulates objective of teaching (i.e. the instructional objectives) and then determine methods and procedures of presenting the contents to the students. This unit is an effort to present a few strategies, which can be used in teaching of the core message of HIV/AIDS. These include:

1. Inquiry Approach
2. Questioning Technique.
3. Simulation and Role Playing.
4. Case study

5. **Designing a Teacher training programme**

While designing a teacher training for HIV/AIDS programme it should be based on following steps.

1. Objectives (Cognitive, Psychomotor effective)
2. Inputs.
3. Curriculum of training.
   a. Theoretical
   b. Practice
4. Modes of training.
5. Duration of training
6. Expected outcomes
7. Evaluation, feedback and revision
8. Sustainability
9. Quality control
10. Supervision, monitoring and evaluation.

6. Teaching Skill: An Area of Emphasis for Teacher Training

The teaching skills of the teachers are extremely weak in general and hence need intensive training regarding HIV/AIDS. The training programmes in general almost invariably highlight the pedagogical parts of the course that is purely theoretical and hardly focus skills development and growth. In such a situation however teachers may possess all the relevant training material in the form of modules, handbooks, teachers guides, activity books, manuals etc, yet they fail to deliver as they themselves lack the basic training skills. The training culture is not at all reflected in the teaching style of the trainers, who do not make use of AV aid and lack group dynamics and interactions. Their classes seem to be adults, who are continuing a ten years continuum of traditional rote learning and memorization.

Knowledge, skills, and attitudes can’t easily be taught using traditional methods of training. Teachers must be trained to handle sensitive issues like HIV/AIDS. This includes first gaining the confidence and skills which might make it easier to talk about the often difficult topic related to HIV/AIDS.

There is a need for appropriate material development, advocacy campaigns through mass media and innovative teaching/ training methodologies, in order to prepare teachers for 21st century. Such a teacher training program specifically with reference to HIV/AIDS needs to be supplemented by TV programs, radio broadcast and audio-visual aids.

Because of the fact that, there is no in-built mechanism in pre-service teacher training program of Pakistan, a working teacher should receive fresh in-service training every five years. Due to paucity of recurrent funds and poor quality of in-service programs, it fails to motivate the teachers and most of them avoid the courses and remain passive without getting anything worthwhile at the end of the course. Such knowledge, skills, and attitudes cannot be easily acquired or taught using traditional methods of training. The teachers themselves, must be trained in the art of exploring these new but culturally sensitive issues and devising innovative methodologies to teach them in the classroom. This includes first gaining the confidence and skills which might make it easier to integrate the often difficult topic as HIV/AIDS in the core curriculum.
7. **Interpersonal Skill – Much More Important**

For the purpose of HIV/AIDS education the teacher must be trained in interpersonal skills. Interpersonal skills training are quite different from the academic training. It comes through experience, self-awareness, insight and spontaneous communication. The person-centered approach, as the name implies, has the people as the focal point and every action revolves around them, thus building the inter-personal relationship. The points that matter most are core conditions of qualities namely internal motivation, hidden motivations, empathy, genuineness, warmth, sympathy and understanding. You inculcate these qualities in others through counseling skills. In addition to these skills there are some more skills like conflict management, teaching styles, negotiations, and feedback.

The interpersonal skills may be mastered in three stages during the training.

<table>
<thead>
<tr>
<th>Stages 1</th>
<th>Conceptual understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Stages 2</td>
<td>Practice exercise</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Stages 3</td>
<td>Revision in the light of feedback (Finalization)</td>
</tr>
</tbody>
</table>

8. **Curriculum for Teacher Training**

It is not the content of the subject matter but the approach to its teaching, which sensitizes the students about HIV/AIDS and influences them profoundly, it is this approach which the teacher education programmes must investigate and revise.

The teacher education colleges also need to undertake the task of evolving a teaching methodology so that we do not have to depend on the secular approach to each subject. We need to educate teachers to teach each subject in such an integrated manner that their students become capable of applying skills to combat HIV/AIDS spread. This approach should neither be dogmatic nor so free that students fail to imbibe the basic of the subject.

It should be based on following focal aspects.

1. Type of teachers expected

2. Teaching method decided on the basis of facilities available (blackboard and other A.V aids), teacher training in participatory methods and other innovative approaches

3. Type of materials that will be provided to students
4. Sensitive issues within a country of which teachers should be sensitized

5. Skill of integration of HIV/AIDS core messages while teaching different subjects

6. Skill of designing the activities & AV Aids relevant to HIV/AIDS.
Work Plan of Teacher Training

1. Curriculum need-National and international data
2. History & issues
3. Causes
4. Effects (social, psychological, economic)
5. Prevention
6. Preferred subjects
7. Plug points identification
8. Activities
9. Lesson planning
10. Skill and attitude development
11. Lesson practice
12. Method of integration
13. Methods of teaching
14. Testing and evaluation

National Level
Curriculum Wing, Min. of Education

Provincial Institutes of Teacher Education

District Level

Teacher Training

4 Master Trainers

Teachers’ skill & attitude development

Classroom Delivery

Monitoring & Evaluation

Feedback & Revision

CWMOE: Curriculum Wing, Ministry of Education
PITE: Provincial Institute of Teacher Education
9. Pedagogical Aspects of Training

The selecting of method, activities and media is based on the objectives, content and assessment of the training program. Factors to consider when planning the activities include abilities, time, materials and facilities but the most important among these are the method of teaching and strategies to achieve the desired objectives and the learning outcomes. The types of activities will also help attain those outcomes.

The methodology should focus around active and participatory learning. This means relating knowledge to the needs of the learner. It is teaching how to learn, make decisions etc.

I. Participatory and active learning: In this method learning is participatory and active when learners do most of the activities. They analyze, study ideas, solve problems and apply what they learn. Active learning is fast-paced, fun and personally engaging. Learning is not pouring of information to learner’s head. There is a lot more to teaching them rather than merely telling.

II. Interactive Teaching: Similar in nature to expository teaching, the essential feature of interactive teaching is the deliberate encouragement of interaction between learner and teacher about the situation and danger of the epidemic in the community. This usually takes the form of question-reaction episodes inter-dispersed with expository information. Sometimes known as the discussion or question-discussion technique, it incorporates the successful features of expository teaching with interactive and feedback elements. Essentially learners are more active in this approach and thinking skills are enhanced through the interactive element.

III. Group Activities: Group activities may be most suitable in Pakistan where teacher is already over-loaded. Whatever may be the setup of the school. Sensitizing all the children about HIV/AIDS is the need of today. In order to carry out this function effectively and rationally, the teacher has to use basic criteria to subdivide the class into groups. There seem to be four broad approaches of handling this situation for HIV/AIDS related group activities in the school or classroom:

- Grouping according to previous achievement in the subject concerned and preparing four to five group lessons appropriate for each group rather than one lesson.
- Grouping randomly as the children enter the class. This grouping is not recommended because it could lead to some injudicious combinations.
• Grouping of pupils according to friendship patterns but teacher must exercise own direction in order to ensure appropriate group formation.

• Grouping based on interest.

In addition to the above four criteria for the grouping, the teacher must approach the HIV/AIDS related task with both academic and social purposes in mind, following two are closely interwoven.

IV. **Small Group Discussion:** The principal feature of this strategy involves the division of a class into small groups, which work relatively independently to achieve a goal. In most cases this task is addressed through a HIV/AIDS related group discussion procedure. Here the role of the teacher changes from one of transmitter of knowledge to coordinator and guide to information and it's processing. In small groups students usually set learning tasks within the classroom context. This may involve, for example, students discussing a “institution of health” in social studies, resolving a problem in “spread of diseases & care” in science or raising questions about blood transfusion in hospitals. Through the interaction engendered by group discussion students acquire the skills of planning and organizing work for HIV/AIDS control, developing arguments, sharing knowledge, dividing tasks, adopting compromise positions and so forth. Examples of small-group teaching include group discussions, some tutorials, some seminars, ‘buzz’ groups, brainstorming groups on problems of HIV/AIDS in Pakistan.

V. **Peer leader Technique or Monitor Technique**

A peer leader or monitor is a student who is selected for his/her leadership potential in helping in the education process. He/she is trained to help other students, learn through demonstrations, listening, role-playing, encouraging, giving feed-back and supporting healthy decisions and behaviors. Curriculum planners and teachers should bear in mind that peer leaders may be used for almost any of the activities-whenever the teacher feels this would be useful and appropriate.

Many successful programs have involved peer leaders. Studies have shown that:

• Young people are likely to imitate or model well liked and respected peers.

• Young people are more likely to what respected peers say.
• Peer leaders who exhibit healthy, responsible behavior can influence in a positive way the behavior of other peers.
• Peer leader can support, encourage and help their peer both inside and outside the classroom.
• They can help the teacher in the classroom.
• They can help manage and solve problems when students are working in small groups, particularly when the class size is large.

Training will insure that the peer leader will:

- Understand the purpose of HIV/AIDS program and the importance of peer leader’s role within it.
- Be skilled in helping the teachers and students with the more difficult activities.
- Be able to help small groups of student operate effectively.
- Be a good listener, provide feedback and be able to understand the feelings of their peers.
- Know the sources of information and counseling so that students can be referred to appropriate help.

10. Operational Aspects of training

Operational Aspects of training are dependant upon the factors like:

- Number of teachers to be trained.
- Time available for completing the training.
- Nature of training either direct or through lead trainers and master trainers.
- Finances available.
- Curriculum for which the training is to be provided.
- Mode of training – Formal, Non formal, In-service, Pre-service or through specially designed workshops.
- Teachers is brought to the training or training is taken to the teacher.
- Educational Technology available for training.
- Resource persons and other materials necessary for training.
- Cooperation and coordination between the organizations and authorities responsible for training both at federal and provincial level.
11. MODES OF TEACHER TRAINING

There may be a variety of modes of teacher training for HIV/AIDS education keeping in view the previously discussed pedagogical, Operational and ethical aspects of training. A single mode or a mix of different modes may be used but it will depend upon the objectives to be achieved.

Teachers can be familiarized with various innovative teaching methodologies, so that they can devise their own interventions or adapt that are available according to their own needs.

i. Formal Teacher Training or Face to Face Training

It is also called conventional system. This system provides qualified and trained teachers of every level to the public school system. The best way is that HIV/AIDS education and its teaching methodology be included in one of the pedagogical subjects of each PTC, CT, B.Ed, M.Ed, and diploma in education courses. This will provide an in built mechanism of teacher training for HIV/AIDS education in the country.

ii. Teacher Training through Non Formal Mode

Allama Iqbal Open University is training teachers using Open Distance Learning System in which courses are developed and students are allotted tutors near to their homes. A number of other Government institutions and NGOs are also organizing Non-formal Education programmes.

iii. In-service Training (INSET)

This training is arranged for serving teachers for upgrading and updating their knowledge, competencies and attitudes. For updating, the programmes are conducted when needs are felt by the administrators. Teachers themselves have a minimal role in this respect. Frequently teachers attend training programmes they have attended previously; some times the timing is inappropriate, compelling teachers to leave their classes to attend the programmes.

For the purpose of HIV/AIDS education In-service training is the usual mode which suits the system.

iv. Teacher Induction

New teachers receive little assistance at the start of their jobs. Mostly, one-shot orientation programmes are organized for a few days by employer institutions. Programmes content is superficial, touching on curriculum structure, subjects to be taught, and teachers’ code of conduct.
v. Training through Modules

In this type of training where it is impossible to train every teacher in a limited span of time, modular approach is used. For example, modules and teacher guide on HIV/AIDS education may be developed these are made available to every teacher so that teacher may teach according to given guidelines.

vi. Other Modes

Many other modules like monitoring, field based training, mobile teacher training, correspondence method, personalized training, residential training, workshops, seminars, internship, etc., may also be used for the purpose of HIV/AIDS education.

12. Effective Teaching of HIV/AIDS

Effective teaching about HIV/AIDS involves being knowledgeable about what you are teaching but also looking for links of HIV/AIDS for the qualities that we wish to develop in our young people.

- The ability to establish and maintain good quality relationship between core message and content of the subject is central to effective teaching.

- Effective teaching involves talking regularly about the one aspect or the other of the epidemic with learners about their learning and listening to them.

- Teachers have both the right and the responsibility to develop a climate in the classroom, which supports effective sensitization about the epidemic.

- Teaching about HIV/AIDS should not be a lonely or isolated activity. Teachers need opportunities not only to talk to others about the epidemic, but also to work together in HIV/AIDS related activities, and use each as a resource.

- Schools need to make the best use of all the resources at their disposal to support teachers “personal and professional” development about the integration and teaching about epidemic.

13. Lesson planning with reference to HIV/AIDS

Preferring a lesson plan can be both a challenging and satisfying task. Keeping in mind the importance of subject matter, the learning environment, and the needs expectations of the student, the sample format provided here can be modified or improved to make it interesting and effective.
1. Link each new topic with previous topics and real-life examples. Not only will this make a lesson more interesting but new knowledge will also help to develop a better overall understanding of the integrated topic rather than accumulation of isolated facts.

2. Ask questions that encourage task at hand. Avoid questions that seek "yes/no" answers.

3. Give clear, specific instructions for all activities. Confusion about expectations will distract participants from the issue of importance.

4. Keep the focus on the content of the lesson. Politely attempt to keep conversation confined to HIV/AIDS.

5. Synthesize knowledge at the end of lesson. Conclude sessions by restarting the session's and then integrating the concept and ideas that arise during the lesson into framework of HIV/AIDS.

HIV/AIDS facts and concepts can be integrated in course contents of School/college curriculum as a holistic approach for adopting preventive measures and dissemination of information and health education among this venerable group - the youth.

The HIV/AIDS epidemic has been shown to have a negative impact on all aspect of human life and endeavor. Even while the search for appropriate drugs and vaccines continues, preventive education programs are also being developed to promote awareness that this disease is indeed preventable. The program in Schools/ Colleges should focus on the capability of young people to make rational decisions for their own well being and safety.
References Cited


AIDS epidemic Update 1999, UNAIDS.


Summary Booklet of Best Practices, UNAIDS, Geneva, Switzerland 1999

The Impact of HIV/AIDS on children and young people, Jan Wijngaarden and Sheldon Shaeffer, UNESCO, Bangkok, 2002


UNAIDS (Joint United nations Programme on HIV/AIDS).


