ISSN: 2755-0133

Journal of Medical & Clinical Nursing

SCIENTIFIC Research and Community

Research Article

Open Access

Enhancing Sexuality Education to Prevent HIV Transmission Among Filipino Young Key Populations: A Policy Analysis

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ABSTRACT

Background: Human Immunodeficiency Virus (HIV) is growing rampant among vulnerable populations in the Philippines. Projected estimates show that the Philippines experienced a 555% increase in new HIV infections between 2010 and 2024. Current projections reveal that 46% of new infections in 2024 were from the 15-24 age group, also referred to as the young key population (YKP). YKPs, especially those belonging to the adolescent age bracket, are more likely to engage in risky behavior and have difficulties in accessing HIV-related services. It is thus important to guide them toward safe sexual practices. While there are existing policies for education campaigns on HIV, there are no clear guidelines for their standardization and implementation. Comprehensive Sexuality Education (CSE) is already included in secondary and tertiary education curricula, as mandated by the HIV and AIDS Policy Act of 2018, yet it is not effectively delivered to the students due to censorship, hesitancy of teachers to convey messages, or inadequate knowledge among teachers in sexuality education. This analysis aims to examine policy alternatives which can improve the implementation of CSE among YKP attending schools.

Methods: A policy analysis which adopted the 2013 US Center for Disease Prevention and Control Policy Analytical Framework was conducted in order to determine alternatives which could improve the coverage and effectiveness of CSE for YKP.

Results: Review of secondary literature and insights from policy and programmatic informants yielded the following policy alternatives:(1) no change but reinforce implementation; (2) issue guidelines on prescribed modules and add feedback mechanisms; (3) regulate educators through certification requirements; and (4) build partnerships with institutions and organizations who can dispatch peer educators. The second and fourth alternative received the highest score based on five domains.

Conclusions: Issuing national guidelines for the implementation of age-appropriate CSE, along with creating evaluation mechanisms to measure the effectiveness of education, can ensure that the youth are receiving quality health education which they can apply in their practice and behavior. Outsourcing peer educators through partnerships may be effective without exhausting internal manpower.

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Received: April 13, 2026; **Accepted:** April 17, 2026; **Published:** April 25, 2026

Keywords: Human Immunodeficiency Virus, Reproductive Health, Sex Education, Youth

Introduction

Background

Philippine HIV Situation

The Philippines is experiencing one of the fastest-growing human immunodeficiency virus (HIV) epidemics globally. According to the recent estimates of the AIDS Epidemic Model (AEM) and Spectrum, the Philippines experienced a 555% increase in new HIV infections and 667% increase in acquired immunodeficiency syndrome (AIDS)-related deaths between 2010 to 2024. While the global incidence for HIV is steadily decreasing, it is evident that the epidemic in the Philippines treads an inverse trajectory. The current projections indicate that annual new infections could reach 36,700 by 2030, bringing the total number of estimated people living with HIV (PLHIV) to more than 457,600 during the same year [1,2].

In order to curb the escalating health concern, the Philippines adapted a global strategy set by the UNAIDS, the "95-95-95 by 2025." This strategy aims to achieve the following targets by 2025: 95% of PLHIV know their status, 95% of PLHIV who know their HIV status are on antiretroviral therapy (ART), and 95% of PLHIV on ART are virally-suppressed for the past 12 months, which is defined by the UNAIDS as having less than 1,000 viral copies per milliliter of blood. To localize the strategic response, the Philippine National AIDS Council drafted the 7th AIDS Medium Term Plan (AMTP7) for 2023 to 2028. The AMTP7 aims to achieve the 95-95-95 targets by 2030, which if attained can avert as much as 162,000 new infections and 8,000 AIDS-related deaths by 2030. While these local targets are being adopted by the National HIV/AIDS Program, the national accomplishment towards the targets is only at 63-67-40 as of December 2024. It must be noted that the current criteria followed locally for the third 95 is having less than 50 viral copies per milliliter of blood, as defined by the Department of Health Administrative Order (DOH-AO) 2022-0024. Barriers to reaching the targets include individual factors such as low perceived need to utilize HIV-related services, and systemic factors such as access limitations and stock-out of test kits, medications, viral load cartridges, and other supplies [3-6].

Young Key Population

According to the 2024 October updates of the HIV/AIDS Registry of the Philippines, nearly one-third (41,701, 30%) of HIV cases belonged to the 15-24 age group, also referred to as the young key population (YKP) group. The AEM-Spectrum estimates reveal that 47% of new infections are from the YKP, making this age group the largest driver for new infections. AEM-Spectrum further projects a continuous increase of estimated PLHIV among YKPs, from 48,200 in 2024 to 70,800 by 2030 [6,7].

The 2022 Integrated HIV Behavioral and Serologic Surveillance (IHBSS) was released by the DOH to capture the underlying behavioral and serologic determinants which influence HIV transmission among key populations. The surveillance study found that YKPs are more likely to engage in risky behavior and have difficulties in accessing HIV-related services. It also discovered that the median age for first sex is at 16 years old among KP respondents from 15 sentinel sites, while the median age for first anal sex between males is at 17 years old. On the other hand, the median age for first condom use is at 17 years old, indicating a lag of one year between age at first sex and age at first condom use [8].

Among MSMs and transgender women aged 15-17 years old, the top reasons for not using condoms were unplanned sex, lack of sensation, and access barriers from being a minor. For the same KPs aged 18-24 years old, the top reasons for not using condoms were unplanned sex, lack of sensation, and disapproval from the partner. On the other hand, the top reasons for not getting tested among MSMs and transgender women aged 15-17 and 18-24 years old were low perceived need to get tested, not knowing where to get tested, and having no time for testing [8].

Health Issue

YKP are at the age of intimate and sexual exploration. However, while their reproductive systems are becoming mature, the executive functions of their brain have yet to develop, as the prefrontal cortex fully matures at the age of 25. The youth are more susceptible to engaging in risky behaviors without realizing the consequences. It is thus important to guide them toward safe sexual practices. This notion is regrettably difficult in the Philippine context, as there are multiple sociocultural barriers to properly implementing sex education and HIV-related services. Stigma emanates from the religious taboo on premarital intercourse, much more so on same-sex premarital intercourse. Abstinence is encouraged, and sex terms are discussed in abstract or scientific ways which make it difficult for the youth to understand. HIV is considered a "double-whammy", associated with both unplanned sex and higher incidence among MSMs and commercial sex workers [9,10].

Given the country's conservative nature, parents and other guiding adults are likely to avoid topics surrounding sex, HIV, and other sexually-transmitted infections (STIs). Many Filipino adults still believe that discussing these topics would proliferate promiscuous behavior. Consequently, young people forgo consulting the adults about topics related to sexuality due to fear of stigma. They end up exploring the topic by themselves, through the internet, through their peers, and through engaging in the act itself [11].

Relevant Policies

National

Republic Act (RA) 11166. The most comprehensive law to date for HIV/AIDS is the Philippine HIV and AIDS Policy Act of 2018. The RA aims to establish policies and programs to prevent the spread of HIV and deliver treatment, care, and support services to PLHIV. It further aims to create an environment free from stigma and discrimination and resolve the inequality and marginalization experienced by PLHIV. The act mandates the creation of HIV and AIDS prevention programs that will "educate the public on HIV/AIDS and STIs with the goal of reducing risky behavior, lowering vulnerabilities, and promoting human rights of PLHIV [12]."

One preventive strategy is on IEC campaigns, as the act mandates the dissemination of HIV and STI information in learning institutions. The Department of Education (DepEd), Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA) must ensure that public and private institutions teach the causes, modes of transmission, and ways of preventing HIV and STIs in an age-appropriate manner. The Philippine National AIDS Council (PNAC) is responsible for collaborating with local government units and civil society organizations in providing community-based education and community-led behavior modification programs to key populations and vulnerable communities to enhance information reach. The Department of Social Welfare and Development (DSWD) is mandated to provide peer-led counseling and support to PLHIV.

The act follows the Mature Minor Doctrine which recognizes the capacity of some minors to provide consent independently to medical procedures, as they have proven their understanding of the procedures and potential consequences. As such, YKP aged 15 to 17 are eligible to provide consent for voluntary HIV testing and counseling without the need for consent from parents or guardians. Social workers and health service providers are trained for the purpose of educating clients and gaining the competency to handle HIV and STI cases during counseling sessions.

RA 10354. The Responsible Parenthood and Reproductive Health Act of 2012 aim to promote the right to reproductive health and the right to make informed decisions in reproductive matters. Likewise, the act also emphasizes its aims of providing quality reproductive health care services to all Filipinos, albeit with a caveat for minors, as they can only access family planning methods if with written consent from their legal guardian. This act stipulates that sexual health for the youth should include reproductive health education and guidance counseling. Modules for age- and development-appropriate reproductive health education shall be created by DepEd and CHED and taught by adequately-trained teachers. This includes topics on values formation, self-protection against discrimination, sexual abuse and violence, teenage pregnancy, gender and development, responsible teenage behavior, and responsible parenthood [13].

Subnational

DOH Administrative Order (AO) 2022-0035. The Guidelines in the Implementation of Differentiated HIV Testing Services provides technical, programmatic, operational guidelines for implementing HIV testing services and counseling in health facilities. It contains a detailed guide for pre-test and post-test counseling. During pre-test counseling, the service provider shall inform the client about HIV and its relevance to the client's current condition, the benefit of knowing one's HIV status, and the flow of HIV testing service delivery points. In both sessions. Post-test counseling focuses on explaining the results which have emerged from the test. Non-reactive results may indicate non-infection or a test done too early to detect antibodies. In this situation, retesting is recommended especially if with recent exposure; and importance of risk reduction through combination prevention is highlighted.

If the initial screening yields reactive results, the client must be informed about the repercussions of a reactive test, the next steps to take in confirmatory testing, and the importance of being screened for other potential comorbidities such as tuberculosis and other STIs. The service provider shall also highlight the importance of combination prevention, facilitate strategies for disclosing one's status to close circles, and encourage the client to convince his/her social networks to also get tested [14].

Policy Issue

While there are existing policies for IEC campaigns on HIV, there are no clear-cut guidelines for standardized education and implementing mechanisms. Comprehensive sexuality education is already a part of the national school curriculum for secondary and tertiary education as mandated by the aforementioned laws, yet it is not effectively delivered to the students due to censorship, hesitancy of teachers to convey the messages, or lack of adequate knowledge among teachers in sexuality education. There are no regulatory mechanisms in place to assess the quality of sex education, despite the sociocultural biases which impact its delivery. As such, many schools do not even implement the supposed mandate. As a result, the youth fail to fully comprehend the magnitude of the situation and continue to engage in risky behavior, propelling a further rise in HIV infections among these populations. A comprehensive guide for HIV education and counseling does exist for health facilities, yet many health care providers lack the competency to fully convey the key messages to their clients. Empirically, the 2021 Young Adult Fertility and Sexuality Survey revealed that only one in five Filipinos aged 15 to 24 had comprehensive knowledge about HIV. The 2022 IHBSS observed that for each KP group, less than 50% had comprehensive knowledge on HIV. Service uptake was lowest among the YKP, likely attributable to their lower level of awareness regarding the benefit of condom use and testing and where to access these services.

Policy Goal

In order to improve the coverage and effectiveness of comprehensive HIV education for YKP, there should be a more standardized and regulated approach toward its implementation. Doing this can minimize the effects of perspective bias among educators, who are especially susceptible to having negative perceptions about HIV and STIs. Improving the quality of HIV/STI and sex education can improve health outcomes because the youth are more knowledgeable about prevention and early management. This can also reduce stigmatizing attitudes toward the subject. The aforementioned policies can be amended to include the recommendations in this policy brief.

Policy Alternatives

To improve the health education on HIV for the youth, relevant national regulatory agencies may consider these recommendations: Option 1: No Change in Existing Curriculum but Reinforce Implementation. There is no need for an amendment of the existing provisions on health education. Rather, the implementation of the current program should be enhanced in order to boost reach and more efficiently disseminate comprehensive sex education. This is done through ensuring a more consistent inclusion of sex education, including HIV/STI information, in the course syllabi of secondary and tertiary-level education

Option 2: Issue Guidelines on Prescribed Modules and Feedback Mechanisms for Health Education per Grade Level. As of writing, only DOH has a detailed guide on what must be taught during HIV counseling. While the RAs enumerate the potential topics to be tackled upon in HIV and sex education, these are mostly vague, with no method of evaluation to assess if the expected competencies were met by the students. This alternative proposes the release of comprehensive guidelines on health education from the two primary national government agencies focusing on school education, DepED and CHED, in collaboration with DOH and PNAC. The guidelines shall propose the specific curricula to be prescribed per grade level and specify the contents to be taught. In particular, sex education may be taught within Grade 8 to 10 and should integrate comprehensive topics on HIV and STIs. Each curriculum must have an evaluation checklist form containing indicators that the prescribed topics have been taught properly. As such, there should be evaluation measures for students and educators alike. Evaluation results shall be consolidated by the school into a written feedback report to be sent to DepEd or CHED annually. The range and median scores of the students in health education, along with open-ended feedback from educators, should be included in the report.

Option 3: Regulate Educators Teaching Health Education through Certification Requirements. The present policies shall include provisions on requiring certifications from teachers, professors, social workers, health workers, and peer educators/counselors prior to being authorized to teach health education which subsumes topics on sex and HIV/STI. Through regulating the qualification of educators, the quality of education received by the youth can be improved. Certification can be in the form of an issued certificate or identification card affirming the educator's competency after taking a standardized test or revalida. The certification test shall be administered by either the Professional Regulation Commission (PRC) or TESDA in collaboration with DepEd, CHED, DOH, and PNAC, with a validity of three years in order to re-assess the competencies of the educator within the ever-changing landscape of health education. This shall be made eligible to health workers, teachers, and individuals with at least two years of experience in teaching, counseling, or health-related work or advocacy. This policy brief recommends the inclusion of a wide array of health topics typically taught from primary to tertiary education level, as well as questions on how to convey health topics to target audiences. In this manner, conveying sensitive health topics such as sex and HIV/STI can be tackled. Renewal of certification shall require retaking a test with up-to-date items.

Methodology

The 2013 US Center for Disease Prevention and Control (CDC) Policy Analytical Framework was adapted to analyze the current status quo and potential alternatives for HIV IEC policy implementation. Five criteria were used to assess the status quo and alternatives: (1) equity which refers to the capacity of policies to produce a wider coverage of quality comprehensive HIV education; (2) efficiency which refers to the most ideal outcome while being less resource intensive; (3) technical feasibility which refers to the capacity to develop and implement the proposed intervention; (4) financial feasibility which refers to the lowest cost impact to implementing agencies; and (5) political feasibility which refers to the degree of acceptability among stakeholders such as policymakers, implementers, and users. For each policy alternative, every criterion is scored from "1" being the lowest, to "3" being the highest. Scores are subjectively discerned based on the thorough triangulation of existing data. Table 1 summarizes the scores per criteria for each option.

Results and Discussion

Table 1: Assessment of Policy Alternatives based on Equity, Efficiency, and Feasibility

Criteria	Definition	Policy Alternatives			
		No change, suggest to reinforce	Specify guidelines, feedback mechanisms	Regulate through certification	Partnerships to outsource educators
Equity	How the policy can make comprehensive HIV education more accessible	1	2	2	3
Efficiency	Produces the most ideal outcome while being less resource intensive	1	2	2	2
Technical feasibility	Capacity to develop and implement the proposed intervention	2	2	2	2
Financial feasibility	Lowest cost impact to implementing agencies	3	2	1	1
Political feasibility	Acceptability to stakeholders (recipients, implementers, policymakers)	2	2	1	2

Option 1: No Change in Existing Curriculum but Reinforce Implementation.

Merely reminding educational institutions and health facilities to reinforce the implementation of existing policies may come off as vague and thus not result in any impactful change, especially if there are no regulatory measures to evaluate the impact of education. Equity and Efficiency were rated low because schools may easily dismiss the directive, hence not creating any opportunities to improve the access and effects of sex and HIV education. Since there are minimal changes, this option remains the most financially-feasible.

Option 2: Issue Guidelines on Prescribed Modules and Feedback Mechanisms for Health Education per Grade Level.

Standardizing health education in secondary and tertiary-level education to a more granular level can better ascertain the proper implementation of prescribed topics; thus, HIV education is made more accessible to the students. Prescribed syllabi and modules can help educators identify the topics that they should teach. Routine evaluation can help educators and policymakers identify the implementation and learning gaps, allowing them to introduce changes which can bring about improvement. This option is technically, financially, and politically feasible. However, evaluation and creation of feedback reports bring extra work to the educators. This is especially difficult in resource-limited institutions with limited manpower, which may potentially cause overwork among educators. Another downside of this option is that it solely focuses on school implementation.

Option 3: Regulate Educators Teaching Health Education through Certification Requirements.

This option is more holistic because it considers the competency of educators across different settings. Educators can provide HIV information more confidently, and there is a lower likelihood of introducing misconceptions. However, since certification is now required to officially become an educator for HIV, the number of educators may decrease. It is also the most expensive option, since examinations need to be held regularly, and salaries need to be raised as a result of certification. The need to retake an exam every three years for renewal can be a burden for educators.

Option 4: Build Partnerships with Institutions and Organizations who can Dispatch Peer Educators.

Social hygiene clinics, community-based organizations, and civil society organizations continue to uphold advocacies toward spreading awareness on reproductive health and sexuality, including comprehensive knowledge about HIV and other sexually-transmitted infections. Financial feasibility might depend on the outsourcing party, as some organizations dispatch peer educators for free. Peer educators are also more knowledgeable about CSE and are thus more effective in proliferating awareness. There is less intensive use of internal manpower. However, the feasibility of this option depends on the school's acceptability and capability to find partnerships.

Recommendations

Of the presented alternatives, Option 2 and 4 seemed to be the most efficient. Issuing specific national guidelines for the implementation of age-appropriate health education including sexuality and HIV/STI information, along with creating evaluation mechanisms to measure the effectiveness of education, can best ensure that the youth are receiving quality health education which they can apply in their practice and behavior. The intervention is relatively low cost, only needing to consider the training and workload of teachers. While this recommendation focuses on policy implementation at the school level, other settings involved in HIV education such as health facilities and community settings may have their own similar detailed policy on implementing and evaluating sexuality and HIV/STI education. While strengthening the implementation of HIV education is the first step in an opposing sociocultural environment, other methods of disseminating education may be explored once educators become more competent and established in teaching sexuality and HIV-related topics. For instance, peer education on HIV and sexual behavior is being explored in countries like China and Nigeria [15,16].

On the other hand, partnerships with community-based organizations or health centers with a robust HIV/STI health promotion program can be cost-efficient for schools, ensuring subject matter expertise by the educator and effective proliferation of subject intent to the students.

Conclusion

Issuing national guidelines for the implementation of age-appropriate CSE, along with creating evaluation mechanisms to measure the effectiveness of education, can ensure that the youth are receiving quality health education which they can

apply in their practice and behavior. Outsourcing peer educators through partnerships may be effective without exhausting internal manpower.

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