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EDUCAIDS TECHNICAL BRIEFS

EDUCAIDS is a UNAIDS initiative led by UNESCO. It aims to prevent the spread of HIV through education and protect the core functions of the education system from the worst effects of the epidemic. EDUCAIDS seeks to support the overall national effort on HIV and AIDS by assisting governments and other key stakeholders to implement comprehensive, scaled-up education programmes on HIV and AIDS, ensuring that the education sector is fully engaged in and actively contributing to the national response to the epidemic.

UNESCO, in consultation and collaboration with key partners, has developed practical implementation support tools that provide guidance on the technical and operational aspects of a comprehensive approach.

The Technical Briefs are two-page summaries of key issues related to the five essential components of a comprehensive education sector response to HIV and AIDS: 1) quality education; 2) content, curriculum and learning materials; 3) educator training and support; 4) policy, management and systems; and 5) approaches and illustrative entry points. All of these components need to be in place and working well to ensure optimal success.

Each brief is intended to reach officials in ministries of education and other organizations that are charged with supporting the development and implementation of policies, determining resource allocations, and implementing programmes for education sector staff and learners. There are currently 35 briefs and new ones will be added as appropriate. Each brief can be used as a stand-alone reference, and together they offer comprehensive and flexible guidelines on the continuum of activities required to respond to the epidemic at the country level.

This includes, for example:

- Ensuring that all learners are reached with relevant and high quality learning opportunities in secure learning environments that are rights-based, learner-centred, gender-responsive, inclusive, culturally sensitive, age-specific and scientifically accurate.
- HIV and AIDS curricula and learning materials that are evidence-based, that build knowledge and skills to adopt protective behaviours (i.e. delaying the onset of sexual activity, reducing the number of sexual partners, and increasing condom use), that start early and are sequenced and appropriate for the age and development stage of the learner, and that are based on interactive education methodologies that focus on building skills for protective behaviours.
- Pre- and in-service educator training to build technical knowledge on HIV and AIDS, confidence and experience, and address educators' own vulnerabilities to HIV and the impact of HIV and AIDS. Training should be further reinforced by supervision and mentoring by experienced teachers, and complemented by appropriate teaching resources and professional and psychosocial support, particularly for teachers living with HIV.
- Sectoral policies on HIV and AIDS, workplace policies to ensure zero tolerance for violence, abuse and discrimination, and strategic plans that are costed and funded to implement, enforce, and monitor policies. Evidence-based planning is essential to monitor the response and to protect the education system from the worst effects of the epidemic.
- A holistic effort which maximises the use of various approaches, opportunities and entry points to address underlying vulnerabilities that reduce individuals' abilities to avoid HIV infection and behaviours that create and perpetuate risks.

The 35 Briefs are accompanied by a number of other implementation support tools including:

Overviews of Practical Resources, which provide technical staff, programme implementers and managers in ministries of education and civil society organizations with an analysis of the most useful published resources on the five essential components of a comprehensive education sector response to HIV and AIDS. Each Overview contains an analysis of around 20 of the most useful resources on the subject, including an identification of crucial resource gaps and needs for further research. Each of the individual resources is then annotated with a brief synopsis, the material's purpose and content, and how to access it.

Practical resources will be developed in the future for areas where practical technical or informational resources are limited. These could include, for example, manuals, technical guidelines, wall-charts, or CD-ROMs for use by decision-makers and operational staff implementing policies and programmes at the country level.

The briefs, overviews, practical resources and other EDUCAIDS materials are available in multiple languages and accessible from the UNESCO and EDUCAIDS websites (http://www.unesco.org/aids and http://www.educaids.org), in hardcopy, and on a CD-ROM, and will be periodically updated as new materials become available.

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Quality education and HIV & AIDS

What is the issue?

Quality education is a basic human right. It provides learners with valuable tools to fight poverty and to promote social progress. It can contribute to increased self-confidence, social and negotiation skills and earning potential.

Quality education not only nurtures children and young people, but it also empowers families and communities, and contributes to national capacity-building. Investing in **quality education for girls has been shown to reduce their vulnerability** to domestic violence, sexual abuse and trafficking, and to provide benefits in terms of better health and education both for present and future generations.

The AIDS epidemic poses a serious challenge to quality education, threatening to halt and reverse progress made towards the Education for All (EFA) goals. Steps must therefore be taken to ensure that all learners have access to education to help reduce their risk and vulnerability while working to guarantee that quality measures continue to be created, implemented and adopted.

Why does it matter?

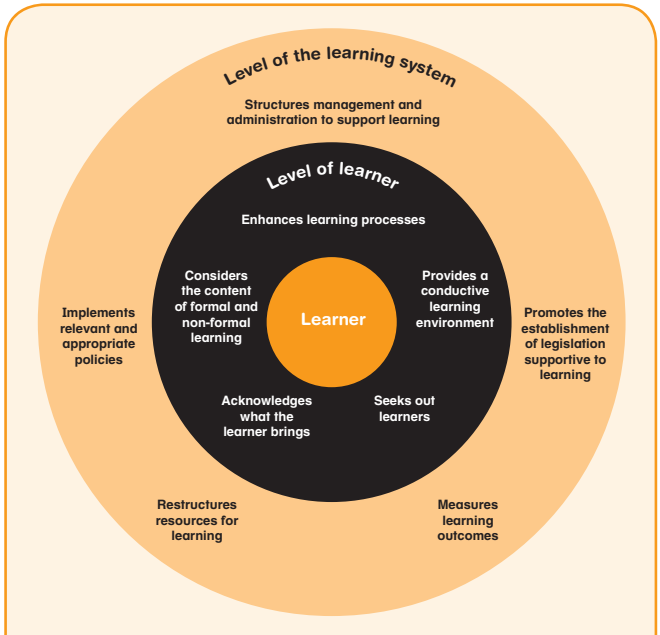
Efforts to promote quality education must shift from an emphasis on *educating to learning*.

The following figure summarises a quality framework that considers the inputs, processes, results and outcomes that surround and foster learning. This includes two dimensions:

- **The level of the learner** (child, young person, adult) in her/his learning environment (formal or non-formal).
- **The level of the system** that creates and supports the learning experience.

Both dimensions must take the AIDS epidemic into account.

A Framework for Considering HIV & AIDS and Quality Education



UNAIDS IATT on Education. 2006. *Quality Education and HIV & AIDS*. Paris: UNESCO.

Country example: Ethiopia

In settings highly affected by HIV and AIDS, flexible school timetables that accommodate the work responsibilities of children who head households, or that provide childcare for younger siblings, can lead to reduced drop-out rates and improved participation in educational activities.

A study in Ethiopia found that schools that began and ended the day earlier than usual, and that scheduled breaks during harvest times, had improvements in students' continuation and achievement rates.

Source: Verwimp P. 1999. "Measuring the quality of education at two levels: A case study of primary schools in rural Ethiopia," *International Review of Education*, 45(2), pp. 167-196.

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What needs to be done at the level of learning systems?

- **Structure management and administration to support quality learning.**
- **Implement policies** that make schools safe and supportive of learners and ensure access to education.
- **Promote a legislative framework** supporting the right to education and EFA.
- **Mobilise resources to meet the increasing human and financial demands caused by HIV and AIDS** to ensure the provision of EFA.
- **Measure learning outcomes** including knowledge, attitudes, skills and behaviours on HIV and AIDS.

What needs to be done at the level of the learner?

- **Seek out learners** from households affected by HIV and AIDS, and assist them, their families and their communities to support learning and fulfil the right to education.
- **Acknowledge what the learner brings**, taking into account experiences or obstacles that can help or hinder educational attainment.
- **Consider the content** of learning materials, ensuring that they are culturally appropriate, gender-responsive, age-specific, contain accurate information on HIV and AIDS, and teach how to protect and respect oneself and others *(*see Brief on: *Life Skills-Based Education for HIV Prevention*).
- **Emphasise inclusion, participation and dialogue** that address HIV- and AIDS-related stigma and discrimination from classmates, teachers, parents and communities.
- **Provide a safe learning environment** that prohibits all forms of violence, provides adequate hygiene and sanitation facilities and ensures access to health and nutrition services.

What works?

In the context of HIV and AIDS, practical and strategic actions in support of quality education should:

- **Support individuals and communities to break the silence on the impact of the AIDS epidemic** on daily lives and institutions, including education systems, while improving community awareness of the value of education;
- **Ensure the involvement of families** by establishing parental education programmes and parents' education committees, and by involving parents in curriculum development with the objective of improving their knowledge about HIV and AIDS education programmes for their children;
- **Improve access to school for all learners** through reducing or eliminating tuition fees and indirect costs and ensuring that schools are safe, healthy and secure;
- **Support interventions that address the impact of power and gender dynamics** on women's and men's vulnerability to HIV. This includes strategies that seek to empower women and girls while also involving men and boys;
- **Develop and implement workplace policies** that are responsive to HIV and AIDS for teachers, administrators and other school staff, including codes of practice and guidelines (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*);
- **Develop teacher training programmes** on HIV and AIDS and related issues, including gender, human rights, sexual and reproductive health, life skills and communication skills;
- **Measure learning outcomes in terms of the acquisition and use of HIV-related knowledge, skills or competencies, values and behaviours,** and use the results for the implementation and assessment of educational policies, programmes and practices;
- **Expand access to antiretroviral treatment (ART) and treatment education**, and combat stigma, discrimination and gender inequality – key barriers to treatment access (see Brief on: *HIV and AIDS Treatment Education*);
- **Develop actions to minimise the impact of the epidemic on the education system** in education planning and management frameworks, including national education sector plans.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, finance, health)
- Civil society organizations, including Education Development Center, Inc. and Education International
- Other international agencies, including the UNAIDS Secretariat and World Bank
- UNAIDS Inter-Agency Task Team (IATT) on Education
- Teacher training institutions
- Parent-teacher associations
- School governing boards

Key resources

- UNAIDS IATT on Education. 2006. *Quality Education and HIV & AIDS*. Paris: UNESCO.
- UNESCO. 2007. *UNESCO Strategy for Responding to HIV and AIDS*. Paris: UNESCO.
- UNESCO. 2004. *Report on Ministerial Round Table on Quality Education*, 32nd Session of the General Conference. Paris: UNESCO.
- UNICEF. 2002. *Quality Education for All: From a girl's point of view*. New York: UNICEF.
- UNESCO. FRESH Toolkit: www.unesco.org/education/fresh

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A rights-based approach to the education sector response to HIV and AIDS

Everyone has the right to education... Education shall be directed to the full development of the human personality and to the trengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(Article 26, Universal Declaration of Human Rights, 1948)

What is the issue?

The protection and promotion of human rights are essential in:

- reducing the vulnerability of people living with HIV and thus supporting prevention, treatment, care and support efforts;
- redressing violations of human rights through HIV-related discrimination;
- achieving universal access to prevention programmes, treatment, care and support;
- ensuring all children have the right to education.

The United Nations has developed a simple 4-A scheme describing governmental human rights obligations to make education available, accessible, acceptable and adaptable:

- **Availability:** All of the key international treaties, including the Universal Declaration of Human Rights and the Convention on the Rights of the Child, state that primary education should be free and compulsory. In the context of HIV and AIDS, this means ensuring that all children attend school, regardless of their HIV status.
- **Accessibility:** In terms of access to basic education, the Dakar Framework for Action emphasises the elimination of all forms of discrimination, and prioritises excluded, vulnerable and disadvantaged children. This includes all children infected or affected by HIV and AIDS.
- **Acceptability:** Building on efforts to achieve greater and more equitable access to education, the Dakar Framework for Action also highlights the need to ensure the quality and relevance of children's learning experiences.
- **Adaptability:** Another result of infusing education with a human rights perspective is that school systems must necessarily adapt to the various needs of individual students, rather than expect children to fit in with a prescribed syllabus or manage with whatever facilities are in place.

Country example: India

In December 2006, a school in Kerala, India, expelled five HIV-positive children because parents complained that they did not want their children in the same class as HIV-positive children. A local NGO intervened on behalf of the five children and used a rights-based approach to education in order to argue that these children also had the right to education. The NGO filed a petition which was taken to the Kerala High Court. The judge issued a notice to the district education officers and the Parent-Teacher Association (PTA), ordering the school to re-enrol the five children. In addition, the state and national Human Rights Commissions became involved and issued notices to the school, highlighting the illegality of discriminating against students because of their HIV status. The school finally re-enrolled the expelled children six months later and requested support in order to change parental attitudes of students enrolled in the school.

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Why does it matter?

Human rights principles related to HIV and AIDS can be found in nearly all major existing international instruments. The inability to exercise some rights, such as the right to education, leads to greater vulnerability of individuals to HIV, and of communities to cope with the impact of the HIV epidemic.

The lack of respect for human rights has a negative impact on:

Availability and Accessibility

- Learners infected or affected by HIV may be denied access to education as a result of discrimination.
- Children affected by discriminatory practices or behaviours in school tend to experience an increase in school drop-out rates.
- Social exclusion increases poverty and a need for caregivers, which can result in reduced enrolments.
- Women and young girls may have less access to education due to gender inequalities and an increased burden of caring for family members with HIV.

Acceptability and Adaptability

- Teachers and staff infected or affected by HIV may be denied the right to employment.
- Access to education is reduced as a result of increased teacher absenteeism due to HIV and AIDS.

What needs to be done?

In order for the education sector to ensure that all learners and educators exercise their rights, regardless of their HIV status, it is important to:

- develop, implement and enforce professional and ethical codes of conduct as well as HIV and AIDS-specific workplace policies in accordance with human rights principles (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*);
- develop prevention, treatment, care and support services that are easily accessible to learners and educators;
- advocate for the establishment of legislative mechanisms to ensure the protection of rights of those infected and affected by HIV;
- work to change discriminatory and stigmatising attitudes towards key populations through education, training and media campaigns (see Brief on: *Addressing HIV-Related Stigma and Discrimination*);
- set up monitoring and law enforcement mechanisms to ensure that HIV-related human rights are protected and cases of discrimination are recorded and addressed;
- ensure the full participation of people living with HIV and vulnerable groups in decision-making processes;
- build partnerships and enhance collaboration and coordination among ministries of education, health, labour and development through intersectorial programmes on HIV and AIDS.

Key partners

- Relevant ministries (e.g. education, health, youth, social affairs)
- National AIDS Commission
- Human rights institutions, ombudsmen, community-based organizations, non-governmental organizations, civil society institutions
- International Council of AIDS Service Organizations (ICASO) and regional secretariats
- Teachers' associations
- Networks of key populations, including networks of people living with HIV
- UNAIDS Global Reference Group on HIV/AIDS and Human Rights
- International agencies, including UNCHR, ILO, UNESCO, UNDP, UNICEF and IOM

Key resources

- UNAIDS. 2006. *International Guidelines for HIV/AIDS and Human Rights*. Geneva: UNAIDS.
- UNESCO/UNAIDS. 2002. *HIV/AIDS and Human Rights: Young People in Action Kit*. Paris: UNESCO.
- UNICEF. 2004. *Framework for Protection, Care and Support of OVC Living in a World of AIDS*. New York: UNICEF.
- ICASO. 1999. *An Advocates Guide to the International Guidelines on HIV/AIDS and Human Rights*.Toronto: ICASO.
- Aggleton, P. *et al.* 2005. *HIV-related Stigma, Discrimination and Human Rights Violations*. Geneva: UNAIDS.
- Richter L.M., Rama S. 2006. *Building Resilience: A rights-based approach to children and HIV/AIDS in Africa*. Stockholm: Save the Children Sweden.

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Gender-responsive approaches in education sector responses

What is the issue?

Gender refers to the socially constructed roles of women and men, and gender inequalities are at the root of many social, economic and political factors contributing to the spread of HIV.

Gender disparities affect the vulnerability of girls, women, boys and men to HIV and AIDS in multiple ways:

- **Women may have little ability to determine with whom and how they will have sex**, while **men may feel societal pressure to have multiple and/or extramarital partners** which increases the risk of sexually transmitted infections, including HIV.
- **Men and women often do not have equal access to information resources**, including on HIV**.** Young women may not be able to learn about sexual health due to societal pressure to appear ignorant about sexual matters. Young men may not seek information, yet pretend to be knowledgeable.
- **In many places, women are particularly vulnerable to HIV infection because of underlying gender disparities.** The response to HIV and AIDS needs to address these gender disparities, to enable men and women to communicate more effectively and adopt healthier sexual behaviours.
- **HIV-related stigma and discrimination impact both sexes** and often prevent men and women from disclosing their HIV status (see Brief on: *Addressing HIV-Related Stigma and Discrimination)*.
- The **burden of caring** for ill partners or family members often falls disproportionately on girls and women, jeopardising their opportunities for education and employment.

Why does it matter?

Education sector responses to HIV and AIDS must incorporate gender-responsive approaches in formal and non-formal initiatives to:

- enable learners to successfully understand their **individual and societal vulnerability to HIV** and to make risk-reductive choices;
- build the **communication, negotiation and critical thinking skills** of learners to enable them to challenge harmful gender norms, resist peer pressure and make healthy decisions about sexuality, sexual expression and related behaviour;
- **confront stereotypes** that contribute to mistrust between women and men, increased discrimination, and stigma against those living with HIV;
- ensure that schools **provide a safe and inclusive learning environment**, including for male and female learners infected or affected by HIV and AIDS;
- **prevent and/or combat gender-based violence** that increases the vulnerability of women and girls to HIV infection;
- **reduce gender-biased poverty**, a key contributing factor to HIV vulnerability;
- **provide gender-responsive prevention education for populations unable to access formal schooling**, including rural populations at higher risk of HIV infection due to collapsing traditional livelihoods, increasing food insecurity, migration and gender disparities.

Country example: Nigeria

The non-formal education programme, Conscientisizing Male Adolescents (CMA), was founded in 1995 to raise awareness among male adolescents in Nigeria about gender equalities. Adult teachers are trained to deliver a two-level curriculum for secondary school boys who demonstrate leadership. CMA's curriculum uses a structured dialogue methodology to foster critical thinking on a variety of interconnected gender topics, including sexual and reproductive health. By 2003, over 3,000 adolescent boys had received gender education. While no systematic evaluation has been undertaken, graduates of the programme have cited increased confidence, better communication and improved attitudes toward girls and women.

Source: Barker, G. and Girard, F. My Father Didn't Think This Way: Nigerian Boys Contemplate Gender Equality. *Quality/Calidad/Qualité*. 2003. No. 14. The Population Council.

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What needs to be done?

As gender inequalities negatively impact both sexes and are at the root of many unsafe behaviours, HIV and AIDS education programmes should actively involve both male and female learners, and encourage them to critically assess and overcome the gender issues that affect their vulnerability to HIV and AIDS.

To mainstream gender into national planning for HIV and AIDS education, recommended actions are to:

- **Determine how gender issues and HIV and AIDS intersect locally** and design rights-based responses in planning processes, including in education sector plans and other initiatives to achieve Education for All (EFA).
- **Develop multilateral partnerships with groups already working on gender, HIV and AIDS issues** to integrate gender-focused programmes into formal and non-formal education to reach all populations, including those at higher risk.
- **Implement appropriate gender-based HIV training for school administrators and teachers** to ensure safe and gender-equitable school environments.
- **Integrate gender-focused HIV components into all subjects**, rather than as a stand-alone topic, as multidisciplinary approaches enable learners to more fully understand gender issues and how they intersect with HIV.
- **Integrate gender into educational monitoring and evaluation** processes to ensure that the needs of male and female learners are being met.

To promote gender equality within schools and classrooms, recommended actions are to:

- **Foster gender-equitable school settings and educational approaches** that transform male/female power relations so that both sexes become less vulnerable to HIV and share equal access to information.
- **Promote a gender-neutral classroom** where equal attention is provided to issues facing females and males.
- **Minimize classroom hierarchy and power relations** in educational settings to ensure equal participation of all groups and individuals.
- **Develop and use materials** that are meaningful and appropriate to local populations, including culturally sensitive approaches (see Brief on: *Providing Culturally Sensitive Education on HIV and AIDS)*.
- **Encourage learners to assess the socio-economic, cultural and religious context** within their local community as these relate to vulnerability, gender and male/female risk patterns for HIV.
- **Ensure that lessons do not reinforce negative gender stereotypes** and encourage students to challenge stereotypes.
- **Foster critical thinking by using process- and skills-based learning approaches** instead of traditional topic-based methodologies. This includes participatory, debate-centred sessions, where students are able to explore their own understanding of gender, power relations and HIV (see Brief on: *Life Skills-Based Education for HIV Prevention)*.
- **Gain the support and involvement of parents, community leaders and others**, and integrate local expertise into the classroom through peer role models, local speakers, and community-focused learning activities.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, health, women's affairs)
- Civil society organizations, including women's, men's, young people's and human rights groups
- Schools, governing boards and teachers
- Non-formal, technical and vocational educators
- International initiatives on education, such as United Nations Girls' Education Initiative (UNGEI), EFA Fast Track Initiative (FTI) and Education for Rural People (ERP)
- Global Coalition on Women and AIDS
- Other international agencies, including UNIFEM and FAO

Key resources

- UNAIDS IATT on Gender and HIV/AIDS. 2006. *Resource Pack on Gender and HIV/AIDS*. UNAIDS IATT on Gender and HIV/AIDS, UNIFEM.
- Hargreaves, H. and Boler, T. 2006. *Girl Power: The impact of girls' education on HIV and sexual behaviour*. London: ActionAid International.
- Thorpe, M. 2005. Learning about HIV/AIDS in Schools: Does a Gender Equality Approach Make a Difference? in: *Beyond Access: Transforming policy and practice for gender equality in education*. London: Oxfam.
- ELDIS Gender and Resource Guide. (http://www.eldis.org/gender/index.htm)

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Providing culturally sensitive education on HIV and AIDS

What is the issue?

In order for HIV and AIDS education to be successful, it needs to be understood and accepted by the target communities.

- As communities differ culturally within and across countries, **it is important that HIV and AIDS education fits within broader cultural factors** such as religious practices, gender issues, sexual norms, traditions and beliefs.
- **Prevention messages which are culturally sensitive are more likely to be successful** as individuals are presented with more options which are relevant and feasible.
- A culturally sensitive approach to HIV and AIDS education is vital for bridging the gap between knowledge and healthy behaviours.
- Teaching about HIV and AIDS involves discussing potentially taboo subjects such as sex, gender, illness and death. Attitudes towards these sensitive subjects are governed by cultural factors. **HIV and AIDS education which conflicts with cultural norms may result in discord among communities and lose relevance**.
- Although efforts need to be made to adapt HIV and AIDS education to local cultural norms, there are some cases in which cultural practices may increase risk to HIV. These practices include child marriages and wife inheritance. Communities need to be given the opportunity to discuss their risks to HIV in an open manner and determine for themselves how to prevent HIV, care for those affected and address stigma and discrimination.

Why does it matter?

HIV and AIDS education must take account of local cultural contexts because:

- the success of HIV and AIDS education hinges on the ability of individuals to change their behaviour, which in turn is influenced by individual and community attitudes towards sexuality, sexual practices, gender, illness and death, all of which are deeply embedded in local cultural contexts;
- for individuals and communities to adopt protective behaviours against HIV, it is crucial that they view HIV as something that can affect their lives directly. In order for this to happen, messages need to be adapted to fit an individual and community's local culture;
- cultures are not rigid but are dynamic and constantly adapting to new conditions, and can therefore evolve to adapt to challenges posed by the AIDS epidemic;
- while some traditional cultural practices can be harmful and increase HIV vulnerability for men and women, each culture possesses valuable resources that can be mobilised to engage communities in addressing sensitive issues;
- culturally appropriate education can challenge harmful traditional practices and assist in developing alternative and safer practices, if carried out in close cooperation with the populations concerned and without the culture as a whole being called into question.

Regional example: Caucasus

A three-country project by UNESCO in the Caucasus region supported the development of culturally appropriate HIV and AIDS education in two phases. First, research was undertaken to identify the cultural factors that are underlying HIV vulnerability in the region. These factors included traditions, beliefs, religions, ways of life and gender norms and practices. The second phase based the response upon the research findings to develop materials and train specialists to respond to HIV and AIDS in culturally appropriate and gender responsive ways.


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What needs to be done?

In order to make HIV and AIDS education culturally sensitive, it is important to:

- **identify (through research) the culturally-specific factors underlying vulnerability** among groups and society as a whole as well as identifying the cultural resources that could be mobilised to increase the efficiency of education messages and programmes;
- include sections on how local culture interacts with HIV in training modules (for example in pre-service and in-service teacher training, see Brief on: *Educator Training on HIV and AIDS*). **Equip teachers with the skills they need to discuss culturally sensitive issues**;
- **strengthen links between schools and communities** in order to gain support from local community leaders such as traditional and religious leaders or traditional healers;
- **Identify and mobilise opinion leaders** (e.g. celebrities, politicians, religious leaders, traditional healers) to support the development and implementation of HIV and AIDS education programmes;
- **address people in their own local languages and dialects** (e.g. indigenous populations) and ensure that any language used is appropriate and does not reinforce negative stereotypes, stigma and discrimination;
- design **curriculum and learning materials** that are scientifically accurate, age-specific and gender-sensitive and culturally appropriate (see Brief on: *Curricula for HIV and AIDS Education*);
- **use creative approaches** which tap into popular cultural practices such as music, films or sports, Edutainment (education through entertainment), theatre or peer education;
- involvement of people living with HIV to advocate against stigma and discrimination (see Brief on: *Promoting the Greater Involvement of People living with HIV in Education Sector Responses*).

Key partners

- Relevant ministries (e.g. culture, education, social affairs, women's affairs and youth)
- National AIDS Commission
- Civil society organizations, including women's and young people's associations, cultural associations, migrant networks
- Networks and associations of people with HIV
- Teacher associations
- Political leaders, religious and traditional leaders, traditional healers, media professionals and artists
- Universities and social science research centres
- International agencies, including ILO, IOM, UNESCO, UNFPA and UNICEF

Key resources

- UNESCO.2006. *UNESCO Guidelines on Language and Content in HIV- and AIDS-Related Materials*. Paris: UNESCO.
- UNESCO. 2005. *HIV and AIDS in the Caucasus Region: A Socio-Cultural Approach*. Paris: UNESCO.
- UNESCO. 2003. *HIV/AIDS Stigma and Discrimination: An Anthropological Approach*. Paris: UNESCO.
- UNESCO. 2002. *Handbook on Appropriate Communication for Behaviour Change*. Methodological Handbook N°1. Paris: UNESCO.
- UNFPA. 2004. *Culture Matters. Working with Communities and Faith-based Organizations*. New York: UNFPA.
- UNFPA. Website on Using Culturally Sensitive Approaches to Achieve Universal Goals: http://www.unfpa.org/culture/
- Rao, V, Walton, M (eds.). 2004. *Culture and Public Action: A cross-disciplinary dialogue on development policy*. Stanford: Stanford University Press.

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Girls' education and HIV prevention

What is the issue?

More than 70 million girls and boys around the world are not benefiting from primary education despite numerous commitments to the right of *all* children and young people to free and compulsory education. For every two boys unlikely ever to enrol there are nearly three girls (EFA Global Monitoring Report 2008). These commitments include the 1948 *Universal Declaration of Human Rights* as well as the 1959 *Declaration on the Rights of the Child*. The 2000 *Dakar Framework for Action* reaffirmed these rights, which are integral to the *Education for All* (EFA) vision.

Even where girls are getting an education, **in most countries their attendance drops sharply after primary school**, resulting in 4.4 less years of education than boys by the age of 18. This gender disparity in education is due to a number of factors, including:

- **poverty**: families may not be able to afford the costs of schooling, or may need their children to earn income, or help in the home. When faced with a choice, they often prioritise the education of boys, taking their daughters out of school.
- **gender**: families may see education for girls as less important than for boys, while teachers may have lower expectations of girls as compared with boys. In families with limited resources, education for boys may be seen as a better investment.
- **safety and security**: parents may not let girls travel to school if the journey is risky, and girls may be particularly at risk of sexual abuse while at school.
- **policies**: lack of appropriate policies might prevent pregnant girls from continuing their education or bar children without a birth certificate (an issue that particularly affects girls) from school admission. Children who drop out of school may not be allowed to continue in later years.
- **quality of education**: the curriculum may be irrelevant to the reality of girls' lives; schools may fail as protective psychosocial environments, or lack safe water and sanitation, and in some countries there may be a lack of female teachers to provide positive role models.

Why does it matter?

Girls' education is particularly vital and urgent as **girls and young women are disproportionately affected by HIV and AIDS, both directly and indirectly.**

Worldwide, two-thirds of young people living with HIV are girls. In sub-Saharan Africa, young women aged 15 to 24 are three times as likely as their male peers to be living with HIV. Meanwhile, girls in families affected by the epidemic are under great pressure to earn family income and/or care for sick relatives. They may also be more vulnerable to the stigma that is associated with HIV and AIDS.

Educating girls and young women yields dramatic social and economic benefits for the current generation and those to come as it not only provides them with knowledge, but also empowers them with better life opportunities and choices. Educated girls tend to:

- marry later and have fewer children – who, in turn, are more likely to survive and be better nourished and educated;
- be more productive at home and have better access to formal employment with better pay;
- assume a more active role in social, economic and political decision-making;
- be better equipped to protect themselves against HIV.

Girls' education and effective HIV prevention are inextricably linked. Firstly, education levels are often correlated with factors that substantially lower HIV risk, such as delayed sexual debut, greater HIV awareness and knowledge, fewer sexual partners and higher rates of condom use. In Zimbabwe, 15 to 18-year-old girls enrolled in school are more than five times less likely to have HIV than those who have dropped out. Secondly, schools and other educational programmes provide a crucial entry point for specific HIV prevention initiatives that not only provide girls with knowledge about HIV and AIDS and reproductive health, but also enable them to build life skills (i.e. critical thinking, values, attitudes and social networks) needed to make informed decisions and adopt behaviours that reduce their risk of HIV infection.

Country example: Mexico

In 1997 in Mexico, the education, health and nutrition programme, Progresa, initiated conditional cash transfers for poor families. Monthly stipends were issued if children regularly attended school and family members visited clinics for nutrition, hygiene education and checkups. In 2003, evaluation results demonstrated that the programme had reached 4.2 million families, and improved girls' school enrolment from 67 per cent to 75 per cent. A subsequent by-product of the programme has been a reduction in child labour.

Source: UNICEF. 2004. *Girls, HIV/AIDS and Education*. New York: UNICEF.

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What needs to be done?

For effective HIV prevention for girls, action is needed on two fronts:

1. **Increasing girls' overall access to education by:**
   - → **revising national policies** that present specific barriers to girls' education;
   - → **actively advocating for girls' education** as a human right, as well as a social and economic investment for the future of families and the nation as a whole;
   - → **addressing economic barriers** to girls' education e.g. by abolishing school fees;
   - → **ensuring that education provides a safe environment** e.g. by promoting zero tolerance to sexual abuse on school grounds;
   - → **ensuring** that curricula cover issues of specific interest and use to girls;
   - → **providing specific opportunities for girls** to access secondary and tertiary education;
   - → **supporting community outreach** to identify out-of-school girls and those at risk of dropping out, and help them to continue their education, either at school or through flexible, community education projects;
   - → **making girls' education of value to parents** e.g. through school food schemes that provide take-home rations for families;
   - → **providing work opportunities for educated girls** in and outside their community.
2. **Ensuring that HIV prevention:**
   - → **is integrated into education for all girls and young women**, not just in formal curricula, but also in non-formal and informal education initiatives;
   - → **starts early**, with age-appropriate information and skills-building activities provided to girls at primary school level;
   - → **uses gender-sensitive methods**, such as single-sex discussion groups to address sensitive issues and enable girls to talk freely;
   - → **ensures girls' participation in planning and implementing interventions to ensure that these address subjects relevant to girls' lives**, including difficult situations, such as pressure from older men to have sex or pressure to earn money through transactional sex;
   - → **is culturally sensitive** and does not put girls at risk of shame or stigma;
   - → **is provided to boys as well, to ensure that boys receive the same messages** about equality and the empowerment of women, and that they understand the necessity of adopting protective behaviours;
   - → **takes a rights-based approach** that builds girls' self-esteem and empowers them to make informed decisions and to act on them;
   - → **builds both knowledge and life skills**, such as how girls can identify and avoid situations that put them at risk and/or enable them to negotiate safer sex;
   - → **aims to achieve not just awareness, but sustained protective behaviour**;
   - → **involves the broader community**, building understanding about why girls are particularly vulnerable to HIV and AIDS;
   - → **is carried out by gender-sensitive and trained female and male teachers and educators**;
   - → **is linked to gender-sensitive services**, such as family planning clinics;
   - → **includes information on care and treatment for HIV.**

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, health, women's affairs)
- Civil society organizations, including women's, young people's and human rights groups
- Other international agencies, including the World Bank
- Global Coalition on Women and AIDS
- International initiatives on education, such as the United Nations Girls' Education Initiative (UNGEI) and the EFA Fast-Track Initiative (FTI)
- Educational policy-makers and programme developers
- Schools, governing boards and teachers

Key resources

- UNAIDS IATT on Education. 2006. *Review of the Evidence: Girls' education and HIV prevention. CD-ROM.* Paris: UNESCO.
- Hargreaves, J. and Boler, T. 2006. *Girl Power: The impact of girls' education on HIV and sex behavior*. London: ActionAid International.
- AED. 2006. *Keeping the Promise: Five benefits of girls' secondary education*. Washington, DC: AED.
- UNICEF. 2004. *Girls, HIV/AIDS and Education*. New York: UNICEF.
- CFR. 2004. *What Works in Girls' Education*. Washington, DC: CFR.
- Rao, N. and Smyth, I. 2005. *Partnerships for Girls' Education*. Oxford: Oxfam.

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Education for orphans and children made vulnerable by HIV and AIDS

What is the issue?

In 2007, the number of orphans attributed to AIDS in Sub-Saharan Africa alone was estimated to be 11.4 million; millions more were made vulnerable. **As the epidemic escalates, the crisis of orphans and vulnerable children will persist for decades**, even as prevention and treatment programmes are expanded.

Orphans and vulnerable children can be at higher risk of becoming infected with HIV as they:

- may be shunned by society, denied affection and left with few resources to fall back on;
- often drop out of school due to economic hardship and reduced parental care and protection;
- may suffer from malnutrition and ill health, as well as the danger of exploitation and abuse.

Studies show that in many countries orphanhood **has a detrimental impact on education**:

- Data from 20 sub-Saharan African countries show that children aged 10-14 who had lost one or both parents were less likely to be in school than their non-orphaned peers.
- In Kenya, Tanzania and Zambia, orphans were less likely than non-orphans to be at the appropriate education level for their age.

Lower school enrolment and completion rates among orphans and vulnerable children are caused and/or compounded by a number of factors relating to HIV and AIDS, including:

- **lack of affordable schooling**: the sudden increase in poverty that can accompany the death of a parent, or the onset of AIDS in a household, often means that families cannot afford school-related costs;
- **family responsibilities**: children, especially girls, are relied on to care for siblings or sick family members;
- **poor quality education**: the shortage of trained teachers and decreased teacher productivity due to HIV and AIDS, as well as larger class sizes due to teacher shortages and other factors, can reduce the quality of education;
- **scepticism about the value of education**: low public confidence in the quality of education, and the economic burden caused by providing for orphans by their extended families, may contribute to scepticism about the value of education;
- **stigma and trauma**: the loss of a family member or caregiver, and the stigma attached to being a child orphaned by AIDS, can cause severe emotional stress;
- **fear of HIV infection**: many parents fear that their children, particularly girls, will become infected with HIV through sexual abuse at or on their way to and from school.

Why does it matter?

Education is a basic human right for all children, including orphans and vulnerable children. This is recognized in the *Convention on the Rights of the Child* and the *Dakar Framework for Action* which incorporates the principles of *Education for All* (EFA).

Education can significantly improve the lives of orphans and vulnerable children by building their knowledge and life skills. It contributes to their social integration and psycho-social development, protects them from child labour and provides a safe, structured environment in difficult times. A child who knows how to read, write and do basic arithmetic, and use life skills, including those relating to HIV and AIDS, has a more solid foundation for continued learning throughout his or her life.

Country example: Zimbabwe

In Zimbabwe, the Chief Charumbira Community-Based Orphan Care programme in Masvingo Province engages volunteers and village communities to ensure that orphans and vulnerable children attend and remain in school. Volunteers in the programme - in place since 1994 - assist with household chores to enable children to attend schools, while village committees ask community members to contribute to the payment of school fees.

Source: World Bank, Partnership for Child Development, UNICEF and UNAIDS. 2002. *Ensuring Education Access for Orphans and Vulnerable Children*. Washington, DC: World Bank.

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What works?

Effective action to improve education for orphans and vulnerable children is underpinned by the following guiding principles:

- **Cross-sectoral partnerships**, as schools and the education sector alone cannot do it all. This includes alliances with ministries (e.g. education, health and social welfare) and civil society organizations (including faith-based organizations and community networks), particularly those already involved in providing education, food and shelter for vulnerable children.
- **Rights-based approaches** at all stages, including decision-making, planning, implementation and advocacy. Decisions should be made in the best interest, and with the active participation, of orphans and vulnerable children.
- **Social policies** that are designed and incrementally revised in order to protect and promote the educational development of orphans and vulnerable learners.
- **System-wide reform that improves access to education**, not only for those orphaned by AIDS, but for *all* children.
- **Regularly reviewed responses that meet both the immediate needs and longer-term objectives for large-scale coverage** e.g. in the short term, the provision of school meals and the abolition of fees might take precedence over curriculum reform.
- **Balanced attention to care, support, treatment and prevention** based on the status of the epidemic and its impact. In emerging epidemics, greater attention is needed on prevention, while promoting care and support for children affected by HIV and AIDS is part of broader efforts for all vulnerable children. For HIV-positive children, this will also include referral for treatment. In more advanced epidemics, simultaneous efforts may be needed on all fronts, including treatment education (See Brief on: *HIV and AIDS Treatment Education*).
- **The involvement of children, young people and their extended families and communities** in developing solutions to practical challenges. Wherever possible, siblings should be kept together and close to their families or in family-like environments.
- **Commitment to the monitoring and evaluation of the response.** This may require training and support for a range of partners at school and community levels to enable the use of local and national indicators in policy-making and reporting.

Efforts need to be supported not only by adequate financial, human and technical resources, but also by political commitment and leadership at all levels.

At all times, it is vital to strike a balance. On the one hand, specific, practical action should be taken to address the needs of orphans and vulnerable children e.g. through homework clubs or mentoring programmes with older learners. On the other hand, it is crucial that orphans and vulnerable children are not treated in isolation – a scenario that might worsen their situation by increasing stigma and distorting local priorities.

What needs to be done?

The priority actions are to:

- **ensure access to education for orphans and vulnerable children** through specific measures such as abolishing school fees and reducing hidden costs (e.g. uniforms and books);
- **expand the role of schools to provide care and support for orphans and vulnerable children** through measures such as building partnerships with social services and community networks;
- **protect orphans and vulnerable children by developing school policies and practices** to reduce stigma, discrimination, abuse and exploitation;
- **manage the supply and ensure the quality of education for orphans and vulnerable children** e.g. by enhancing staff knowledge about them and strengthening education management and information systems.

The EFA goals and frameworks are vital resources because they assist:

- governments in affected countries to review their policies and strengthen education responses;
- implementing agencies to better plan, manage and evaluate their work;
- donors to assess their policy commitments and plan for increased resource allocation;
- the international community to attract new partners and place orphans and vulnerable children higher on the development agenda.

Key partners

Under the UNAIDS division of labour, UNICEF is the lead organization for orphans and vulnerable children, with WFP, ILO and WHO as main partners. Key partners also include:

- Relevant ministries (e.g. culture, education, health, social welfare, women's affairs)
- National HIV/AIDS Commission
- Civil society organizations, including FHI, Constella Group, Save the Children
- Other international agencies, including UNESCO
- The UNAIDS Inter-Agency Task Team (IATT) on Children Affected by HIV and AIDS, and the IATT on Education.

Key resources

- UNAIDS IATT on Children Affected by HIV/AIDS. 2004. *Framework for the Protection, Care and Support of OVC Living in a World with HIV and AIDS*. New York: UNICEF.
- UNAIDS IATT on Education. 2004 *The Role of Education in the Protection, Care and Support of OVC Living in a World with HIV and AIDS*. Paris: UNESCO.
- UNAIDS, UNICEF and USAID. 2004. *Children on the Brink 2004: A joint report of new orphans estimates and a framework for action.* New York: USAID.
- World Bank, Partnership for Child Development and UNICEF. Second edition 2006. *Ensuring Education Access for Orphans and Vulnerable Children: A Planners' Handbook*. Washington, DC: World Bank.
- FHI. 2005. *Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Guidelines and Tools*. Arlington: FHI.
- International HIV/AIDS Alliance. 2006. *Orphans and Other Vulnerable Children Support Toolkit*. CD-ROM (version 2). Brighton: International HIV/AIDS Alliance.

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HIV and AIDS education for minorities

What is the issue?

Minorities may include ethnic, religious, sexual and linguistic communities, indigenous and tribal peoples, migrants and refugees. For these people, linguistic, geographical, social, cultural, and economic barriers can present formidable obstacles to formal employment and public services, such as education and health care. Stigma and discrimination can also result in a choice by minorities not to integrate in the societies in which they live, while isolation and disempowerment can lead to exploitation and marginalisation.

HIV and AIDS interventions focusing on minorities can be difficult to implement as:

- minorities are not readily defined**, as there are no universally accepted definitions. At the same time, national legislation may not take their existence into account;**
- minority groups are not homogenous, **and people can identify with several minority groups at the same time. For example, minorities may face further marginalisation due to age, poverty, disability, gender, sexual identity or other factors;**
- the range of groups labeled as minorities is quite wide **and the specific needs and situations often vary between groups. For instance, the distinctive circumstances of refugees and asylum seekers are not commensurate with, for example, those of migrants or tribal peoples** (see Brief on: *HIV and AIDS Education for Refugees and Internally Displaced Persons*).

Why does it matter?

In many countries, the cumulative impact of **poverty, lack of legal status, social and legal discrimination, fragile or non-existent employment, little or no access to health care and low educational attainment contribute to a heightened vulnerability of minorities to HIV infection**:

- Poor infrastructure in many minority communities results in poor or no access to HIV and AIDS information or services **for early diagnosis of HIV and for antiretroviral treatment (ART)**.
- Information and services are often neither tailored to minorities, nor available in minority languages, nor sufficiently sensitive to the specific needs, conditions and risks of minority groups.
- Minorities may be excluded from formal, school-based sexual and reproductive health and life skills education**, as levels of schooling tend to be much lower among groups isolated by language or geography, and among mobile populations (e.g. migrants, nomads and seasonal workers)**.
- Minorities are more likely to be vulnerable to human and sex trafficking and drug abuse (see Brief on: *Drug Use Prevention in the Context of HIV and AIDS Education*).
- Stigma, discrimination and poverty reinforce minorities' vulnerability and **diminish their ability to adopt risk-reductive behaviours**.

What works?

- **Advocacy** undertaken by minority group representatives and minority group organizations.
- HIV prevention, care, support and treatment services that are linked to developmental approaches, **such as poverty reduction and expanded access to education and communication**.
- **Evidence-based policy** that develops understanding about behaviour e.g. about gender roles, norms and values, livelihoods, community rules, social behaviours and cultural codes.
- **Adoption of inclusive attitudes and policies** towards minorities.
- Establishment of sustainability mechanisms through **support for local initiatives and capacity**.

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What needs to be done?

In order to communicate effectively with minorities, **education managers and educators** in general must **welcome and respect diversity and promote quality education for all** (see Brief on: *Quality Education and HIV & AIDS*). This means **confronting linguistic, geographical, cultural, social and economic barriers to HIV- and AIDS-related information and services.** To ensure that HIV and AIDS education is accessible for those most vulnerable and hardest to reach, **cross-sectoral actions are required to**:

- **Protect minority rights in law** by:
  - → reviewing and revising the legislative framework to ensure equality of rights for minority groups;
  - → taking specific measures to remedy and redress human rights abuses among minority populations;
  - → engaging political leaders and media professionals to publicly address minority issues and human rights (see Brief on: *A Rights-Based Approach to the Education Sector Response to HIV and AIDS*).
- **Ensure that indicators are adapted to reveal appropriate information about key groups** by:
  - → collecting and disaggregating data on population distribution, economic activity, health and educational status, and HIV prevalence and modes of transmission;
  - → conducting qualitative research assessing the risks specific to each minority group.
- **Customise and tailor messages and learning materials to minority groups** by:
  - → designing targeted messages that include the importance of knowing one's HIV status;
  - → involving minority groups in the development of programmes and for linguistic and cultural minorities developing materials directly in minority languages;
  - → developing learning materials that are appropriate to local conditions and contexts, including media-based learning materials that are adapted to the technology commonly used in the communities (e.g. radio, television, theatre);
  - → supporting peer education.
- **Build partnerships and local capacity for HIV education that involves minority populations** by:
  - → identifying groups that have been reached inadequately or not at all and developing direct and targeted interventions for them;
  - → securing the involvement of minority leaders in project development, management and evaluation;
  - → identifying and using the competencies of NGOs and community-based organizations (including religious groups) in mobilising community support.
- **Developing services adapted to the target populations** by:
  - → diversifying and expanding prevention, treatment, care and support services for marginalised groups;
  - → ensuring that prevention efforts include people living with HIV and their partners (see Brief on: *Promoting the Greater Involvement of People living with HIV in Education Sector Responses*).

Regional example: Asia

UNESCO has implemented a number of HIV-, drug- and trafficking-related programmes for hill tribes and ethnic minorities across the Greater Mekong sub-region. One of the projects is a radio soap opera with storylines based on community research, real-life stories and factual information. Each soap opera is culturally appropriate and sensitive to the audience's needs and interests, and is developed by, and delivered in the local minority language by native authors and speakers. All of the songs and music are traditional and, if possible, produced specifically for the programme.

Radio has been demonstrated to be effective in transmitting educational and health messages to minority audiences as it is cost-effective, has a wide reach and is a credible source of information.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. culture, education, interior, health)
- Civil society organizations, including community- and faith-based organizations
- Other international agencies, including, UNDP, UNHCR, and the World Bank
- University and research institutes for social and cultural research
- Media (print, broadcast and traditional) practitioners

Key resources

- UNESCO Bangkok. *Minority Language Radio Drama Against HIV/AIDS, Trafficking and Drugs*. Available at http://www.unescobkk.org/index.php?id=1020
- ADB. 2005. *Technical Assistance to the Greater Mekong Subregion for HIV/AIDS Vulnerability and Risk Reduction Among Ethnic Minority Groups Through Communications Strategies*. Manila: ADB.
- CDC. 2005. *Report on Specific Populations. How Are They Affected?* Atlanta: CDC.
- HRSA. HIV/AIDS Bureau. 2004. *Racial and Ethnic Minority Populations Access to HIV/AIDS Care Issues*. Rockville: HRSA.
- Needle, R.H. *et al.* 2003. Rapid Assessment of the HIV/AIDS Crisis in Racial and Ethnic Minority Communities: An Approach for Timely Community Interventions. *American Journal of Public Health*. American Journal of Public Health, (93), pp. 970-79.

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HIV and AIDS education for refugees and internally displaced persons

What is the issue?

Refugees and internally displaced persons (IDPs) are people fleeing conflict and persecution who often experience hunger, disease, lack of security, discrimination and difficulties exercising their rights. During conflict and its aftermath, women and young people are particularly vulnerable – 80 percent of the world's approximately 35 million refugees and IDPs are women and children.

Refugees and IDPs constitute one of the most difficult populations to reach with HIV and AIDS information and services. Many children and young people, particularly girls, lack the opportunity or resources to go to school. Furthermore, refugees and IDPs are often hosted in remote and inaccessible areas, far from urban sites where HIV and AIDS programmes are most developed. A multisectoral response that includes HIV and AIDS as a cross-cutting issue is key to reducing refugees' and IDPs' vulnerability and promoting their right to protection.

Why does it matter?

Contrary to popular belief, HIV prevalence is often lower among refugees than their host populations. However, refugees and IDPs **can be particularly vulnerable to HIV** due to:

- **an increased risk of sexual violence and exploitation** during conflict, flight and asylum – particularly for women and children;
- **the breakdown of family ties, the deterioration of social structures, and the collapse of public health and education services** caused by emergency situations;
- **a rupture in people's normal sources of income** leading, in some cases, to transactional sex by women and children for food and money;
- **limited experience and capacity in HIV and AIDS education in humanitarian agencies responding to conflict and emergency settings**, as their focus is often on providing immediate means of survival (food, shelter, health care);
- **the exclusion of refugees and IDPs from national HIV and AIDS plans and programmes.**

There are many reasons why **it is vital to carry out HIV and AIDS education among refugees and IDPs**, including:

- **Access to HIV information and services is an integral component of refugees' and IDPs' right to protection.**
- **Interventions with refugees and IDPs may also benefit the local population**, both directly and indirectly.

Country example: Republic of Congo

In the Republic of Congo, UNHCR has undertaken 'Community Conversations' to offer space for dialogue, mutual learning, reflection and introspection on HIV. Between December 2004 and March 2005, 92 such conversations were held. UNHCR reports initial signs of behaviour change including increased openness of men and women to explore and address difficult and sensitive issues related to HIV/AIDS; increased demand for information on HIV/AIDS; and increased demand for condoms.

Source: UNHCR. 2005. *Community Conversations in Response to HIV/AIDS*. HIV/AIDS Field Experience Series Number 3. Geneva: UNHCR.


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What needs to be done?

HIV and AIDS education programmes for refugees and IDPs require actions at multiple stages, including:

Programme development and implementation actions:

- Design national HIV and AIDS education policies that include components of overall refugee and IDP protection.
- Develop and support advocacy, capacity-building and monitoring strategies for HIV and AIDS education.
- Provide refugees and IDPs equal access to the types and levels of HIV and AIDS education offered to the host community.
- Strengthen programmes – for refugees and IDPs, host populations and decision-makers – to provide training on gender-based violence and human rights.
- Progressively increase and effectively target the allocation of funding and other resources to promote overall access to formal and non-formal education for refugees and IDPs.
- Ensure the systematic, coordinated and mandatory integration of reproductive health and HIV & AIDS into the school curriculum and parents/teachers' activities for refugees and IDPs.
- Develop culturally relevant, age-specific and gender-sensitive approaches, strategies and tools on HIV prevention education and sexuality for refugees and IDPs.

Community mobilisation actions:

- Use multidisciplinary and community-based approaches for information, skills and training activities relating to HIV and AIDS education among refugees and IDPs.
- Address HIV-related stigma and discrimination in the broader refugee and IDP community through sustained mobilisation, outreach groups and task forces.
- Ensure the participation of key refugee and IDP stakeholders – including children and young people – in decision-making about HIV and AIDS education.

Responses in emergency settings:

- Promote voluntary and confidential counselling and testing services for refugees and IDPs.
- Use the guidelines of the *United Nations Inter-Agency Standing Committee on HIV/AIDS in Emergency Settings* to ensure the provision of essential HIV- and AIDS-related services, including condoms and other key prevention commodities.
- Ensure that all services, including those related to HIV and AIDS and reproductive health, are appropriate and supportive for refugees and IDPs, especially for girls and young women.
- Ensure immediate and adequate care for cases of sexual violence among refugees and IDPs, including information and counselling on HIV and AIDS.

Monitoring and evaluation actions:

- Assess progress by developing measurable and accurate indicators specific to HIV and AIDS education among refugees and IDPs.
- Conduct research and evaluation of HIV and AIDS education programmes, as part of ongoing situation analyses of refugees and IDPs.
- Recruit staff with appropriate knowledge and attitudes about HIV prevention education.

Key partners

Under the UNAIDS division of labour, UNHCR is the lead organization for addressing HIV among refugees and internally displaced people, with UNESCO, UNFPA, UNICEF, WFP, WHO and UNDP as main partners. Key partners also include:

- Relevant ministries (e.g., education, health, home affairs, interior) and national AIDS control programmes
- Civil society organizations, including international and national non-governmental organizations and the International Federation of the Red Cross and Red Crescent Societies
- Other international agencies, including IOM, UNIFEM, and the World Bank
- Inter-Agency Working Group on Reproductive Health in Refugee Situations, Women's Commission for Refugee Women and Children

Key resources

- UNESCO/UNHCR. 2007. *Educational Responses to HIV and AIDS for Refugees and Internally Displaced Persons.* Paris: UNESCO.
- UNHCR. 2004. *Refugees, HIV and AIDS: Fighting HIV and AIDS Together with Refugees. Report on UNHCR HIV and AIDS Policies and Programmes for 2005.* Geneva: UNHCR.
- UNHCR. 2002. *HIV/AIDS Education for Refugee Youth: The window of hope.* Geneva: UNHCR.
- Holmes, W. 2003. *Protecting the Future: HIV prevention, care, and support among displaced and war-affected populations.* New York: IRC.
- CARE/RHRC. 2002. *Raising Awareness for Reproductive Health in Complex Emergencies: a training manual.* Washington, DC: CARE.

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Focused HIV prevention for key populations

What is the issue?

Focused prevention educational programmes aim to decrease the incidence of HIV and other sexually transmitted infections (STIs) by reducing risk behaviours and factors that contribute to vulnerability among key populations, understood as members of groups critical to the dynamic of the AIDS epidemic.

This strategy is considered to be particularly useful in countries with low HIV prevalence rates, including those countries with limited human and financial resources for prevention activities.

Education can be an important part of strategies designed to reduce the risk and vulnerability of young people to HIV infection for example, by using drug education to discourage young people from using drugs (see Brief on: *Drug Use Prevention in the Context of HIV and AIDS Education*). Education is also important to reduce the vulnerabilities of these key populations.

Why does it matter?

There is growing recognition that focused HIV and AIDS educational efforts that target key populations can have a dramatic impact on the epidemic, especially in low prevalence countries.

These educational interventions, as part of a comprehensive package of services, not only assist in reducing HIV transmission among key populations, but also slow the spread of HIV more widely in the general population.

Risky behaviours (e.g. frequent sexual partner change and unprotected sex) increase the possibility of HIV infection. Since certain populations may more frequently engage in these practices, they represent an obvious target for limited educational resources.

Who are "key populations"?

- Key populations for focused HIV programmes include:
  - → those most vulnerable to HIV infection;
  - → those who are already infected.
- Identifying beneficiaries of such programmes depends on *predominant HIV transmission modes* (e.g. unprotected sex during casual sex, sex work, unprotected sex between men, and sharing injection equipment).
- On the basis of these criteria, key populations usually involved in focused programmes include:
  - → sex workers;
  - → men who have sex with men (MSM);
  - → injecting drug users (IDUs).
- Depending on local contexts and feasibility, focused prevention may also include:
  - → clients of sex workers;
  - → people seeking treatment for STIs;
  - → people with HIV and AIDS;
  - → additional populations identified to be particularly vulnerable to HIV infection may also be targeted.

Country example: Dominican Republic

In the Dominican Republic, focused prevention efforts by The Population Council/Horizons to prevent HIV among sex workers employed an environmental-structural approach which tackled the physical, social, and political contexts in which individual behaviour takes place. The interventions were implemented in 68 sex establishments in two Dominican cities following extensive formative research and consultation with sex workers. A community-based solidarity approach to 100 percent condom use was implemented, combined with changes in government policy and regulation.

Solidarity-building activities included workshops and meetings with sex workers, sex establishment owners and employees to strengthen collective commitment to HIV/STI prevention, particularly in supporting sex workers to use condoms with partners. The intervention was shown to lead to an increase in consistent condom use, an increase in ability to reject unwanted sex, and a decrease in STIs.[1]

1 For more details, see: http://www.popcouncil.org/horizons/ressum/drcmntygvtplcy/dr_intro.html

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What needs to be done?

Focused programming involves the delivery of five key sets of interventions, all of which can benefit from the engagement of the education sector:

1. **Health promotion** to support protective behaviours, including:
   - → development of culturally appropriate information, education and communication on STIs, including HIV;
   - → condom promotion, access to sterile injection needles;
   - → voluntary counselling and testing (VCT) and referral to other appropriate services.
2. Provision of **sexual and reproductive health services and commodities, and HIV & AIDS care and support** including:
   - → male and female condoms and lubricants;
   - → diagnosis and treatment of STIs;
   - → VCT and psychosocial support;
   - → care and treatment access for people with HIV, including antiretroviral therapy.
3. **Community mobilisation** to support empowerment for prevention, including:
   - → activities to build solidarity e.g. self-help groups, advocacy and leadership training and involvement of people with HIV;
   - → development of communication and negotiation skills;
   - → facilitated group discussions on gender, sexuality, sexual health and related themes;
   - → establishment of safe and private meeting spaces for members of key populations.
4. Interventions to create an **enabling environment**, such as:
   - → inclusion such as of key populations in decision-making bodies related to HIV;
   - → awareness-raising and anti-stigma education of the general population;
   - → educational activities with those who shape community norms and opinions (e.g. police, outreach workers, cultural and religious leaders);
   - → provision of legal services.
5. **Capacity strengthening** of programme implementers in order to:
   - → support strategic planning, and resource mobilisation and management;
   - → facilitate networking and partnership building;
   - → ensure quality, including STI diagnosis and treatment and AIDS care and support;
   - → strengthen monitoring and evaluation mechanisms.

What works?

- **Work closely** with key populations from the beginning in the planning, implementation and evaluation of efforts.
- Undertake **strategic planning** with each key population and determine education and health-related needs, the scale and range of existing HIV programmes and gaps, and existing programme implementers and partners.
- **Focus on risk situations and target behaviours** potentially resulting in the largest number of infections, referring to evidence-based studies where possible.
- **Collect, analyse and share data** on key populations and their environment, including size, HIV/STI prevalence and characteristics, socio-cultural issues, geographic locations, etc.
- Mobilise participation, ownership and resources through **advocacy** that targets opinion leaders, and identify relevant partners (e.g. community-based organizations, NGOs, government agencies and the private sector).
- Develop culturally appropriate and gender-responsive activities among each key population, and **monitor and apply results** and lessons learned.
- **Build implementation capacity** to scale up and obtain good coverage of demonstrated effective programmes among key populations.
- **Expand prevention** efforts to those who may not be readily identifiable as part of a key population but may still engage in risk behaviours.
- **Address risk, stigma and discrimination**.
- **Develop resources** to promote mainstreaming of prevention, treatment, care and support activities, such as materials seeking to address gender and power dynamics that increase risks of HIV transmission or hinder access to services.
- **Monitor and evaluate behaviour change** using, where possible, widely accepted indicators and good practice in social and epidemiological science.
- Build a **long-term** risk and vulnerability reduction programme.

Key partners

- Ministries of Education and other relevant ministries
- National AIDS Commission
- International agencies including all UNAIDS Cosponsors and the UNAIDS Secretariat
- Networks and support groups of people living with HIV and AIDS, including local affiliates of GNP+ and ICW
- The Asian Harm Reduction Network
- Network of Sex Work Projects
- International HIV/AIDS Alliance
- Family Health International (FHI)
- Marie Stopes International

Key resources

- UNAIDS. 2005. *Intensifying HIV Prevention: UNAIDS Policy Position Paper*. Geneva: UNAIDS.
- USAID, UNAIDS, WHO, UNICEF, and the FUTURES Group/POLICY Project. 2004. *Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low and Middle Income Countries in 2003*. POLICY Project.
- Hoffmann, O. *et al.* 2006. *Achieving the Global Goals on HIV among Young People Most at Risk in Developing Countries: Young sex workers, injecting drug users and men who have sex with men*. WHO Technical Report Series, 2006; 938:287-315
- Family Health International (FHI). 2001. *Effective Prevention Strategies in Low Prevalence Settings*. Arlington: FHI

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Promoting the greater involvement of people living with HIV in education sector responses

What is the issue?

People with HIV have a critical role to play in designing, implementing and evaluating HIV- and AIDS-related prevention, treatment, care and support programmes. The movement towards the **greater involvement of people with HIV and AIDS (GIPA)** in comprehensive education sector responses to HIV and AIDS is based on:

- recognition that people with HIV have a personal understanding of the importance and urgency of the issue and the types of responses that are most needed and effective;
- understanding that their involvement gives a human face and voice to the epidemic in the minds of people and communities.

This contribution can be made **at various levels** (by decision-makers, experts, implementers, spokespersons, or contributors) **and across sectors** (in communities, workplaces and schools).

An international commitment:

At the **Paris AIDS Summit** in 1994, 42 governments agreed to support an initiative to *strengthen the capacity and coordination of networks of people living with HIV and AIDS and community-based organizations.*

This principle was reinforced at the **United Nations General Assembly Special Session on HIV/AIDS** (UNGASS) in 2001. It was further reaffirmed in a high-level meeting of Member States in 2006.

Numerous **networks of people living with HIV and AIDS** have been established at local, national and regional levels in support of GIPA. The Global Network of People Living with HIV/AIDS (GNP+) and the International Community of Women Living with HIV/AIDS (ICW), have also played a critical role in stimulating the creation of supportive political, legal and social environments for people living with HIV and AIDS.

Global programme example

The **Leadership for Results Programme,** implemented by UNDP, is a large-scale initiative to strengthen the capacity of a broad range of actors, including people living with HIV, to influence behaviour change, improve knowledge, reduce stigma and discrimination and enhance local and national HIV and AIDS responses. The programme employs transformative methodologies to help participants build upon their personal commitment, develop leadership competencies and strengthen their abilities to work collaboratively with others to address HIV and AIDS. Training programmes have been established in various countries including Cambodia, China, India, Malaysia, Nepal, Swaziland, Thailand, the Ukraine and Viet Nam.

Source: UNDP. 2005. *Responding to HIV/AIDS: Measuring results.* New York: UNDP.

Why does it matter?

The involvement of people living with HIV in education sector responses to the epidemic is important because it:

- **breaks down myths and combats stigma and discrimination** – key barriers to accessing and disseminating information on HIV and AIDS, and to accessing prevention, treatment, care and support services;
- **educates people** about the existence and needs of people living with HIV;
- **promotes a safer environment** where people more readily undergo testing and become aware of their HIV status;
- **helps to educate people living with HIV** on the importance of healthy living, including accessing treatment, care and support, adhering to antiretroviral therapy (ART), and avoiding opportunistic infections;
- **assists people living with HIV to focus on their individual health needs and to advocate for their right** to make informed decisions regarding their health and health care;
- **engages people living with HIV to take part in activities** such as counselling, training, medical care and support groups;
- **gives people living with HIV a place at the table for negotiation** on HIV-related issues such as workplace and anti-discrimination policies, use of financial resources, and access to medical treatment and psychosocial support;
- **assists in scaling up resource mobilisation and service delivery.**

In the education sector, it is especially important to support and involve teachers with HIV (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*).

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What works?

The involvement of people living with HIV must be carried out in a planned, sensitive and responsible manner to avoid tokenism and exposing people living with HIV to further stigma or discrimination. This may require that education systems provide people living with HIV with the following:

- **Training and other educational opportunities** to develop HIV and AIDS knowledge, communication, organization and management skills.
- **Psychosocial and material support,** such as through peer counselling, financial compensation, food, medicines and medical care, travel reimbursement, child care and education programmes.
- **Links to referral services** for medical care, counselling, training, support groups and positive living skills.

What needs to be done?

Address the obstacles to greater involvement of people living with HIV by:

- **encouraging people to know their HIV status** through increased access to and use of HIV testing, treatment, support and care;
- **making it easier for people to disclose their HIV status and to get involved in interventions** through reinforced efforts to reduce stigma and discrimination (see Brief on: *Addressing HIV-Related Stigma and Discrimination*);
- **supporting the creation of networks or organizations of teachers with HIV and including active partnership with ministries of education and teacher unions;**
- **strengthening the advocacy, leadership, and/or counselling skills of people living with HIV, particularly teachers,** in prevention, treatment, care and support activities;
- **making accessible the necessary material, financial and technical support** required for their participation;
- **promoting the social recognition of people living with HIV and their partners or families** associated with their participation.

Comprehensive programmes to encourage the greater involvement of people living with HIV should also:

- **support the expansion of services for people living with HIV** including medical care, counselling, training and the development of positive living skills (see Brief on: *HIV Prevention with and for People Living with HIV*);
- **promote culturally appropriate and gender responsive non-discriminatory attitudes, policies and programmes** for people living with HIV;
- **build the capacity of people living with HIV** for involvement through improved HIV and AIDS knowledge, communication, organization and management skills;
- **provide financial, material, technical, and/or psychological remuneration**, where possible, to those involved in HIV and AIDS interventions. This is particularly important for people with few resources, who may not become involved in the absence of some support;
- **encourage and support the engagement of members of marginalised groups** who are particularly vulnerable to HIV.

Key partners

- Networks of teachers living with HIV
- Relevant ministries (e.g. education, health, human rights)
- Networks of people with HIV, including the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS (ICW), and other national and local associations
- Civil society organizations, including Family Health International (FHI) and the International HIV/AIDS Alliance
- International agencies including all UNAIDS Cosponsors and the UNAIDS Secretariat

Key resources

- UNAIDS, IFRC and GNP+. 2003. *A Vital Partnership: The work of GNP+ and IFRC on HIV/AIDS*. Geneva: UNAIDS.
- UNAIDS. 1999. *From Principle to Practice: Greater involvement of people living with or affected by HIV/AIDS (GIPA)*. Geneva: UNAIDS.
- Global HIV Prevention Working Group. 2004. *HIV Prevention in the Era of Expanded Treatment Access*. www.hivpolicy.org
- NAPWA. 2003. *Principles of HIV Prevention with Positives*. Silver Spring, Md: NAPWA.
- Population Council/Horizons Project. 2002. *Greater Involvement of PLHA in NGO Service Delivery: Findings from a Four Country Study*. Washington, DC: Population Council/Horizons Project.

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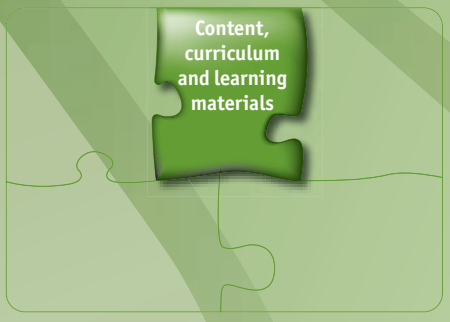
Curricula for HIV and AIDS education



What is the issue?

Although many countries include HIV and AIDS education in their curricula, recent evaluations in school settings highlight a number of common shortcomings:

- within already crowded curricula, HIV and AIDS education often gets **little or no attention**;
- when part of the curricula, HIV and AIDS are usually **not covered comprehensively**;
- **teachers frequently lack adequate training** or access to appropriate resources to meet HIV curriculum requirements effectively;
- HIV and AIDS curricula generally **emphasise fact acquisition over life skills-based education and behaviour or attitude changes**;
- HIV and AIDS curricula often **do not incorporate sensitive but important** topics such as gender issues, sexuality, and sociocultural contexts;
- **specific or relevant monitoring or evaluation strategies** are seldom employed to assess learning outcomes or behaviour changes.

Overall, these weaknesses demonstrate that curricula often do not cover the topic in a meaningful and relevant way, and that sensitive but vital issues remain untaught. In some cases, HIV and AIDS are simply not addressed at all.

Early start

Children and young people are age groups with low HIV prevalence and hence present a window of opportunity for prevention activities.

HIV and AIDS curricula must be age-appropriate, be sequenced to begin early in primary school, and continue through secondary and higher education because:

- HIV and AIDS education that addresses children before sexual activity begins (ages 10-14) can greatly minimise the spread of HIV;
- The majority of children in many countries heavily affected by HIV and AIDS do not go on to secondary school; thus the only opportunity to reach them is at the primary level;
- Studies show that young people are more likely to adopt safer sexual practices if they receive gender-sensitive, learner-centred sex and HIV education *before* their sexual debut.

Why does it matter?

HIV and AIDS education should be incorporated into school curricula because:

- **schools are located in most communities** and have the potential to reach more children and young people than many other institutions;
- **schools often serve as community hubs and outreach centres**, where individuals and groups convene and where important decisions are made;
- **teachers and other community members are invaluable information resources**, often motivated to contribute to HIV and AIDS awareness when given the opportunity.

Regional example: The Caribbean

The University of the West Indies (UWI), which serves 15 Caribbean countries, has established a multidisciplinary curriculum development committee to identify opportunities to integrate HIV and AIDS into existing courses and establish stand-alone courses in tertiary education. The consultative and cooperative process has led to impressive results: UWI integrated HIV content into 23 of the 40 targeted courses in the 2003-2004 school year and developed 17 new courses, exposing nearly 1,000 students to HIV and AIDS education.

Source: UNESCO. 2006. *Expanding the Field of Inquiry: A cross-country study of higher education institutions' responses to HIV and AIDS*. Paris: UNESCO.

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What needs to be done?

National coverage of effective HIV and AIDS education can be achieved by employing a three-fold curriculum approach, combining:

- **local-level innovation and experimentation**, by developing curricula based on good practices, and implementing programmes in both schools and teacher training institutions;
- **coverage of HIV and AIDS in official curricula**, alongside pre- and in-service teacher training and learning material development, to support teachers in meeting curricula requirements;
- **strategies to prevent curricula from becoming overcrowded.** It may be necessary to make cuts in existing curricula to implement a strong HIV and AIDS education content so that learners are provided with the skills to remain healthy and safe.

Specifically:

- **the HIV and AIDS curriculum should have clear, practical requirements and be taught as an 'examinable' subject** to ensure implementation;
- **systematic assessment of learning outcomes and behaviour changes** should be undertaken and used to guide future curriculum development;
- **adequate teaching time and resources** must be allocated to HIV and AIDS and age-appropriate curricula should be implemented at all schooling levels;
- **HIV and AIDS curricula should be comprehensive**, and should address prevention, treatment, care and support as well as the underlying causes of the epidemic e.g. poverty, gender inequality, cultural practices, stigma and discrimination.

Curricula should include life skills-based approaches that assist learners to develop the knowledge, attitudes and skills necessary to adopt healthy and safe behaviours (see Brief on: *Life Skills-Based Education for HIV Prevention)*. These should also be **gender-responsive, age-appropriate, culturally sensitive and start before the onset of sexual activity** when children are beginning to develop related values, attitudes and behaviours.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, culture, health, sports, youth, social affairs)
- Textbook authors and publishers
- Teacher training institutes
- School governing boards
- Civil society organizations, including the Global Campaign for Education, Education Development Center, Inc. and Education International
- Community and religious leaders
- Other international agencies, including the World Bank
- UNAIDS Inter-Agency Task Team on Education

What works?

Knowledge sharing alone is not enough for effective HIV and AIDS education. **Experience and evaluations show that successful curricula and programmes**:

- **actively involve young people, teachers, community leaders and other community members, including those who are affected or infected by HIV,** in the development and implementation of curricula;
- **provide learners with demonstrations of positive communication, negotiation and decision-making skills** and allow for practice;
- **use interactive education methodologies that teach learners to minimise vulnerability and risk** and adopt safe and healthy behaviours;
- **allocate adequate time and resources** to guarantee comprehensive coverage and ensure completion of learning activities;
- **provide pre- and in-service teacher training** in HIV and AIDS topics alongside curricula implementation (see Brief on: *Educator Training on HIV and AIDS)*;
- **specifically address high-risk behaviours** and provide effective risk-reduction strategies.

HIV curricula are most successful when governments actively support development and implementation by:

- **setting content standards and minimum time allocation** in national curricula;
- **providing practical examples of simple but comprehensive programmes and resources**;
- **developing tools and mechanisms** to adapt and implement curricula for local contexts.

Key resources

- UNAIDS IATT on Young People. 2006. *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*. Geneva: WHO.
- UNESCO IBE. 2006. *HIV/AIDS Curriculum Manual.* Geneva: UNESCO IBE.
- World Bank. 2003. *Education and HIV/AIDS: A Sourcebook of HIV/AIDS prevention programs*. Washington, D.C.: World Bank.
- Boler, T. *et al.* 2003. *The Sound of Silence. Difficulties in communicating on HIV/AIDS in schools*. Johannesburg: ActionAid.
- Kirby, D. and Senderowitz, J. 2006. *Standards for Curriculum-Based Reproductive Health and HIV Education Programs*. Arlington: FHI.
- Kirby, D., Laris, B. and Rolleri, L. 2005. *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing Countries.* Arlington: FHI.

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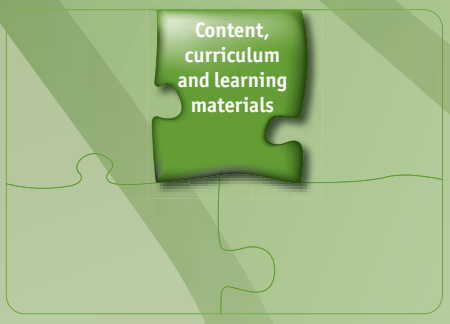
Addressing HIV-related stigma and discrimination



What is the issue?

Stigma and discrimination related to HIV and AIDS are significant obstacles to the prevention of new infections, and to the provision of HIV treatment, care and support. HIV-related stigma and discrimination build upon and reinforce other existing forms of discrimination related to sexuality, gender, race and poverty. For example, key populations such as men who have sex with men, sex workers or injecting drug users, who already experience discrimination economically and socially, suffer even more disproportionately from HIV-related discrimination (see Brief on: *Focused HIV Prevention for Key Populations*).

In fact, **stigma and discrimination have harmful impacts not only at the individual level but also in the broader social, cultural, political and economic spheres**. They can lead to violations of human rights and in turn threaten countries' efforts to promote quality education and achieve the Education for All (EFA) goals by 2015.

Stigma can be underpinned by numerous factors such as:

- Social fears and anxieties about sexuality, illness and death;
- Misconceptions about HIV transmission;
- Prejudice against those with HIV and AIDS or particularly vulnerable to HIV;
- Lack of treatment options.

Discrimination then ensues when actions are directed against those stigmatised, often leading to violations of human rights and fundamental freedoms. The UN Commission on Human Rights resolutions (1999/49 and 2001/51) unequivocally stated that the non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV and AIDS.

Although HIV- and AIDS-related stigma and discrimination occur in a range of contexts and at a number of levels, this information brief focuses on the issue of stigma and discrimination within the education sector.

Why does it matter?

Stigma and discrimination can affect learners, teachers and other education sector personnel living with HIV and AIDS, as well as those indirectly affected by the epidemic (e.g. persons whose family and friends are infected). They manifest in physical and visible ways, but also in more subtle but nonetheless psychologically damaging practices.

Learners with or affected by HIV and AIDS may face a number of reactions from peers, educators, other parents and community members, such as:

- bullying and harassment, physical or verbal violence, ostracism and rejection;
- differential treatment from educators and other staff in the learning environment;
- exclusion from physical and recreational activities, the use of sanitation or other facilities, access to health care facilities, school-boarding accommodation, or campus residences;
- barred access to educational programmes, loans, bursaries, scholarships or grade advancement.

Educators, education planners and other education sector staff with or affected by HIV may face:

- refusal of employment or dismissal from work;
- required HIV testing as a condition of employment or violations of confidentiality regarding their HIV status;
- physical or verbal violence and harassment, ostracism and rejection;
- restriction on participation in educational events, career advancement, or training programmes;
- limited medical, financial, or other support for affected family members.

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What is the impact of stigma?

Stigma and discrimination can have a dramatic impact on infected and affected learners, such as:

- reduced opportunities for learning;
- decreased school enrolments and increased absenteeism and drop-out;
- increased vulnerability of affected groups to child labour and exploitation in the case of interrupted schooling.

Among infected/affected educators and education sector staff, stigma and discrimination can result in:

- reduced productivity and motivation and increased absenteeism;
- reluctance to be tested for HIV for fear of repercussions;
- reluctance to disclose HIV status to partners or change their behaviour to avoid negative reactions;
- reduced efforts to seek care and support due to concerns of public recognition of their HIV status ;
- diminished income-earning opportunities.

Country example: Thailand

The Ministry of Education in Thailand, supported by UNICEF, has established "child-friendly" community school approaches for the promotion of health and psychosocial support, and the development of knowledge and life skills in the context of HIV and AIDS. A recent evaluation[1] of the programme demonstrated:

- improved support for children's rights, including their right to education and the right to care and support among teachers and school management;
- greater acceptance among students of learning with children affected by HIV and AIDS;
- Improved understanding among caregivers of the special needs of children affected by HIV and AIDS.

1 Thatun, S. 2004. "Promoting Sympathy and Acceptance of HIV/AIDS Infected and Affected Children in Schools", Presentation at the XV International AIDS Conference, Bangkok, 11-16 July 2004.

Key resources

- UNESCO IIEP. 2006. *Educational Planning and Management in a World with AIDS*. HIV/AIDS related Stigma and Discrimination. Paris: UNESCO IIEP.
- UNESCO. 2006. *HIV/AIDS Stigma and Discrimination: An Anthropological Approach*. Paris: UNESCO.
- UNESCO. 2004. *Living and Learning in a World with HIV/AIDS: HIV/AIDS in school*. Paris: UNESCO.
- Aggleton, P. *et al.* 2005. *HIV-Related Stigma, Discrimination and Human Rights Violations: Case studies of successful programmes*. Geneva: UNAIDS.
- Brown, L. *et al.* 2001. *Interventions to Reduce HIV/AIDS Stigma: What have we learned?* New York: Population Council.
- ICRW. 2007. *Understanding and Challenging HIV Stigma: Toolkit for action*. Washington, DC: ICRW.

What needs to be done?

Effective strategies to reduce stigma and discrimination in learning environments should include efforts to:

For learners:

- Promote quality education that includes the inputs, processes, results, and outcomes that foster learning (See Brief on: *Quality Education and HIV & AIDS*).
- Provide clear messages about the principal modes of transmission of HIV and also challenge false ideas about the epidemic.
- Promote life skills education to enable young people to maintain healthy lifestyles, resist negative pressures and avoid risk-taking behaviours (see Brief on: *Life Skills-Based Education for HIV Prevention*).
- Provide teacher training on HIV and AIDS, gender, human rights and life skills, and on effective communication.

In the community:

- Involve people with HIV in HIV and AIDS education and care activities.
- Support the establishment of anti-AIDS clubs and youth associations, and promote school campaigns against stigma and discrimination.
- Involve parents in education programmes and school committees to improve their knowledge of and attitudes about HIV and AIDS.
- Support advocacy at the community level to better understand stigma and discrimination and its effects.

At the policy level:

- Develop and reinforce existing legislation and administrative rules to protect the human rights of those infected with HIV (right to employment, right to education, right to health).
- Ensure that mechanisms are in place to protect the confidentiality of information related to learners, teachers and education sector staff's health status, including HIV.
- Establish workplace policies for educators and other staff that are responsive to HIV and AIDS, including codes of practice and guidelines to tackle instances of discrimination and human rights violations.
- Ensure that educators, education planners and their families have access to comprehensive health services including voluntary counselling and testing (VCT), and follow-up care and treatment.

Key partners

- Relevant ministries (e.g. education, health, youth, social affairs)
- International student associations, peer educators and school governing councils
- Networks of people with HIV, including the Global Network of People Living with HIV/AIDS (GNP+) and National Association of People Living with AIDS (NAPWA)
- Civil society organizations, including ActionAid, International Council of AIDS Service Organizations (ICASO), International HIV/AIDS Alliance, Population Council and Save the Children
- International agencies, including UNESCO, UNICEF, WHO and the UNAIDS Secretariat
- Parliamentarians

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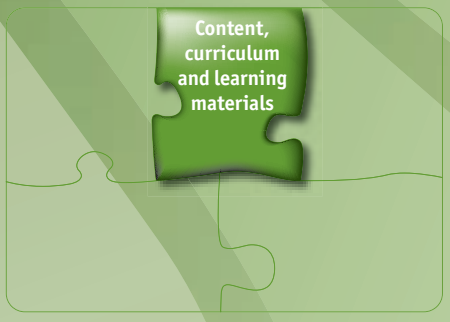
HIV and AIDS education in primary school



What is the issue?

In many countries heavily affected by HIV and AIDS, most children never attend secondary school. Therefore the most important opportunity to reach them with HIV and AIDS education is in primary school. Furthermore, **it is vital to provide education on HIV and AIDS before students become sexually active**.

Introducing education on HIV and AIDS into primary schools can be controversial and faces the following challenges:

- Some parents and communities might think that primary-age children are too young to start learning about HIV and AIDS.
- HIV and AIDS curricula are often not gender-sensitive and age-appropriate and lack an element of progressive learning which parallels children's emotional and physical development.
- HIV and AIDS curricula designed for younger children tend to avoid addressing the sexual transmission of HIV. Although this might be desirable for pre-pubescent children (under the age of ten), it is not appropriate for children who are undergoing puberty and who may be starting to become sexually active.

Often the most difficult issue is whether or not primary school children should be taught about sexual activity. Many countries (such as Australia, Cambodia, Kenya, Mexico, Nigeria and Zambia) have introduced sex education into primary schools. Experiences in these countries show that **curricula can be appropriately adapted in approach and content according to the student's age and sexual experience.** For example, with young children, more basic information and less advanced cognitive tasks and less difficult activities should be used.

Why does it matter?

In order to maximise the potential of schools to provide quality education on HIV and AIDS, primary schools should include age-appropriate and gender-sensitive curricula because:

- studies show that young people are more likely to adopt safer sexual practices if they receive sexual and reproductive health education before becoming sexually active;[1]
- the majority of children in many countries never attend secondary school which makes primary schooling the easiest way of reaching the largest number of children with education on HIV and AIDS;
- children of all ages are affected by HIV and AIDS – by having HIV themselves, living with family members who have HIV or being orphaned. HIV and AIDS education can be used to mitigate the impact of the epidemic on communities and to reduce stigma and discrimination from an early age;
- In many countries, over-age children are attending primary schools. These young people have already entered adolescence and might already be sexually active and at risk of HIV infection.

[1] Kirby, D., Short, L. and Collins, J. *et al.* 1994. School-based Programs to Reduce Sexual Risk Behaviors: A review of effectiveness. *Public Health Reports*. 109:339-60.

Country example: Nigeria

In Nigeria, Action Health International (a local NGO) has been working with the Nigerian government to develop age-appropriate guidelines for introducing sexuality and reproductive health curricula into primary and secondary schools. The first level is designed for children aged 6 to 8 and includes discussion on:

- each body part has a name and function;
- a person's genitals and genes determine whether the person is biologically male or female;
- physical differences between men and women.

The next developmental level is for children aged 9 to 12 and includes lessons on:

- How bodies change physically during puberty;
- How at puberty, girls begin to menstruate and boys become capable of ejaculation.

Finally, older children in secondary school are taught more explicitly about healthy sexual behaviours and how to avoid unwanted pregnancies and sexually transmitted infections.

The introduction of sexuality education in Nigeria has been controversial. However, Action Health International has been working to address the concerns of parents, teachers and communities, and even in conservative communities, opposition has been diminished through the active engagement of religious leaders and parents.

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What needs to be done?

To support learning about HIV and AIDS in primary schools, the curriculum needs to be adapted to the age and sex of learners. For children in the early years of primary school, who are not yet sexually experienced, it is still important to teach about HIV and the epidemic.

Furthermore, these early stages of children's development offer an important opportunity to lay a strong foundation for healthy values, attitudes and skills. Successful strategies for teaching about HIV to younger children – without necessarily teaching about sexual activity – include:

- **Develop curricula** which build basic skills such as self-esteem, problem solving and negotiation.
- **Discuss the AIDS epidemic and the impact** it has had globally as well as at the community level.
- **Teach about the developmental stages of life** and the physical and emotional changes that occur during puberty.
- Develop **healthy living** through school health programmes and values such as respect for others' rights, oneself and social responsibility (see Brief on: *School Health and HIV Prevention*).
- **Address stigma** toward adults or children who are infected or affected by HIV by creating compassion and respect for one another.
- **Foster critical thinking** and broader critical reflection on issues in the school and community. Such critical thinking can – among other benefits – lead to the rejection of negative stereotypes and greater tolerance of diversity.
- **Provide care and support to children affected by HIV and AIDS** through measures such as building partnerships with social services and community networks. In countries with an advanced epidemic, HIV and AIDS education in primary schools can provide children with the skills they need to mitigate the impact of HIV and AIDS on their lives.

Over 75 percent of all HIV infections are caused by sexual transmission[2] and therefore, at some stage, HIV and AIDS education must introduce the subject of sexual transmission of the virus and provide choices on how to minimise risk. Teaching about sex should happen before young people become sexually active because:

- the process of adolescence is a period of preparation for adulthood. Behaviour patterns that are established then can have long-lasting positive or negative effects on future health and well-being;
- teaching about sex before young people become sexually active does not increase the likelihood that they will start having sex;[3]
- young people need to have the knowledge and skills to decide when and if they want to start having sex in the first place. Sex education can equip young people with the ability to negotiate or refuse sex until they are physically and emotionally ready (see Brief on: *Life Skills-Based Education for HIV Prevention*);
- if young people decide to start having sex, then sex education can help them adopt safe and healthy behaviours and avoid unwanted pregnancies or sexually transmitted infections.[4]

In order to introduce sex education in accordance with the development needs of learners, efforts are needed to:

- base the curriculum on a needs assessment of risk behaviours and knowledge gaps;
- encourage discussion of puberty and the changes that occur in becoming an adult;
- actively involve parents and communities to diminish any possible preliminary resistance;
- support teachers through pre-service and in-service training on how to teach about sensitive issues such as gender, sex or HIV;
- encourage frank and respectful discussions of sex and HIV which are scientifically accurate;
- develop information, counselling and care services that are effectively used by students and staff or that provide referrals to expanded services;
- deliver messages that are sensitive to ethnicity, local culture and traditions, language and age.

See Briefs on: *Curricula for HIV and AIDS Education, Gender-Responsive Approaches in Education Sector Responses, HIV and AIDS Education in Secondary School, Quality Education and HIV & AIDS.*

[2] UNAIDS. 2006. *Report on the Global AIDS Epidemic*. Chapter Six (Comprehensive HIV Prevention). Geneva: UNAIDS.

[3] Kirby, D., Laris, B. and Rolleri, L. 2005. Impact of Sex and HIV Education Programs on Sexual Behaviours in Developed and Developing countries. Arlington: FHI.

[4] *Ibid*.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, culture, health, sports, youth, social affairs)
- Textbook authors and publishers
- Teacher training institutes
- School governing boards
- Teacher's unions
- Civil society organizations, including national education coalitions and the Global Campaign for Education (GCE)
- Community and religious leaders
- International agencies, including UNESCO, UNFPA, UNICEF and World Bank
- UNAIDS Inter-Agency Task Team (IATT) on Education

Key resources

- UNAIDS. 1997. *Impact of HIV and Sexual Health Education on the behaviour of young people: a review update*. Geneva: UNAIDS.
- UNESCO IBE. 2006. *HIV and AIDS Curriculum Manual*. Geneva: UNESCO IBE.
- Kirby, D., Laris, B. and Rolleri, L. 2005. *Impact of Sex and HIV Education Programs on Sexual Behaviours in Developed and Developing countries*. Arlington: FHI.
- FOCUS on Young Adults. 2001. *Developmentally Based Interventions and Strategies: Promoting reproductive health and reducing risk among adolescents*. Arlington: FHI
- Future's Group 2004. *Sexuality Education in Schools: The International Experience and Implications for Nigeria*.
- SIECUS. 1999. *Developing Guidelines for Comprehensive Sexuality Education*. New York: SIECUS.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

HIV and AIDS education in secondary school

What is the issue?

Secondary schools provide an important mechanism for reaching large numbers of learners with education about HIV and AIDS during a period of their lives when they are undergoing puberty and maturing sexually. HIV and AIDS can be integrated into the main curriculum through different entry points (see Briefs on: *Life Skills-Based Education for HIV Prevention* and *School Health and HIV Prevention*) and needs to provide well-sequenced learning that reflects the emotional, physical and cognitive developmental stages of childhood and adolescence.

Although many countries have made efforts to include HIV and AIDS education in secondary school curricula, the following challenges remain:

- Teaching about sex and HIV requires certain skills and many teachers do not feel adequately trained and confident to discuss such sensitive issues.
- Curricula at the secondary level are already very full and the strong focus on examinations can reduce the priority given to HIV and AIDS education.
- Some communities resist the introduction of sex education in the schools and not enough effort has gone into building community understanding and support.
- HIV and AIDS curricula often exclude detailed discussions on the sexual transmission of HIV, thus failing to provide young people with the information necessary to reduce their vulnerability.

One of the most difficult issues is deciding at what stage, and how, learners should be taught about sex (a prerequisite for HIV prevention programmes). (See Brief on: *HIV and AIDS Education in Primary School*).

Why does it matter?

HIV and AIDS education in secondary education is vital because:

- education on HIV and AIDS that reaches students before sexual activity begins can greatly minimise the risk of HIV;
- some students in secondary schools are sexually mature and may already be sexually active, and therefore at potential risk of HIV infection;
- children of all ages are affected by HIV and AIDS – by having HIV themselves, living with family members who have HIV or being orphaned. HIV and AIDS education can be used to mitigate the impact of the epidemic on communities and to reduce stigma and discrimination from an early age;
- learners attending secondary school are undergoing a process of preparation for adulthood. Behaviour patterns that are established during this process can have long-lasting positive or negative effects on future health and well-being;
- pregnancy is a major cause of school dropout for girls in many countries. Sex education can reduce girls' chances of an unwanted pregnancy or sexually transmitted infection, including HIV, and may thereby increase their chances of staying in school. In turn, staying in school will provide greater protection from HIV for girls (see Brief on: *Girls' Education and HIV Prevention*).

Country example: Tanzania

The Mema Kwa Vijana (Good Things For Young People) programme in Tanzania is a school-based programme delivered to adolescents aged 14 and above. The programme includes sexual and reproductive health education, youth-friendly health services, community-based condom distribution and community activities. It focuses on supporting young people to delay the initiation of sex, reduce the number of sexual partners and increase condom use. The programme has a strong participatory dimension and includes many skits put on by students to demonstrate common situations that might lead to unwanted sex and its consequences. After each skit, the class discusses what the young people could have done differently.

The success of the programme was evaluated through a randomised control trial and showed a decrease in the number of sexual partners, increased condom use and more positive attitudes among those receiving the programme compared with those who did not.

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What needs to be done?

There is strong evidence from around the world that learning about reproductive and sexual health does not increase the likelihood that young people will start having sex earlier.[1] On the contrary, research shows that learning about sex and HIV before young people start sexual activity reduces their risk of contracting HIV.

HIV and AIDS education can be taught as part of a wider curriculum on comprehensive sexuality education (for example, as done in Nigeria or Russia). Comprehensive sexuality education programmes[2] have been found to be more effective when they include:

- information on human sexuality;
- an opportunity to question and assess sexual attitudes;
- an opportunity to develop interpersonal skills;
- issues of responsibility regarding sexual relationships.

However, teaching about the transmission of HIV can be difficult, and if done incorrectly, can increase stigma towards people with HIV. Successful strategies include educational efforts that:

- **provide a range of options** for young people to choose how to reduce their risk to HIV;
- **reach out** to include the views of parents and communities as well as to gain their support for HIV and AIDS education in secondary schools;
- **create developmental messages** because adolescents are a heterogeneous group who have distinct needs that require various approaches depending on the stage of development;
- **train educators** on how to talk frankly and accurately on sensitive topics such as gender, sex and HIV;
- include HIV and AIDS in the **main curricula** by building on existing curricula rather than creating stand-alone processes which are difficult to integrate;
- **support teachers** by providing pre-service and in-service training;
- **develop information, counselling and care services** that are effectively used by students and staff or provide referrals to expanded services;
- **conduct assessments** of the students' needs and sexual risk patterns to ensure that learning about HIV and AIDS is suited to their specific contexts;
- **focus on specific behaviours** that lead to or prevent sexually transmitted infections. This will mean clear, consistent and scientifically accurate discussion of the sexual transmission of HIV;
- **adapt the curriculum** for each local context because of the culturally specific aspects of sexuality. Messages developed for one country may not be suitable for use in another country (see Brief on: *Providing Culturally Sensitive Education on HIV and AIDS*).

(See Brief on: *Curricula for HIV and AIDS Education* for more general strategies for successful implementation.)

1 Kirby, D., Laris, B. & Rolleri, L. 2005. *Impact of Sex and HIV Education Programs on Sexual Behaviours in Developed and Developing countries*. Arlington: FHI.
2 SIECUS. 1999. *Developing Guidelines for Comprehensive Sexuality Education*. New York: SIECUS.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, culture, health sports, youth , social affairs)
- Textbook authors and publishers
- Teacher training institutes
- School governing boards
- Teacher unions
- Civil society organizations, including national education coalitions and Global Campaign for Education
- Community and religious leaders
- International agencies, including UNESCO, UNFPA, UNICEF and the World Bank
- UNAIDS Inter-Agency Task Team (IATT) on Education

Key resources

- UNAIDS. 1997. *Impact of HIV and Sexual Health Education on the Behaviour of Young People: A review update*. Geneva: UNAIDS.
- FOCUS on Young Adults. 2001. *Developmentally Based Interventions and Strategies: Promoting reproductive health and reducing risk among adolescents*. Arlington: FHI.
- Boler, T. and Jellema, A. 2006. *Deadly Inertia. A Cross-country Study of Educational Responses to HIV and AIDS*. Brussels: Global Campaign for Education.
- Kirby D, Laris, B & Rolleri. L 2005. *Impact of Sex and HIV Education Programs on Sexual Behaviours in Developed and Developing countries*. Arlington: FHI.
- Senderowitz, J., and Kirby, D. 2006. *Standards for Curriculum-based Reproductive Health and HIV Education Programmes*. Arlington: FHI.
- SIECUS. 1999. *Developing Guidelines for Comprehensive Sexuality Education*. New York: SIECUS.

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Tertiary education responses to HIV and AIDS

What is the issue?

HIV and AIDS education in tertiary education institutions is vital because:

- **young people** between the ages of 15 and 24 **are most vulnerable to HIV infection;**
- **campus life can increase young people's vulnerability** through limited on-campus accommodation, sexual mixing among staff and students, risk of exposure to HIV-contaminated fluids in medical or laboratory environments, coercive sex and limited access to condoms or other means of prevention;
- **increased AIDS-related morbidity and mortality is undermining the core functions of tertiary institutions** to train future leaders, professionals and experts, and to fulfil the educational, research and information functions necessary for economic and social development.

Why does it matter?

AIDS-related illnesses and deaths affect:

- **the demand for tertiary education** by reducing the number of students attending these institutions. As parents fall ill, they become more reliant on their children for care and economic support, which may contribute to decreased enrolment and graduation rates;
- **the supply and quality of education** by dramatically increasing absenteeism and attrition as teachers and education staff fall ill and die;
- **institutional capacity** by undermining the important educational and financial investments made in tertiary education.

In many countries, tertiary institutions have not assessed the full impact of the epidemic:

- While small-scale knowledge, attitudes and practices surveys have been undertaken, **there are few rigorous institutional impact or risk assessments.**
- **Information on staff and student morbidity and mortality are usually unavailable,** or only reported anecdotally.

Few tertiary institutions have developed formal policy guidelines to address HIV and AIDS or to address the **replacement and training costs** of those leaving university positions.

What works?

Comprehensive responses to HIV and AIDS by higher education institutions include:

- **data collection and impact assessments** to determine the vulnerability of the tertiary education sector to HIV and AIDS and the actual or potential impact of HIV and AIDS on the institution;
- **HIV and AIDS policies and plans** that involve HIV and AIDS as part of the core business of institutions;
- **sensitive and strong leadership** that keeps the institutional focus on HIV and AIDS;
- **pre- and in-service educational programmes,** in formal and non-formal settings, that support knowledge generation, skills transfer, and the promotion of attitudes needed to reduce risk and vulnerability;
- **coordinated research** that drives evidence-based decision-making and investments;
- **partnerships** between departments, across institutions and with Government agencies, multilateral organizations, NGOs and private enterprises currently supporting HIV-related activities;
- **additional financial resources** for sustainable HIV and AIDS programme implementation;
- **effective monitoring, review and evaluation mechanisms** to assess achievements and failures.

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What needs to be done?

To effectively address HIV and AIDS, tertiary institutions should develop **institutional strategies** that:

- recognise that HIV and AIDS can undermine the availability, quality and quantity of educational and training services;
- target the entire higher education community, including students, teachers and non-teaching staff;
- develop a long-term, concerted and coordinated response;
- focus both on protecting the institution's own functioning as well as serving the needs of an AIDS-affected society.

These strategies require **institutional capacity**, including:

- **cross-institutional HIV and AIDS focal units or focal points** able to accelerate action and engagement;
- **consultative and collaborative procedures** for the design, planning, implementation, monitoring and evaluation of the response;
- **mobilisation of technical and financial resources** to sustain the institutional response;
- **comprehensive understanding of the** AIDS-related impact (e.g. absenteeism, morbidity and mortality) among students, teachers and non-teaching staff.

These strategies **establish HIV and AIDS prevention, treatment, care and support for students and staff** to:

- **mainstream HIV and AIDS education into teaching and training programmes** for students and staff;
- **develop information, counselling, treatment and care services** that are accessible for students and staff, or provide referrals to expanded services;
- **support reduction of risk behaviours** and promote healthy living;
- **create an institutional environment free from stigma and discrimination,** and decrease vulnerabilities among students and staff;
- **improve the learning environment.**

These strategies **mitigate the impact of the epidemic on tertiary institutions** by:

- **protecting the social and human rights** of students, teachers and staff infected or affected by HIV;
- **establishing human resource and workplace policies** (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*).

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. education, finance, planning and development)
- National AIDS Commission
- Other international agencies
- EduSector AIDS Response Trust
- University governing boards, research committees, and campus health centres
- University associations, student associations, national teacher unions and associations such as the Association for the Development of Education in Africa (ADEA) Working Group on Higher Education
- Research Institutes such as HEARD (Health Economics and HIV/AIDS Research Division), University of KwaZulu-Natal

Key resources

- UNESCO IIEP. 2006. HIV/AIDS Impact on Education Clearinghouse. *HIV/AIDS and Higher Education: A collection of resources*, CD-ROM. Paris: UNESCO IIEP.
- UNESCO. 2006. *Expanding the Field of Inquiry: A cross-country study of higher education institutions' responses to HIV and AIDS*. Paris: UNESCO.
- AAU. 2004. *An HIV/AIDS Toolkit for Higher Education Institutions in Africa*. Accra: AAU.
- Katjavivi, P.H. and Otaala, B. 2003. *African Higher Education Institutions Responding to the HIV/AIDS Pandemic*. Paper presented at the AAU Conference of Rectors, Vice Chancellors and Presidents of African Universities (COREVIP). Mauritius.
- Kelly, M. 2002. *Crafting the Response of a University to HIV/AIDS*. Lusaka: University of Zambia.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

Educator training on HIV and AIDS

What is the issue?

In order **to teach effectively about HIV and AIDS as well as address HIV and AIDS in their own lives**, **educators must be provided with appropriate HIV-related knowledge, skills and resources, and be supported by institutions and communities** in their work with their colleagues and students.

Teacher education, administered through universities and teacher training institutions, and complemented by continuing professional development, is part of a comprehensive response by the education sector to prevent and mitigate the effects of HIV and AIDS on teachers and students, institutions and communities.

Why does it matter?

Education institutions reach further into communities around the world than many other establishments. Teachers are strategically placed to develop learners' HIV- and AIDS-related knowledge and life skills, and to combat stigma and discrimination against people living with HIV. This should begin in primary school and continue through secondary and tertiary education.

In order to be effective in both formal and non-formal educational settings, teachers need to have **technical knowledge on HIV and AIDS**, **confidence and experience** in interactive and participatory learning methodologies**,** and **appropriate resources** such as teaching equipment and aids.

Educator training programmes strengthen the ability of educators to:

- **gain confidence and comfort in discussing sensitive issues** such as sexuality, gender, drugs, illness and death;
- **establish conducive learning environments** that promote the adoption of safe and healthy behaviours and skills related to HIV and AIDS prevention, treatment, care and support;
- **develop participatory and interactive teaching materials** for HIV and AIDS education programmes;
- **encourage other teachers to incorporate HIV and AIDS** into their curricula and learning materials, and into professional discussions that they may have with other colleagues and community members;
- **advocate for workplace policies and guidelines** to prevent the spread of the epidemic, mitigate its impact on teachers and learners, and provide social protection to help cope with it (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*);
- **strengthen parental support for HIV education** through participation in parent-teacher associations, teachers' and family welfare groups and other venues.

When is it needed?

Teacher education programmes should include pre-service education and be supported by continuing professional development programmes:

- **Pre-service education programmes** should train prospective teachers on HIV- and AIDS-related knowledge and skills, promote positive attitudes toward people with HIV, and develop teacher confidence in delivering HIV and AIDS education.
- **Continuing professional development and in-service training** should enable those already teaching to gain or update their HIV and AIDS-related knowledge, attitudes and skills. It should provide teachers in formal and non-formal education settings with up-to-date information, teaching pedagogies and relevant learning materials for HIV and AIDS education.

Both are important to ensure the quality of education and the preparation of students for their future roles as citizens, and as family and community members, living in a world with HIV and AIDS.

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What needs to be done?

Effective teacher education programmes for HIV education should:

- **address educators' own vulnerability to HIV infection** and acknowledge how HIV and AIDS have affected teachers and their institutions as well as education systems;
- **provide guidance on and practice of interactive and participatory methodologies** including role playing, debates and life skills-based education (see Brief on: *Life Skills-Based Education for HIV Prevention*);
- **develop counselling and support skills for educators**, including how to work with students, colleagues and other teachers affected by HIV;
- **supply learning materials that are appropriate** to the age, gender and culture of students and their communities (see Briefs on: *Curricula for HIV and AIDS Education* and *Providing Culturally Sensitive Education on HIV and AIDS*);
- **effectively access and use information and communication technologies** as well as distance learning programmes, where available;
- **involve communities, including people living with HIV**, to share knowledge, build support and encourage dialogue;
- **provide incentives and motivation,** through the provision of continuing education credits or certifications to teachers;
- **be reinforced by ongoing encouragement** through peer coaching and support groups or mentoring by experienced teachers;
- **be supported by institutional efforts** to prevent the further spread of HIV and to mitigate the effects of the epidemic on individuals, campuses and communities.

More research is needed to determine the long-term impact of teacher education programmes on HIV and AIDS education. Additional studies should document:

- which training approaches and modes of delivery lead to effective learning and successful skills outcomes for teachers;
- the effect of refresher courses and in-service training on teachers' HIV- and AIDS-related knowledge, attitudes and skills;
- relevant indicators to monitor and evaluate teacher education programmes on HIV and AIDS.

Regional example: Eastern and Southern Africa

A UNICEF review of projects in Eastern and Southern Africa concluded that life skills-based programmes that addressed HIV and AIDS were effective when teachers had explored their own attitudes and values, established a positive personal value system, and nurtured an open, positive classroom climate. Teacher education programmes can build teachers' own knowledge and skills, self-esteem and ability to negotiate risk-reductive behaviours which, in turn, enable them to better support their colleagues and learners.

Source: Gachuhi, D. 1999. *The Impact of HIV/AIDS on Education Systems in the Eastern and Southern Africa Region, and the Response of Education Systems to HIV/AIDS*. New York: UNICEF.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for HIV prevention for young people in education institutions, with ILO, UNFPA, UNICEF, WHO and WFP as main partners. Key partners also include:

- Relevant ministries (e.g. culture and education)
- Civil society organizations, including Education Development Center, Inc., Education International, InWent
- Teacher training centres
- World Confederation of Teachers and regional and national teacher associations
- Other international agencies, including the UNAIDS Secretariat and the World Bank

Key resources

- UNESCO IBE. 2006. *HIV and AIDS Curriculum Manual*. Geneva: UNESCO IBE.
- UNESCO. 2008. *Good Policy and Practice Series in Education and HIV & AIDS. Booklet 3: HIV & AIDS and Educator Development and Support*. 2nd Edition. Paris: UNESCO.
- UNESCO. 2005. *Reducing HIV/AIDS Vulnerability among Students in the School Setting: A teacher training manual*. Bangkok: UNESCO.
- EI, WHO and EDC. 2004. *Participatory Learning Activities from the EI/WHO Training and Resource Manual on School Health and HIV and AIDS Prevention*. Geneva: WHO.
- James-Traore, T.A. *et al.* 2004. *Teacher Training: Essential for school-based reproductive health and HIV/AIDS education*. Arlington: FHI.

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Creating supportive environments for teachers in the context of HIV and AIDS

What is the issue?

The AIDS epidemic has changed the needs of students and educational personnel. **Schools need to consider the extent to which their workplace environment is a supportive or a stigmatising one:**

- Teachers, like everyone else, are at risk of HIV infection. In some settings, high rates of staff mobility, isolated locations and separation from spouses or partners may increase teacher vulnerability.
- Teachers working in isolation in small or remote schools, and less experienced teachers can benefit from the mentoring and assistance of peer support networks.
- For educational settings to respond to the impact of HIV, it is critical to implement policies that address workplace issues and guarantee the rights of affected and infected teachers and staff.
- Workplace policies often do not make adequate provisions to promote supportive environments for staff who are affected or infected by HIV (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector*).

What needs to be done?

To encourage and enable schools to provide supportive environments, national policy-makers and planners should:

- **support teachers** through the provision of HIV prevention, treatment, care and support;
- **develop and implement policies** that prohibit HIV-related discrimination in schools and protect the rights of all teachers and students;
- **advocate for legislation** that prohibits teacher-student sexual relations and sexual harassment within the workplace;
- carefully **monitor teacher deployment and transfers** and provide extra teaching cover for schools with teachers who are living with HIV or AIDS;
- **implement workplace HIV education and prevention programmes** for all teachers and school staff;
- **create peer networks** for HIV-positive teachers. These can lead to increased acceptance by communities, increased access to services and increased self-esteem.

To develop supportive teacher environments in individual schools and communities, school administrators, teachers' unions, teachers and community leaders can work together to:

- set up **workplace programmes** that provide access to information, voluntary counselling, testing and antiretroviral therapy (ART) and develop peer support systems for infected and affected teachers;
- establish **school and community norms and mechanisms** to protect students and teachers from discrimination or violence;
- ensure **teacher support** from school administration, head teachers and teacher unions;
- promote **understanding, compassion and non-discriminatory attitudes** within the school setting;
- invite **speakers from networks of people living with HIV** to schools to talk about living positively and address stigma and discrimination;
- implement a **hub-school system** to support small schools and teachers working in isolation, and to provide isolated schools with appropriate HIV resources through a rotation system.

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Why does it matter?

- Teachers play a pivotal role in the response to HIV and AIDS. However, as custodians of children, HIV-positive teachers who have disclosed their status may be highly stigmatised by communities, resulting in barriers to accessing services. In turn, these high levels of stigma further decrease the likelihood that teachers who do not know their status test for HIV.
- Education quality suffers through HIV-related illness and death in two ways. First, learning is undermined by the illness and death of HIV-positive teachers who are unable to access treatment and, second, teachers are affected by relatives and friends who have HIV.
- The impact of HIV on educational settings may reduce teachers' ability to provide effective and accurate HIV education because teachers may feel uncomfortable teaching about HIV without policy, school or community support.

Country example: Zambia

The Ministry of Education in Zambia initiated the design of a comprehensive workplace policy and programme in 2003. The programme's aims were to raise employee awareness of HIV and AIDS, prevent HIV infection among the workforce, create a supportive environment for all staff, provide counselling services to infected and affected employees, and communicate information about care and support services available to infected staff and their families. Programme activities have included: 1) promotion of behaviour change using staff as peer teachers; 2) condom distribution; 3) promotion of voluntary counselling and testing; 4) provision of treatment and nutrition advice for infected staff; and 5) strategies to tackle sexual misconduct by teachers.

Key partners

Key partners include:

- Relevant ministries (e.g. education and health)
- Civil society organizations including Education Development Center, Inc. and Education International
- International agencies, including UNESCO, IIEP, and ILO
- UNAIDS Inter-Agency Task Team (IATT) on Education
- Teacher training institutes and academic programmes for future school administrators, education policy-makers and planners
- School governing boards, teachers' unions and parent-teacher associations

Key resources

- UNESCO. 2007. *Supporting the Needs of HIV-positive Teachers in East and Southern Africa*. Technical Consultation Report. Paris: UNESCO
- UNESCO. 2008. *Good Policy and Practice Series in Education and HIV & AIDS. Booklet 3: HIV & AIDS and Educator Development and Support*. 2nd Edition. Paris: UNESCO.
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Psychosocial support for students affected or infected by HIV

What is the issue?

The AIDS epidemic has affected millions of students around the world. Although AIDS increases the poverty and vulnerability of children, **the emotional impact can be just as damaging and is less understood** (see Brief on: *Education for Orphans and Children made vulnerable by HIV and AIDS*).

As a consequence, **the education sector may need to provide specialised psychosocial support to HIV-affected and -infected students**. Psychosocial support is the process of meeting emotional, social, mental and spiritual needs, all of which are considered essential elements of human development.

How countries will be able to provide this support will vary:

- in some countries, such **guidance and counselling services** already exist in schools and the challenge therefore becomes how to sensitise the counsellors to the impact of HIV and AIDS on a child or young person;
- in other circumstances, counsellors might not be available in schools but are part of the wider social services system. In this case, it is possible for **teachers to refer vulnerable children** to these existing services;
- **schools can act as a link between students in need and social services provision**. Teachers may not have the skills to offer counselling to students but they can refer to the relevant professionals and services;
- in many high prevalence countries, there is no functioning social services system to provide psychosocial support. This has led to situations in which teachers are taking on this counselling role themselves. This is problematic because teachers are not trained counsellors and are already over-burdened. Some countries have dealt with this challenge by **training teachers while** other countries have started using **volunteers or para-professionals**.

It is important that psychosocial support be available for all vulnerable children rather than targeting only those children who have been affected by HIV and AIDS. Counsellors may need specific training on HIV but targeted counselling can be stigmatising. In some many circumstances, such targeted counselling may be inappropriate because HIV is often only one of many factors affecting the vulnerability of a child.

Why does it matter?

After home and family, school plays the most significant role in children's social and emotional development and in helping them to develop resilience against the impact of the AIDS epidemic:

- parental illness and death (as well as illness and death in the community) can cause trauma and stress for children, perhaps causing long-term, harmful effects on the individual. These negative impacts undermine the ability of education systems to provide meaningful education for all;
- as children become orphaned because of AIDS, many schools will need to respond to the changing needs and profiles of the students. Schools will need to take on responsibility for ensuring children's well-being which extends beyond traditional learning;
- educators play an important role in identifying children and young people suffering from neglect or physical or sexual abuse, and need guidance in dealing with such cases;
- infected or affected students gain considerable psychological benefits from peer support, counselling, self-help groups or clubs;
- students who have HIV may get sick frequently or have less energy and need special support without being overprotected;
- educators can reduce stigma and discrimination by showing that they care, taking a positive attitude to infected and affected students, and enabling them to build on their own strengths and skills rather than viewing them as passive victims.

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What needs to be done?

Schools often operate on small budgets and are unable to meet the combined educational, physical and psychosocial needs of their students. Ministries of education will need to decide what approach is most appropriate. Approaches include:

- the training of existing school counsellors to understand the effects of HIV on students;
- the training of teachers to provide a rudimentary level of counselling and skills to spot vulnerable children;
- providing teachers with a directory of available counsellors so that they can refer students in need;
- linking with the Department of Social Welfare to increase the availability of social workers and counsellors in and out of school.

To facilitate the integration of psychosocial support into learning environments, ministries should:

- **devise ways to provide psychosocial support to students** which build upon existing social service provision within schools;
- **advocate for HIV and AIDS training** to be incorporated into teacher training institute curricula and in-service teacher training initiatives so that all teachers can understand how the epidemic is affecting students;
- **promote partnerships with other ministries, NGOs, faith-based organizations and communities** to ensure that children have access to social welfare and health services, good nutrition and psychosocial support.

To mitigate the negative impact that HIV has on students and ensure that their psychosocial needs are met, schools and learning centres should:

- **develop child-friendly schools to promote understanding, compassion and non-discriminatory attitudes** within the school setting;
- **sensitise teachers to recognise children and young people who need help, and train educators in counselling** or employ school counsellors or guidance officers;
- **provide care and counselling to students caring for ill family members or suffering from grief and loss** by developing partnerships with local service providers as well as referral networks and protocols;
- **encourage development of peer support systems for students** so they may support and counsel one another;
- **strengthen school-community links** to bridge the gap between what is taught in school and in the community by involving parents, guardians and care-givers in psychosocial support training and provision (see Brief on: *Strengthening School and Community Linkages*);
- **create safe spaces for students** to talk to teachers, do homework and access peer support;
- **establish protocols and support systems to enable students to catch up with school work** after long absences, and create alternative learning situations for infected and affected students who cannot participate in normal schooling for whatever reason.

Regional example: Southern Africa

Between 2003 and 2005, a programme entitled Circles of Support was piloted in 36 schools across Botswana, Namibia and Swaziland. Children are at the centre of this model, and fundamental to the approach of circles of support is that, without the collaboration of local communities, the school can never deliver the range of activities that are needed in the life of a vulnerable child.

The first circle of support around a child is a network of individuals in the child's immediate environment – family, friends and neighbours. The second circle of support is the school and its staff, other members of the local community, and local professionals such as a nurse or counsellor; the third circle of support consists of the provincial and national social sector policy framework. Teachers, parents and community members are trained to identify vulnerable children and then to refer them to social workers or counsellors for additional support.

Key partners

Under the UNAIDS division of labour, UNESCO is the lead organization for prevention for young people in education institutions with UNFPA, UNICEF, WHO and ILO as main partners. Key partners also include:

- Relevant ministries (e.g. education and health)
- Civil society organizations including Education Development Center, Inc. and Education International
- Teacher training institutes, school governing boards, teachers' unions, and parent-teacher associations
- Local NGOs, CBOs and FBOs with the capacity to provide psychosocial support to young people

Key resources

- UNESCO. 2008. *School-centred HIV and AIDS Care and Support in Southern Africa*. Technical Consultation Report. Paris: UNESCO.
- UNESCO. 2008. *Good Policy and Practice Series in Education and HIV & AIDS. Booklet 2: HIV & AIDS and Safe, Secure and Supportive Learning Environments*. 2nd Edition. Paris: UNESCO.
- UNESCO. 2004. *Coping Skills: A facilitator's manual*. Harare: UNESCO.
- Kidd, R. and Clay, S. 2003. *Understanding and Challenging HIV Stigma: Toolkit for action*. The Change Project. Washington: ICRW.
- The Life Skills Development Foundation. 2004-05. *Child-friendly Community Schools Approach for Promoting Health, Psychosocial Development and Resilience in Children and Youth Affected by HIV/AIDS*. Chiangmai: TLSDF.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

Strengthening school and community linkages

What is the issue?

Schools need to respond to the HIV-related needs of their students, teachers and communities – both as part of efforts towards universal access and also as a necessary part of achieving Education for All (EFA).

Building strong links between schools and communities helps the HIV and AIDS response because:

- many children have been made vulnerable because of HIV and AIDS. Strong links between schools and communities will contribute to a **more comprehensive response for children in need**;
- involving parents and community members in the design and implementation of curricula on HIV and AIDS will **ensure it is culturally acceptable** (see Brief on: *Providing Culturally Sensitive Education on HIV and AIDS*);
- **school councils or parent-teacher associations** are the link between community and school and can become an important resource in supporting HIV and AIDS education;
- schools can be used as **centres for community learning and resources**, providing trustworthy education on HIV or acting as a referral mechanism to existing support services;
- many children and young people are not participating in school yet still need to access HIV and AIDS education. **Schools with strong community links have the potential to provide outreach services**.

Why does it matter?

Schools are well suited to supporting communities in their HIV and AIDS response because:

- schools have the existing infrastructure to reach a large number of individuals in the community with HIV and AIDS education (e.g. school councils, school management committees, parent-teacher associations);
- schools can act as a bridge between communities and social services. For example, schools can act as a site for government services such as the provision of social grants, food ration distribution or antiretroviral therapy (ART);
- schools are highly accessible even in remote areas and provide long-term and sustainable opportunities to develop community-based programmes;
- in areas highly affected by HIV and AIDS, schools need to adapt to the additional needs of affected children, including their psychosocial needs (see Brief on: *Psychosocial support for students affected or infected by HIV*).

Country example: South Africa

In KwaZulu-Natal, South Africa, the Media in Education Trust has been involved in reducing the negative impacts of poverty and HIV & AIDS on clusters of rural school communities. The aim is to empower schools and community structures to effectively care for orphans and vulnerable children while reducing their vulnerability to HIV.

Each school develops a vision of itself as a centre of care and support and then supports a health committee consisting of parents, teachers, community members, out-of-school youth and a few student representatives. The committee conducts an audit of vulnerable children in the school and communities as well as an audit of services available in the community. An outreach programme is then implemented which:

- assists children and families to access social grants;
- conducts home-based visits and organises care for children whose parents are too sick to care for them or who have died;
- runs after-school clubs to help children with homework, provides recreational activities and adult supervision.

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What needs to be done?

Schools can support communities in the response to HIV and AIDS by:

- **ensuring the continuation of education:** this is the overarching objective of the education system. In the context of high HIV prevalence rates, this is increasingly difficult because HIV compounds the difficulties which communities were already experiencing;
- **providing psychosocial support:** in addition to strategies to ensure that all children stay at school, it is necessary to provide or ensure links to psychosocial support to HIV-affected children;
- **treatment education:** with the increase in access to treatment, a growing number of teachers and students who are HIV-positive are taking treatment. Schools, therefore, might need to respond to a number of related issues such as supporting HIV positive students and teachers to understand what ART is, how to access and take treatment, visit medical centres for frequent check-ups (and provide cover for absent teachers) and support students (in particular young students) to follow their treatment regimens (see Brief on: *HIV and AIDS Treatment Education*);
- **home-based care and education:** teachers and students can provide outreach work to support community members who may be ill. This support can be categorised as students supporting ill community members or teachers providing home-based education to sick students;
- **responding to basic needs:** many communities are dealing with the combined effects of HIV, poverty and hunger. In some contexts, schools can become important providers of basic needs by providing school feeding programmes or, for example, by creating vegetable gardens. Schools may also, in partnership with community leaders, mobilise their communities to collect and provide other basic needs such as school uniforms or pens.
- **developing livelihood skills:** schools can play an important role in providing livelihood programmes to improve children's agricultural and livelihood skills for livelihood support and food security.

In order to strengthen school-community links in the education sector response to HIV and AIDS, it is important to build upon the following principles:

1) **Involve communities:** HIV and AIDS are everybody's problem and no one can deal with the crisis alone. A large number of resources exist in the community which can be harnessed to support the school and vice versa.
2) **Schools as centres for integrated service delivery:** schools will not be able to deliver all the HIV support services that a community might need; however, schools can take on varying roles depending upon the kinds of other services already available in a community, resources at hand, and the level of capacity and support from within and outside the school.
3) **Build on existing services:** it is important that the care and support system links in with any pre-existing community support structures to avoid reinventing the wheel or competition between programmes, and to encourage community ownership.
4) **Child-centred programming:** children need to be at the centre of any school-based programme. The views of children and young people need to be included from the programme inception stage and it is crucial to keep children at the centre of the response.

Key partners

- Relevant ministries (e.g. education, health, social welfare, and youth)
- National AIDS Commission
- Civil society organizations, including CARE, the International Federation of the Red Cross and Red Crescent societies, Save the Children and others providing education, food and shelter for vulnerable youth
- International agencies, including the International Planned Parenthood Federation (IPPF) and its member associations
- UN agencies including UNESCO, UNICEF, UNFPA, WFP and the World Bank
- School governing boards and parent-teacher associations

Key resources

- UNESCO. 2008. *School-centred HIV and AIDS Care and Support in Southern Africa*. Technical Consultation Report. Paris: UNESCO.
- UNAIDS IATT on Education. 2006. *HIV and AIDS Treatment Education: A critical component of efforts to ensure universal access to prevention, treatment and care*. Paris: UNESCO.
- UNICEF. 2004. *Framework for Protection, Care and Support of OVC. Living in a World with AIDS*. New York: UNICEF.
- WFP. 2004. *Getting Started: HIV Education in School Feeding Programs*. Rome: WFP.
- Media in Education Trust (MIET). 2006. *Schools as Centres of Care and Support*. Durban: MIET.
- University of KwaZulu Natal, HEARD/Mobile Task Team on Education. 2005. *Education Access and Retention for Educationally Marginalized Children: Innovations in social protection*. Durban: MTT.

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HIV and AIDS workplace policies for the education sector

What is the issue?

Workplace policies which address HIV and AIDS are important to:

- **ensure a supportive and non-discriminatory working environment**;
- **provide vital information** on HIV and AIDS to employees and employers;
- **support social dialogue** processes in planning and implementing the policies at the workplace.

In the education sector, HIV and AIDS workplace policies will address the needs and impact of HIV and AIDS on teachers and other educational staff from the school to the Ministry of Education. New HIV- and AIDS-specific policies in the workplace can be developed or existing general workplace policies can be adapted to include issues around HIV and AIDS.

Why does it matter?

It is important to develop a workplace policy on HIV and AIDS in the education sector because:

- Education sector employees remain a vulnerable category of a nation's workforce in many countries;
- Some human resource policies and the nature of work for teachers can create situations that increase vulnerability to HIV, such as the deployment and transfer of teachers to remote areas (see Brief on: *Creating Supportive Environments for Teachers in the Context of HIV and AIDS*);
- In highly affected countries, the AIDS epidemic is weakening governments' capacity to plan and deliver ongoing basic educational and social services. Workplace policies can provide a framework to mitigate the impact of HIV and AIDS on the workforce and minimise the long-term impact on the delivery of quality education;
- Comprehensive workplace policies are needed to protect all staff from HIV-related stigma and discrimination (see Brief on: *Addressing HIV-related Stigma and Discrimination*).

Regional example

ILO initiated a programme to develop a sectoral approach to HIV and AIDS education sector workplaces (2004), as a complement to the ILO Code of Practice on HIV/AIDS in the world of work (adopted in 2001). UNESCO joined the ILO in a collaboration (2005 to present) aimed at the development of an HIV and AIDS workplace policy and related resource materials for use by education staff and stakeholders at national and institutional levels.

This initiative has now been implemented at the regional level - the Caribbean and in Southern Africa - each resulting in:

- a workplace policy on HIV and AIDS for the education sector adapted and specific to each region;
- implementation guidelines; and
- action plans/strategy outlines for each country participating in the development of the regional policy.

Following the regional policy formulation for Southern Africa, workplace policies for the education sector are currently being operationalised at the school level in Zambia and Mozambique (September 2007 to May 2008), and the Namibian Ministry of Education is in the process of developing a country-specific policy and an implementation plan (June 2007 to present).

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What needs to be done?

All policies must ensure, amongst other issues, continued support to staff infected or affected by HIV and provide a framework for ensuring a caring and supportive environment for HIV-positive learners.

Moreover, all policies must be developed in partnership with all key stakeholders – teachers' unions, networks of people living with HIV, civil society and community-based organizations.

Ministries of education should consider the following components in a workplace policy:

- **guiding principles**: including the recognition of HIV as an issue affecting the education workplace; non-discrimination and reduction of stigma; gender equality; confidentiality; social dialogue and the continuation of the employment relationship based on the *ILO Code of Practice on HIV/AIDS and the World of Work*;
- **rights and responsibilities** of teachers and other staff, students, parents and other education stakeholders. This might include a commitment to non-violence, a code of conduct for staff and zero tolerance for HIV-related stigma and discrimination;
- **employee-student relationships**: includes a code of conduct prohibiting sexual relationships between education personnel and students, with clear guidance on disciplinary action;
- **prevention, treatment, care and support**: including information on available prevention, treatment, care and support services;
- **testing, confidentiality and disclosure**;
- **employment**: including recruitment, job security and provisions related to benefits and assistance programmes, in particular for teachers and non-teaching staff living with HIV;
- **disciplinary procedures and grievance resolution**: for dealing with breaches of the policy, including stigma, discrimination or refusal to work or study with a person with HIV, violation of confidentiality, and employees who engage in sexual relationships with students in breach of the code of conduct.

Implementing workplace policies

A workplace policy is limited in scope unless prioritised, implemented and enforced in schools nationally. To support implementation, it is important to:

- train education leaders (e.g. head teachers) on the content of a policy and on how to implement workplace policies in the school-setting. Internal advocacy is needed to ensure leadership in implementing workplace policies (see Brief on: *Creating Supportive Environments for Teachers in the Context of HIV and AIDS*);
- complement the development of workplace policies with financial resources to ensure significant implementation;
- build the capacity of human resource departments to play a key role in ensuring that educational institutions uphold workplace policies;
- establish joint committees or structures including the Ministry of Labour, teachers' unions, HIV-positive teachers' networks (where existing) and private education authorities at national and workplace level – to discuss the development of policies, to plan for implementation and finally, to operationalise policies at the school level;
- ensure that grievance mechanisms are functioning and that any grievances are processed in strictest confidence without fear of discrimination or punishment. This will help teachers and students to feel confident and comfortable with using the workplace policy, thus increasing its utility;
- strengthen collaboration and consultation with teachers' unions in order to increase the potential of the policy reaching a large number of teachers.

Key resources

- EI/WHO/EDC. 2004. *Participatory Learning Activities from the EI/WHO Training and Resource Manual on School Health and HIV and AIDS Prevention*. Geneva: WHO.
- ILO/UNESCO. 2006. *A Workplace Policy on HIV and AIDS for Educational Institutions in the Caribbean Region*:
- ILO/UNESCO. 2006. *A Workplace Policy on HIV and AIDS for the Education Sector in the Southern African Region*. Paris: UNESCO.
- ILO. 2002. *Implementing the ILO Code of Practice on HIV/AIDS and the World of Work: An education and training manual*. Geneva: ILO.
- UNESCO. 2007. *Supporting HIV Positive Teachers in East and Southern Africa*. Technical Consultation Report. Paris: UNESCO.
- Ministry of Education, Republic of Zambia. 2003. *HIV/AIDS Guidelines for Educators*. Zambia: Ministry of Education.

Key partners

Under the UNAIDS division of labour, ILO is the lead organization for HIV and AIDS workplace policies and programmes, with UNESCO and UNDP as main partners. Key partners also include:

- Teachers' and education workers' organizations (associations or unions), and in particular networks or groups of HIV-positive teachers
- Relevant ministries (education, health, labour, and social and community affairs)
- District level education and local government officials
- Teachers/trainers, principals, and education support staff in schools and training institutions
- Parent-teacher associations and student associations

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Situation analysis and effective education sector responses to HIV and AIDS

What is the issue?

A situation analysis is an essential step in programme development in order to ensure that the programmes and policies of the education sector respond to the needs and realities of those they are trying to reach, namely teachers and learners. It can also help avoid duplication and reveal opportunities for partnership and collaboration.

A situation analysis is similar to a needs assessment because it is **an information gathering and analysis process**. However, a needs assessment tends to focus on investigating why a specific problem or issue exists, while a situation analysis is broader in scope and also looks at existing strengths and capacities and current action in order to identify weaknesses and suggest promising and feasible solutions.

A situation analysis should inform the development, implementation and review of an education sector HIV and AIDS strategy and a costed workplan. Unfortunately, in many cases, programmes are developed without allocating adequate time and resources to assess the current situation. **Bypassing the preparation of a situation analysis runs the risk of weak programmes, inappropriate intervention strategies and inefficient use of resources.**

Why does it matter?

A situation analysis is critical for planning comprehensive education sector responses to HIV and AIDS because it helps to:

- clarify the issues that need to be addressed;
- identify causal factors;
- pinpoint policy, programmatic and information gaps;
- identify existing strengths and capacities as well as potential interventions and partners;
- avoid duplication and builds on existing efforts.

The results of a situation analysis help to inform and guide policy development and to prioritise programmatic strategies in order to:

- inform policy and planning;
- ensure better use of resources by avoiding programme duplication and identif ypotential synergies between programmes;
- provide a mechanism for building community participation and support from the outset;
- help guide the development of monitoring and evaluation activities;
- act as a tool for mobilising support and resources.

Country example: Jamaica

The UNESCO Office for the Caribbean funded a situation analysis to support capacity-building for effective and comprehensive responses to HIV and AIDS of the education sector in Jamaica. The education sector response was analysed in terms of its actions in four key areas:

1) policy, strategic planning and institutional capacity;

2) HIV prevention;

3) impact mitigation; and

4) leadership.

The status of Jamaica's current and future education sector response was assessed, highlighting strengths and identifying areas for further investment. The methods involved included a review of documents, stakeholder interviews and field visits throughout Jamaica. Following the situation analysis, recommendations were made as to how to improve the HIV and AIDS response and which strategies should be discontinued.

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What needs to be done?

There is no single way to conduct a situation analysis. A situation analysis can be done on a small or large scale and may take different forms depending on the goals and objectives and the resources available.

The aim of a situation analysis is to describe what is happening at one particular point in time. The core activity of a situation analysis is to gather and analyse data. The data collected will depend on the goals of the situation analysis. However, in most cases it is ideal to **collect data from a variety of sources and stakeholders utilising different methodologies**, including qualitative and quantitative approaches. Data collection methods may include, but are not limited to, a review of relevant published and unpublished literature, behavioural surveillance, surveys, individual interviews, focus group discussions, stakeholder analysis and resource mapping. Many tools exist to assist users in these methodologies.

It is important to review the available information, identify knowledge gaps and select appropriate strategies to obtain the desired information.

The following are among the possible questions to be answered through a situation analysis of the education sector response to HIV and AIDS:

- Are there systems in place to provide information about the supply and demand of teachers, the quality of the education on HIV and AIDS, the number of children in and out of school and the number of orphans and vulnerable children?
- What is the current state of HIV- and AIDS-related knowledge, attitudes and behaviours of young people and school staff?
- Is there a dedicated committee or management unit that is responsible for coordinating the response to the HIV and AIDS in the education sector?
- Is there an education sector HIV and AIDS strategic plan?
- How does the education sector HIV and AIDS strategic plan link to the overall national AIDS strategy?
- How are teachers trained to deliver HIV and AIDS education?
- Is HIV and AIDS education compulsory, and what is the content of the curriculum?

When undertaking a situation analysis, it is useful to:

- **establish a planning group** to guide the situation analysis process. Ensure representation and active engagement from key stakeholders, including the target group(s) themselves;
- **develop a plan and timeline** with clear goals and objectives. The plan and corresponding timeline should articulate the goal of the situation analysis, the anticipated use of the results, the type of data that will be collected, what methodology will be used to gather the needed information and who will collect it;
- **use a holistic framework for analysing issues.** Consider not only the behavioural factors impacting the issue, but also the environmental conditions in order to ensure that the findings capture a holistic representation of the current situation;
- **disseminate the findings** from the situation analysis once it is complete. Share the results with stakeholders and decision-makers, as well as the communities where the data was collected. Be creative. Tailor communication products to the needs and interests of different audiences. Utilise varying formats including reports, briefs, presentations and community meetings;
- **apply the results to policy planning and programmatic decisions**. A situation analysis is only useful if the results are used to inform action. Link findings to planning and utilize the results as a tool for mobilising resources;
- **update regularly**. Situations are constantly changing and thus situation analysis activities should be repeated in order to remain relevant.

Key resources

- UNAIDS Inter Agency Task Team (IATT) on Education. 2006. *2004 Education Sector Global HIV/AIDS Readiness Survey*. Paris: UNESCO.
- UNAIDS/World Bank. 2007. *Country Harmonization and Alignment Tool* (CHAT). Geneva: UNAIDS.
- UNESCO IIEP and ESART. 2007. *Module 3.1. Education Planning and Management in a World with HIV and AIDS. Analyzing the Impact of HIV/AIDS in the Education Sector*. Training Series. Paris: UNESCO IIEP.
- UNESCO. 2008. *Good Policy and Practice Series in Education and HIV & AIDS. Booklet 5: Partnerships in Practice*. Paris: UNESCO.
- UNESCO Kingston. 2005. *The Response of the Education Sector in Jamaica to HIV and AIDS: Final Report*. Kingston: UNESCO.
- Chalmers, H., *et al.* 2006. *Dynamic Contextual Analysis: A context-specific approach to understanding barriers to, and opportunities for change. 2nd Edition*. London: University of London and University of Southampton.
- Daileader Ruland, C. and Finger, W. (eds). 2006. *Engaging Communities in Youth Reproductive Health and HIV Projects: a guide to participatory assessments*. Arlington: FHI.
- Williamson, J., Cox, A. and Johnston, B. 2004. *Conducting a Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS*. Washington, DC: USAID.

Key partners

- Relevant ministries (e.g. education, health, youth)
- Universities and research institutes
- International agencies including UNESCO, UNICEF, UNFPA and WHO
- Community-based organizations such as youth groups and associations of people living with HIV and AIDS
- Donors
- Private sector

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Projection models for HIV and AIDS in the education sector

What is the issue?

Projection models are an integral part of any educational planning system and allow ministries of education to estimate the demand and supply for education and plan for meeting identified shortfalls.

Projection models are based on past trends and present what might happen given different scenarios. Most education projection models cover a period of 15 to 20 years. Projecting likely scenarios for the future depends on factors affecting the demand side of education such as the demographics of the school-age population, enrolment rates and progression rates as well as factors affecting the supply side of education such as levels of teacher attrition.

HIV and AIDS have produced new demands on education systems and can create a loss in the numbers of both educators and learners (see Brief on: *Addressing Human Capacity in Education in the Context of HIV and AIDS*). Existing educational projection models need to be adapted to take HIV and AIDS into account, and additional tools should be developed for different stages of policy development: analysis, planning, policy-making, management, monitoring and evaluation.

The challenge is how to incorporate the impact of HIV and AIDS into educational projection models. Difficulties exist because:

- in many places, data on HIV prevalence among the general population are limited;
- the impact of HIV and AIDS will depend on the level of access to HIV prevention services, counselling, testing and affordable treatment;
- countries are already over-burdened with numerous data collection requirements;
- it is difficult to measure the impact of HIV and AIDS on education systems because most people hide their HIV status due to stigma and discrimination.

Why does it matter?

Projection models need to be adapted to include HIV-related indicators because:

- in high prevalence countries, **HIV and AIDS will significantly affect both the demand and supply of education**. Education planners need to factor in potential changes in order to meet any shortfalls;
- projection models are the key tools available to **assess the probable impact of HIV and AIDS in the future**. These models can also be used to assess the impact of education on HIV prevention;
- strategic planning requires good data which reflect changing conditions. Projection models **provide alternative scenarios** which can take account of the different stages of the epidemic;
- projection models can be used for **"what-if analysis"**: evaluating what will occur if a proposed policy change were (or were not) implemented. By experimenting with a model, it is possible to assess the effects of action or inaction, individually or for groups, before decisions are taken;
- projections showing the negative impact of HIV and AIDS are an important **advocacy tool to negotiate for resources and to prioritise** a comprehensive education sector response to HIV and AIDS.

Key partners

- Ministries of education, health, and finance
- Decentralised bodies with responsibility for education and health
- National Statistics Institutes, National Population Bureaux, National Census Bureaux (if not in the National Statistics Institute)
- National AIDS Commission
- UNAIDS, including UNESCO IIEP and the World Bank

Key resources

- UNESCO. 2005. *Education For All 2006 Global Monitoring Report, Box 3.6.*
- World Bank and Partnership for Child Development. 2006. *Modelling the Impact of HIV/AIDS on Education Systems: How to use the Ed-SIDA model for education-HIV/AIDS forecasting*. 2nd Edition. Washington: World Bank.
- Boler, T. 2004. *Approaches to Examining the Impact of HIV/AIDS on Teachers*. London: UK Working Group on Education and HIV/AIDS.
- Channing, A. 2002. *HIV/AIDS and Macroeconomic Prospects for Mozambique: An initial assessment*. West Lafayette, Ind., Purdue University Press.
- P. Dias Da Graça. 2005. *Projecting Education Supply and Demand in an HIV/AIDS Context*. In: *Educational Planning and Management in a World with AIDS*. Paris: UNESCO IIEP.

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What needs to be done?

To make projections, a model of how the education system works is needed. The model allows planners to review how a system will unfold over time and should:

- **provide a situation analysis**, including the impacts of the epidemic on the education sector (see Brief on: *Situation Analysis and Effective Education Sector Responses to HIV and AIDS*);
- **define human, material and financial resource requirements**;
- **draw conclusions** about targets;
- **lead to an action plan and time frame**, including a monitoring and evaluation process (see Brief on: *Monitoring and Evaluation of HIV and AIDS Education Responses*).

In order to adapt projection models to include HIV-related indicators, estimates on the following factors need to be included:

- levels of HIV-related illness among teachers;
- levels of HIV-related death among teachers;
- availability of prevention, treatment, care and support;
- changes in recruitment and retention of teachers and other personnel because of HIV and AIDS;
- number of children affected and infected by HIV and AIDS;
- changes in enrolment rates as a result of HIV and AIDS;
- increased need for support services such as school fee exemptions or school counsellors.

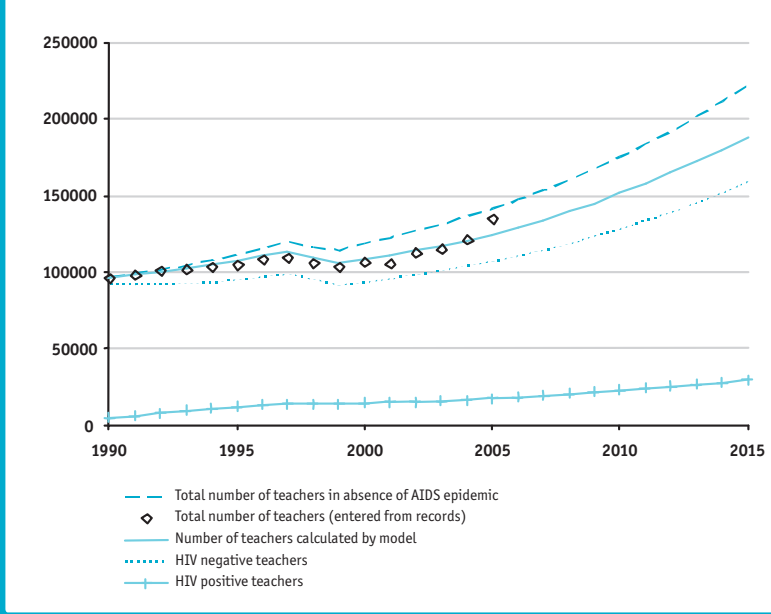
In addition:

- data need to be relevant, accurate and timely;
- new data requirements should be kept as simple as possible and should be linked to ongoing processes and entities, such as national AIDS plans and EFA monitoring mechanisms;
- Education Management Information Systems (EMIS) need to be strengthened, especially at the local level;
- projection models should be frequently validated and revised with epidemiological, demographic and risk behaviour data;
- models need to build in different scenarios depending on availability of antiretroviral therapy and the changing epidemiology of the epidemic;
- factors such as sex, age group and geographical location are vital to include in all models.

Country example: Tanzania

Ed-SIDA is an Excel©-based spreadsheet programme which has proven to be beneficial for the dual purposes of advocacy and educational planning in the face of HIV and AIDS. The model was developed by the Partnership for Child Development and has been applied in fifteen sub-Saharan African countries. Furthermore, Ed-SIDA is currently being implemented in the Caribbean and South-East Asia. The modelling process works by inputting data on teacher numbers, teacher training, recruitment and school-age population projections. The model then outputs variables such as teacher attrition rates due to AIDS mortality, teacher absenteeism due to AIDS illness, impacts on pupil-teacher ratios and necessary changes in annual teacher recruitment levels to account for losses arising from AIDS. Financial analyses performed with the aid of Ed-SIDA allow for the projection of the cost of HIV and AIDS to education systems as well as necessary investments to mitigate the impacts.

Impact of HIV on teachers in mainland Tanzania



Ed-SIDA was presented to the Tanzanian Ministry of Education and Vocational Training (MoEVT) as part of a workshop series in 2006. As a result of the workshop, the MoEVT requested Ed-SIDA training for a number of Tanzanian educational planners in 2007. Educational planners were successfully trained in all aspects of using Ed-SIDA and are now able to generate the statistics used for educational planning. The figure above shows how the model was used to estimate the impact of HIV and AIDS on teacher supply.

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Addressing human capacity in education in the context of HIV and AIDS

What is the issue?

Ensuring adequate human capacity in the education sector is central to the delivery of sustainable quality education. The AIDS epidemic **is weakening the sector's capacity to provide essential services and to support its members, particularly in high-prevalence countries.** HIV-related absenteeism, disease and death among key staff, including educational policy-makers, administrators and teachers, are straining institutional capacity to train replacements and are making the finding of new recruits more difficult. In addition, high turnover is progressively undermining the education sector's planning, management and administrative capacity as well as increasing the costs of maintaining education services.

In consequence, **planning to deal with the effects of HIV on the demand, supply and quality of human resources is a key task in all countries.** The impact of HIV must be considered and addressed at every stage of the recruitment, training, retention and retirement process, and as part of the operational management of the sector. These effects often differ for primary, secondary and tertiary levels.

Why does it matter?

Gains in education made over the last decades in many developing countries are likely to be eroded by HIV and AIDS. In some countries, a tenfold increase in teacher mortality and absenteeism due to HIV and AIDS has severely reduced both teaching time and quality. Permanent or temporary absenteeism of one teacher has strong repercussions on many scores of children.

Teachers and other key educational personnel are not easily replaced. For example, in South Africa and Zambia, the entire annual output of teacher training colleges will not be enough to make up for those lost to HIV and AIDS each year. When teachers are lost, schools fail and whole communities suffer. When ministries lose key staff, there are consequences for the entire education system. Loss of educated and skilled individuals also reduces the transfer of knowledge (both formal and informal), skills and on-the-job training.

Damage to the education system tends to reduce demand for education, thus **increasing the vulnerability of young people.** Out-of-school young people are less likely to have access to the information and education they need to adopt risk-reductive behaviours, while being out of school itself increases vulnerability to HIV and AIDS (see Brief on: *HIV and AIDS Education for Out-of-School Young People*).

What needs to be done?

To cope effectively with HIV and AIDS, the **education sector** has to establish and implement:

1. **HIV and AIDS impact assessments:** Educational Management Information Systems (EMIS), demand and supply analyses, and other decision-support systems can support educational planning in the context of HIV and AIDS.
2. **A rapid response** to:
   - → **stabilise the sector's existing capacity in the short-term** by promoting access to treatment and care;
   - → **introduce measures to replace losses** through the recruitment of retired professionals and the training and support of paraprofessionals.
3. **A long-term strategic response** to:
   - → **prolong the life and health of education personnel** by promoting access to treatment and care, and addressing stigma and discrimination related to HIV and AIDS;
   - → **integrate the impact of the epidemic** into government planning, budgeting and monitoring tools and activities;
   - → **improve the quality and performance of the education sector**, including through the use of innovative means of education management and delivery, such as new information and communication technologies.

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What works?

Action to develop and retain human capacity involves cross-sectoral work to:

- **strengthen personnel, EMIS, and other decision-support systems** to assess the actual and projected impact of HIV-related morbidity, mortality, absenteeism and attrition, and the capacity of ministry of education staff **to use these data for planning purposes**;
- **review and amend human resource and workplace policies** to minimise sector vulnerability and susceptibility to HIV (see Brief on: *HIV and AIDS Workplace Policies for the Education Sector);*
- **expand access to prevention, treatment and care services for education sector personnel** and establish the necessary safeguards of confidentiality, non-discrimination and non-stigmatisation of people affected by HIV and AIDS;
- **build capacity of education managers and professionals** in management, analysis, training and workplace issues related to HIV and AIDS, including responsive institutional systems, and ways to secure additional internal and external resources;
- **effectively integrate HIV and AIDS** information and issues **into national planning**, not only for education, but also for other sectors that affect education.

Key partners

Under the UNAIDS division of labour, the World Bank is the lead organization for supporting human resources, capacity and impact alleviation, with ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF and WHO as main partners. Key partners also include:

- Relevant ministries (e.g. education, finance, planning and development, health and social welfare)
- Civil society organizations, including Education Development Center, Inc. and Education International
- Other international agencies
- Teachers' unions
- School governing boards

Country example: Malawi

A study supported by UNDP found that the Ministry of Education, Science and Technology in Malawi was operating with very high levels of staff vacancies – 52 percent among primary teachers and 77 percent among secondary teachers – due to AIDS and outward migration. Recommendations included:

- setting up mechanisms to cope with immediate shortages in human resources and to respond to longer-term needs;
- developing a comprehensive incentive package to cater for staff whose skills are difficult to replace;
- exploring the possibility of utilizing United Nations Volunteers (UNVs) for short-term replacement of critical capacities;
- developing critical skills by increasing the Government's scholarship fund.

Source: Government of Malawi. UNDP. 2002. *Impact of HIV/AIDS on Human Resources in the Malawi Public Sector*. New York: UNDP.

Key resources

- UNDP. 2004. *Supporting National HIV/AIDS Responses: An Implementation Approach.* New York: UNDP.
- UNDP. 2004. Southern Africa Capacity Initiative (SACI).
- UNESCO. 2006. *The Impact of HIV & AIDS on Education: Regional and country education sector impact assessment studies: A matrix of documents*. Paris: UNESCO IIEP.
- World Bank, Partnership for Child Development. Second edition. 2006. *Modeling the Impact of HIV/AIDS on Education Systems: How to use the Ed-SIDA model for education-HIV/AIDS forecasting.* 2nd Edition. Washington, DC: World Bank.
- FHI. 2001. *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic*. Arlington: FHI.
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Coordination and strategic partnerships in HIV and AIDS education

What is the issue?

HIV and AIDS are a cross-cutting issue impacting all levels of society. It is clear that **no single sector is capable by itself of delivering the type and level of response necessary to deal with HIV and AIDS**, and **that a multisectoral response is needed**, in which the education sector works in partnership with other relevant sectors (e.g. labour, health). Experience shows that national responses are more effective when relevant sectors work together through strategic partnerships in a coordinated way.

Strong coordination necessitates strong partnership. However, coordinating activities and developing strategic partnerships can be challenging because:

- there is a broad range of actors and partners in the field – ministries and government sectors, civil society organizations, including non-governmental organizations, the private sector, faith-based organizations, as well as bilateral and multilateral agencies;
- working with different sectors can be challenging as most government sectors may be used to working in isolation;
- the flow of resources is increasing, and with it too, the diversity of funding sources and the requirements for reporting and monitoring;
- approaches to the HIV response differ according to technical considerations and different religious and ideological viewpoints. Disagreements (for example, on the role of condom promotion) can undermine partnerships and coordination, and more worryingly, result in inconsistent messages to young people.

Why does it matter?

To ensure the best use of resources in support of national needs and priorities on HIV and AIDS, governments and donors now advocate for the 'Three Ones':

- ***One agreed HIV and AIDS Action Framework*** *to provide the basis for coordinating the work of all partners*
- ***One National AIDS Coordinating Authority*** *with a broad-based, multisectoral mandate*
- ***One agreed country-level Monitoring and Evaluation System.***

Strategic partnership and coordination are the fundamental principles underlying The Three Ones.

Strategic partnerships and coordination are also necessary in order to:

- ensure the most effective and efficient use of available financial and technical resources and to pool experience and expertise;
- avoid duplication of effort and to learn from past experiences;
- prevent a piecemeal response with uneven coverage of service provision and inconsistent messages being promoted;
- engage different partners in the education sector response to HIV and AIDS through increased dialogue, consultation and collaboration;
- foster collective efforts, joint responsibility and mutual trust.

Key resources

- UNAIDS IATT on Education. 2008. *Improving the Education Sector Response to HIV and AIDS, Lessons of Partner Efforts in Coordination, Harmonisation, Alignment, Information Sharing and Monitoring*. Paris: UNESCO.
- UNAIDS. 2005. *The Three Ones in Action: Where we are and where we go from here*. Geneva: UNAIDS.
- UNAIDS. 2005. *Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors: Final report*. Geneva: UNAIDS.
- UNDP. 2006. *UNDP and Civil Society organizations: A toolkit for strengthening partnerships*. New York: UNDP.
- UNESCO. 2008. *Good Policy and Practice Series in Education and HIV & AIDS. Booklet 4: Strategic Partnerships in HIV & AIDS and Education*. Paris: UNESCO.
- United Nations. 2006. *Delivering as One. Report of the Secretary General's High Level Panel*. New York: United Nations.
- International HIV/AIDS Alliance. 2002. *Pathways to Partnerships*. Brighton: International HIV/AIDS Alliance.
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What needs to be done?

At the national level:

There is no universal model for coordination and partnership: institutional linkages must be adapted to the national context and to the particular needs of the country. Nevertheless, experience shows that there usually are broad similarities in the way HIV and AIDS management and coordination structures are established:

- **A Statement of Intent** is signed by the government and key stakeholders.
- **A Memorandum of Understanding** outlining agreements on divisions of labour between the government, funding organizations and technical agencies participating in defining sectoral strategies is endorsed.
- **Partnership Principles** outlining issues related to means of cooperating and information-sharing between partners are adopted.
- **A Lead Authority** (agreed with the government) is appointed to coordinate all stakeholders and to act as a mediator with the government.
- **Forums** for formal consultation between partners are created. These are usually led by the government within a sector-management structure and range from technical working groups to high level decision-making bodies.
- **Sector Reviews** are carried out, usually annually or twice a year, for monitoring, evaluation and accountability.

In the education sector:

The Ministry of Education has the ultimate responsibility to plan, implement and monitor the education sector response to HIV and AIDS. A common mechanism for forming strategic partnerships and to increase coordination is to set up a working group on HIV & AIDS and education, which works closely with the national AIDS coordinating body.

This working group will benefit strongly from broad-based representation such as relevant NGOs and bilateral agencies as well as the various United Nations agencies active in the field of education.

This working group can be set up in different ways, for example:

- within the Ministry of Education, chaired by the Secretary of State for Education or Deputy Minister, and attended by the Department Chiefs with their technical staff when available (e.g. Cambodia);
- as a forum of decision-makers encompassing different ministries – in countries where the education sector is divided between different ministries (e.g. a working group under a national AIDS authority consisting of all relevant ministries, as in Indonesia);
- to ensure coordination between the UN agencies, the working group could be UN-facilitated (secretariat), but chaired by the Ministry of Education.

Strategic partnerships with the UN

Developing a comprehensive educational response to HIV and AIDS can benefit from a number of key UN coordination mechanisms and technical resources that already exist at the country level. These include:

- *the UNAIDS Division of Labour*: UN agencies are currently implementing the division of labour, which was recommended by the Global Task Team on improving coordination among multilateral institutions and international donors. The division of labour outlines 17 different areas of technical expertise, with one UN agency as the lead organization and other agencies as main partners;
- *the UN Resident Coordinator system*: The UN resident coordinator system provides leadership for a strong and coordinated UN system response on HIV and AIDS that can assist in incorporating HIV and AIDS education into the UN system's development frameworks – the *Common Country Assessment* (CCA) and *UN Development Assistance Framework* (UNDAF);
- *delivering as One*: in 2006 a high level UN panel developed a set of clear recommendations that would enable the UN to operate more efficiently at headquarters, in each regions, and in each country;
- *the UN Theme Group on HIV and AIDS*: The UN theme group brings together country representatives of UNAIDS Cosponsors and other UN agencies. The UN theme group is the forum to plan, manage and monitor a coordinated UN system response;
- *joint UN Teams on AIDS*: In some countries, UN agencies are now undertaking a joint programme of work in which case UN coordination occurs within a joint team on AIDS set up to provide strengthened inter-agency collaboration and coordination at country level in support of national responses to the HIV epidemic.

Country example: Brazil

In Brazil, there is a strong collaboration between the health and education sectors and between UNICEF and UNESCO on a programme for HIV-preventive education in public schools. A Federal Management Group, with representatives from the above-mentioned agencies, oversees coordination of HIV and AIDS education in the public schools. Implementation of HIV and AIDS education is adapted to local needs by state health and education secretariats with consultation of teachers, students and parents. Bringing the health and education sectors together has been an important success factor. Previously, the education sector was left out of planning and management of HIV-preventive education for young people as this was done by the state and municipal health departments. UNESCO and UNICEF played an important role in facilitating collaboration between the two ministries.

Key partners

- Relevant ministries (e.g. education, culture, health, sports, youth, social affairs, justice)
- National AIDS Commission
- International agencies, including UNESCO, UNFPA, UNICEF and the World Bank
- Civil society organizations, including national education coalitions and groups of people living with HIV
- Teacher training institutes
- School governing boards
- Teacher unions
- Community and religious leaders

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International funding for the education sector responses to HIV and AIDS

What is the issue?

Global funding for HIV and AIDS has increased significantly over the past decade: between 1996 and 2005, the annual funding for HIV and AIDS in low- and middle-income countries grew from an estimated US$300 million to US$8.3 billion.[1]

However, a number of funding challenges remain:

- **Over-complicated and tied funding**: the response to HIV and AIDS is financed through a multitude of channels (foreign, bilateral and multilateral channels of assistance). Donor strategies vary across several dimensions, such as funding cycle, country or regional focus, the period over which funds must be committed, and how much aid is "tied" (whether there are specific conditions attached to the receipt of aid).
- **Funding gaps**: UNAIDS estimates that resources currently pledged are only half what is needed for a comprehensive response.[2] A serious funding gap still remains while the estimated amount needed to effectively respond to the epidemic continues to rise: by 2010, an estimated US$23 billion will be needed annually.[3]
- **Low priority funding of the education sector**: despite recognition that the response to HIV and AIDS needs to involve all sectors, the vast majority of available funds still goes to the health sector.
- **Low levels of knowledge within education the sector on how to access HIV funding**: many education organizations or ministries of education may not aware of the various sources of HIV funding available to them in their countries.

Strong efforts are being made to streamline, simplify and further harmonise procedures and practices to improve the effectiveness of country-led responses and reduce the burden placed on countries. Aid effectiveness is currently being addressed through donor harmonisation initiatives and agreements (such as the 'Three Ones'[4] and the Global Task Team recommendations). This is a challenge for both recipients and donors.

1 UNAIDS. 2005. *Resource Needs for an Expanded Response to AIDS in Low- and Middle-income Countries*. Geneva: UNAIDS.
2 *Ibid*.
3 United Nations. Resolution adopted by the General Assembly, 60/262 Political Declaration on HIV/AIDS. 15 June, 2006. http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf
4 The Three Ones refers to having in place one agreed HIV and AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system.

Country example: Namibia

In 2003-4, the Ministry of Education (MoE) in Namibia submitted a costed proposal to the Global Fund to fight AIDS, Tuberculosis, and Malaria in response to an invitation from the Ministry of Health. The proposal was developed with education specialists and targets the formal education sector (including adult learners). During Phase 1 (2005-6) the MoE received US$3.2 million and for Phase 2 which will run from 2007 to 2009 the MoE will receive an additional US$3.2 million. A component of the proposal was a country-wide mid-term plan laying out how the funds would be spent by the education sector.

The funds have benefited HIV and AIDS programmes in 12 directorates and divisions; including the strengthening of the sector-wide HIV and AIDS Management Unit (HAMU) established in 2003 within the Ministry of Education. The programme specifically addresses awareness raising and empowerment; mainstreaming of HIV and AIDS; strengthening regulatory frameworks; meeting the needs of orphans and vulnerable children (OVC); and strengthening the management of the education sector response through establishing effective financial and monitoring systems for the HAMU and Regional AIDS Committee of Education.

One of the key elements of successful resource mobilisation was that the Ministry of Education worked closely with the Ministry of Health to jointly submit proposals to the Global Fund.

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What needs to be done?

In coordination with relevant partners, the Ministry of Education should plan activities on a multi-year, costed, and prioritised basis and develop a strategy for resource mobilisation which takes into account the following factors:

- The costs for the response to HIV and AIDS need to be clearly stated in the planning instruments and budgets of the education sector. They should also be clearly identified in development instruments, such as the United Nations Development Assistance Framework (UNDAF), Poverty Reduction Strategy Papers (PRSPs), EFA plans and others.
- In parallel, funding needs for the education sector can be discussed with education donor groups (when existing) and development partners who are active in the field of education, with the aim of identifying relevant international funding sources and defining a well-agreed and coordinated fund-raising strategy.
- The National AIDS authority is a key partner in the process and needs to help ensure that the education sector HIV strategy is aligned with the overall national response to HIV and AIDS.
- Finally, a financial proposal should be drafted which is in tune with the recommendations and eligibility criteria of the relevant funding mechanism.

Strategies for successfully mobilising international funding include:

- **Having a policy and strategy on HIV and AIDS for the education sector** in place is essential to provide a basis for deciding priorities and indicating where resources will be allocated and which partners will be involved in undertaking various activities (as below), particularly if preceded by a good situation analysis (see Brief on: *Situation Analysis and Effective Education Sector Responses to HIV and AIDS*).
- **Knowing about sources and mechanisms of funding/resources** helps with planning and, for example, with identifying "matching" funds required by many donors. Many education sector partners are not aware that they are eligible to access HIV and AIDS funding.
- **Knowing about partners** is equally important, whether these are donors (as above), agencies involved in implementing programmes, or beneficiaries. Access to funding often has a greater chance of success if in a consortium.
- **Ensuring good programme planning and management**, which includes effective proposal-writing skills, having clear objectives, ensuring activities are technically sound and implemented as planned, and building in monitoring and evaluation at an early stage.

Key partners

Coordination with other HIV and AIDS implementing partners within the country is vital. For all the partners listed below, it is normally best to approach contacts at country level in the first instance.

- **The Global Fund to Fight AIDS, Tuberculosis and Malaria** is one of the principal multilateral sources of funding. Activities are coordinated nationally through a **Country Coordinating Mechanism (CCM)**. CCMs, which are country-level partnerships made up from the public and private sectors, develop and then submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation.
- **The World Bank** concentrates its activity in Africa and the Caribbean through its **Multi-Country AIDS Programs (MAP)**. It also provides assistance for HIV and AIDS through the **International Development Association (IDA)**, which provides grants and interest-free loans; and through the **International Bank for Reconstruction and Development (IBRD)**, which provides loans at commercial rates.
- In the **United Nations**, **UNESCO**, **UNFPA** and **UNICEF** are the main agencies involved in HIV and AIDS and education, and will be brought together at the country level in the **United Nations Theme Group on HIV and AIDS**.
- For bilaterals, the **US President's Emergency Plan for AIDS Relief (PEPFAR)** is a key source. Other bilaterals and other institutions (such as the European Commission) may also provide a potential source of support.
- Key foundations include **Bill and Melinda Gates, Clinton, Ford** and **Hewlett**. Additionally, NGOs and civil society organizations should be considered.

Key resources

- UNAIDS. 1998. *Guide to the Strategic Planning Process for a National Response to HIV/AIDS: Resource Mobilization*. Geneva: UNAIDS.
- UNESCO IIEP and ESART. 2007. *Funding the Response to HIV/AIDS and Education*, Module 5.2. Educational Planning and Management in a World with AIDS Training Series. Paris: UNESCO IIEP.
- International HIV/AIDS Alliance. 2002. *Raising Funds and Mobilizing Resources for HIV/AIDS work: A toolkit to support NGOs/CBOs*. Brighton: International HIV/AIDS Alliance.
- MTT West. 2005. *Financial and Technical Resources available to the Education Sector in Senegal, Mali, Guinea and Ghana*. West African Mobile Task Team for HIV/AIDS in Education and USAID. Dakar: MTT West.

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Advocacy for a comprehensive education sector response

What is the issue?

Despite knowledge on how to prevent and treat HIV and AIDS, the scale of the response remains insufficient to the magnitude of the problem. Countries with the most success all have had strong commitment on behalf of key stakeholders and leaders. **Creating this commitment or "political will" is essential to the success of the HIV and AIDS response, requiring advocacy with many different partners and at different levels**.

What is advocacy?

- Advocacy means trying to bring about a change – either on your own behalf or on behalf of a group or cause.
- Advocacy on the educational response to HIV and AIDS might focus on bringing about a change in policies and laws, increasing the prioritisation given to the educational response or changing people's opinions about HIV.

Advocacy is needed to:

- engage policy-makers as well as the general public, and to set forth the arguments, issues and actions for an adequate education sector response to HIV and AIDS;
- ensure that the educational response to HIV and AIDS remains on the agenda of policy-makers, notably ministries of finance, national AIDS authorities and elected officials, when resource allocations are made.

Why does it matter?

Advocacy is the first step in dialogue and is needed because:

- many decision-makers are reluctant to go beyond formal acknowledgement of the problem to in-depth reflection and action;
- without strong advocacy, many decision-makers might resist discussing controversial subjects such as sex and HIV;
- sex education is a controversial subject and advocacy may sometimes be needed to persuade communities that it should be an integral part of the educational response to HIV and AIDS;
- many of those involved in making policy decisions and allocating resources are not specialists in HIV and AIDS and need information and dialogue;
- strong advocacy groups for HIV and education can give governments the visible support they need to propose changes;
- some of the groups that are highly vulnerable to HIV infection (see Brief on: *Focused HIV Prevention for Key Populations*) are highly stigmatised and in a difficult position to advocate for their needs. Efforts are needed to advocate for these stigmatised groups in a people-centred way (see Brief on: *Addressing HIV- Related Stigma and Discrimination*).

Country example: Uganda

Uganda adopted a multisectoral approach on advocacy for HIV prevention early on in the epidemic, employing multiple channels for spreading HIV prevention messages. The programme was established under the auspices of the National AIDS Commission and was supported by a national AIDS budget. It was also monitored and evaluated through control programmes set up in several national ministries, including the Ministry of Health. In parallel, civil society organizations as well as community and religious leaders brought their own contribution to support the initiative. Throughout the country, radio messages on HIV and AIDS were broadcast widely while the Islamic Medical Association of Uganda supported community education programmes on HIV and AIDS, including condom distribution.

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What needs to be done?

To achieve comprehensive HIV and AIDS education, there is a need for advocacy at different levels:

- **Regional level**, with regional networks of governments, United Nations agencies, civil society organizations and universities.
- **National level**, with ministers, civil servants, opinion leaders (politicians, religious leaders, artists, entertainment and sports celebrities), United Nations agencies, donors, companies, professional associations, news organizations and international and national NGOs. Here, strategic planning and agreement on targets are often an important first step.
- **Institutional level**, with universities, teacher training colleges, education research institutions and providers of in-service training for education staff, and services for students including HIV testing, counselling and family planning.
- **School level**, with school directors, head teachers, administrators and teachers. For example, with directors, the work could focus on emphasising a school's institutional responsibility to take action on HIV prevention.
- **Family level**, with parents, grandparents, siblings and members of the extended family. For example, with parents (through parent-teacher associations), the work could focus on seeking their approval and endorsement of HIV and AIDS education – by emphasising the positive benefits to their children.
- **Community level**, with religious groups, local leaders, health workers, NGOs, CBOs and groups of people living with HIV and AIDS. For example, with local leaders, the work should focus on emphasising the positive benefits of HIV and AIDS education, not only to children and young people in school, but to the broader community and its future.

What works?

For advocacy to be successful, it is important to include strategic planning, message development and public speaking. It also involves working in non-traditional settings to gain attention and participation.

The key components of an advocacy campaign on HIV and AIDS and education include:

A coordination mechanism, involving all key partners, both within and outside the education sector, so that advocacy efforts are strategic and mutually reinforcing

▼

A strategic plan to outline the goals, objectives, strategies, targets, activities and indicators of the advocacy efforts

▼

Key messages to be used to communicate with and convince the selected advocacy targets at different levels (see below)

▼

An action plan to provide further details about the activities of the campaign, including the division of roles and responsibilities among the partner organizations

▼

Advocacy tools to be used to support the campaign, such as fact sheets, impact projections and case studies of successful programmes in similar contexts

▼

A monitoring and evaluation framework to track and assess the campaign's progress and lessons learned.

Advocacy messages benefit from being:

- short, positive and powerful;
- consistent and coherent;
- simple, in culturally appropriate language;
- realistic and relevant to the target audience;
- supported by facts and figures.

Those who deliver messages should be knowledgeable and have legitimacy with the target audience.

Key partners

- Ministries of education
- National AIDS Commission
- UNAIDS Cosponsors, especially UNESCO, UNICEF, the World Bank, UNFPA, WHO, UNDP and ILO
- Teacher training institutions
- Teachers' unions
- Parent teacher associations
- Student groups and associations
- National and international NGOs
- Opinion leaders, including journalists

Key resources

- UNAIDS IATT on Education. 2006. *Education Sector Global HIV & AIDS Readiness Survey 2004: Policy Implications for Education and Development*. Paris: UNESCO.
- UNESCO-PROAP. 2003. *Education and HIV/AIDS: An advocacy toolkit for ministries of education*. UNESCO: Bangkok Office.
- Hovland, I. 2005. *Successful Communication: A toolkit for researchers and civil society organizations*. London: Research and Policy Development of the Overseas Development Institute.
- International HIV/AIDS Alliance. 2003. *Advocacy in Action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*. Brighton: International HIV/AIDS Alliance.
- Veneklasen, L., Mille, V. 2002. *New Weave of Power, People & Politics: The action guide to advocacy and citizen participation*. Washington, D.C.: Just Associates.

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Monitoring and evaluation of HIV and AIDS education responses

What is the issue?

Monitoring and evaluation (M&E) need to be an integral part of the response to HIV and AIDS. Countries are working towards 'The Three Ones' in HIV and AIDS responses, which commit governments to:

1. One agreed HIV/AIDS Action Framework;
2. One National AIDS Coordinating Authority;
3. One agreed country-level Monitoring and Evaluation System.

The **Three Ones concept thus requires the education sector to develop and implement sector-specific M&E systems which complement and inform national M&E efforts**.

It has been **challenging to set up HIV- and AIDS-specific monitoring and evaluation systems** because:

- including HIV- and AIDS-sensitive indicators into the collection of education indicators is difficult due to HIV-related stigma and the lengthy process involved in changing underlying monitoring systems;
- it is difficult to measure the specific impact of HIV and AIDS on teachers and learners because often the cause of illness, death and absenteeism is unknown;
- monitoring of HIV and AIDS education programmes will only be as good as the underlying monitoring and evaluation system. In many countries, educational data are not collected on a regular basis nor with the coverage or depth needed;
- it is difficult to link M&E into the education sector and the national HIV and AIDS M&E framework within the Three Ones;
- evaluating the effectiveness of HIV and AIDS education programmes is challenging due to the difficulty in measuring behaviour change and demonstrating that observed changes are due to the programme and not other factors.

Why does it matter?

Monitoring and evaluation are critical components of any intervention or programme because:

1. Ministries of education and other education stakeholders need to design and use M&E systems to **appraise whether they are achieving desired outcomes on the ground**. Monitoring and evaluation of programmes can only be effective, however, if this is carried out when there are clear programme objectives, targets and a time-frame from the outset;
2. M&E is **key to successful implementation, to build cohesion among partners about objectives and their achievement, and for the work of country coordination mechanisms** such as National AIDS programmes.
3. A substantial proportion of the funding for education responses to HIV and AIDS comes from international sources. These **sources increasingly demand that there be effective M&E systems** to demonstrate the results of financial support and to continue funding additional instalments.

Instituting a **monitoring system** at the beginning of a programme ensures that the goals and objectives defined during the programme design are clear, measurable and relevant.

Monitoring is important for:

- tracking the key elements of programmes (both inputs and outputs);
- assessing how and where resources are used;
- ensuring transparency in resource expenditure;
- assessing the coverage and quality of HIV and AIDS programmes (from implementation of workplace policies to HIV and AIDS education);
- supporting educational planning in the context of HIV;
- making timely adjustments to project planning and implementation.

Evaluation is the assessment of whether or not programmes have led to the desired results. Evaluating HIV and AIDS programmes is important for:

- knowing if the programme has led to the desired change in knowledge, attitudes or behaviours;
- identifying success factors and elements of the programme that can be scaled up;
- identifying failures and what is not working;
- identifying the circumstances under which programmes can work optimally.

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What needs to be done?

In order to develop a successful M&E system, it is important to ensure that there is:

- **clarity of aims and simplicity of data collection and analysis**: While it may seem attractive at the design stage of an M&E system to collect the broadest possible amount of data, the more complex a system, the more likely it is to fail. To serve any purpose, an M&E system has to last;
- **a standardised core**: In keeping with The Three Ones, each national system needs to be harmonised. M&E of educational interventions needs to be consistent with data collection systems of the education sector, as well as those of the National AIDS programmes;
- **agreement among partners about the process**: No matter how sound an M&E system may be, it will fail without widespread stakeholder buy-in and ownership;
- **adequate capacity**: Programmes have to be designed with M&E as integral elements. Where technical capacity is not adequate, training and technical assistance need to be part of the programme design;
- **relevance and transparency**: Monitoring of programmes needs to be conducted in a transparent way and data should be locally owned and locally driven;
- **ability to feed results into future planning processes**: The results from M&E need to feed into the planning process;
- **ethical criteria**: monitoring and evaluation should be culturally appropriate and pass ethical standards set by each country.

When **choosing indicators**, try to design indicators which are:

- simple: clear and understandable measures of effectiveness;
- reliable: leading to the same conclusions regardless of the circumstances of the assessment;
- replicable: allowing for comparisons and replication (of a project or intervention);
- available: using available data and consistent where possible with existing standard indicators;
- meaningful to users.

UNAIDS provides guidance on HIV-related indicators. Some of the main education-related indicators promoted by UNAIDS include:

- current school attendance among orphans and non-orphans aged 10–14;
- percentage of schools that provided life skills-based HIV education in the last academic year;
- percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmissions;
- percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

Country example: South Africa

In the South African province of KwaZulu Natal, the EduSector AIDS Response Trust has developed a database on all government and NGO agencies providing support services to orphans and vulnerable children (OVC) which has been consolidated by organization, activity, programme type, target group and area of operation/reach. This Management Information System (MIS) contains details of over 1,300 programmes, mapped and spatially analysed in relation to demographics, socio-economic indicators, geography, infrastructure and need. The outcome is a comprehensive, geo-located guidance system for OVC, government and NGO service providers, research organizations and development agencies. Access is unrestricted and free and the database is located in the Office of the Premier.

Key resources

- UNAIDS. 2007. *Monitoring the Declaration of Commitment on HIV and AIDS: Guidelines on construction of core indicators. 2008 reporting*. Geneva: UNAIDS.
- UNAIDS. 2000. *National AIDS Programmes: A guide to monitoring and evaluation*. Geneva: UNAIDS.
- UNDP. 2005. *Responding to HIV/AIDS. Measuring Results: The answer lies within*. New York: UNDP.
- WHO *et al.* 2006. *Monitoring and Evaluation Toolkit: HIV/AIDS, tuberculosis and malaria, 2nd Edition*. Geneva: WHO.
- Webb, D., Elliott, L. 2002. *Learning to Live: Monitoring and evaluation in HIV/AIDS programmes for young people*. London: Save the Children Fund.

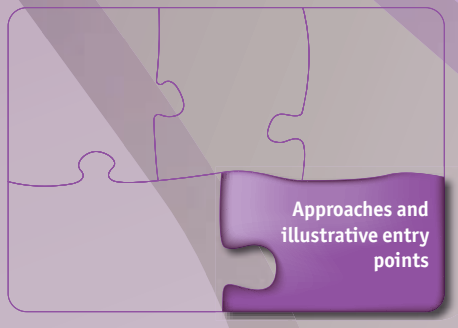
Key partners

Under the UNAIDS division of labour, the World Bank is the lead organization for supporting human resources, capacity and impact alleviation with ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF and WHO as main partners. Key partners also include:

- Relevant ministries (education, finance, health and social welfare)
- National AIDS Commission
- UNESCO IIEP (International Institute for Educational Planning)
- Universities and research institutes such as: EduSector AIDS Response Trust, Health Development Africa (HAD)

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

Life skills-based education for HIV prevention



What is the issue?

Knowledge alone is not enough to prevent the transmission of HIV:

- Knowing that HIV is a risk has not led to everyone changing their behaviour to prevent infection.
- Changing behaviour requires action, which is dependent on knowledge but also many other factors such as skills, motivation, beliefs and external pressures (from sexual partner or community).
- Education for HIV prevention is more effective if it also tackles these multiple factors which affect sexual behaviour and other risk behaviours.

Innovative approaches to education for HIV prevention include teaching skills to reduce risk (such as how to use a condom) or to reduce underlying vulnerability (such as to become more assertive). One of the most popular skills-based approaches is called life skills.

The term "life skills" covers skills which include critical thinking, development of personal knowledge and attitudes, and communication and negotiation skills. Life skills education can assist young people to develop a wide range of capabilities including:

- thinking critically and to solve problems;
- decision-making, stress management and coping;
- communication and negotiation.

At the *World Education Forum* (2000), world leaders, governments, NGOs and members of civil society reaffirmed their commitment to life skills-based education for young people. The resulting ***Dakar Framework for Action*** **made life skills a priority in two of its six Education for All (EFA) goals**:

- Goal 3 requires countries to ensure inclusive access to relevant and appropriate life skills programmes through the school curricula.
- Goal 6 includes quality education to ensure measurable learning outcomes are achieved by all, especially in literacy, numeracy and life skills. The Framework confirmed the human right to an education that meets young people's basic learning needs throughout their lives, including learning **to do, to know, to be and to live together**. These four pillars of education represent the crucial *combination* of manual skills and life skills.

Implementing the goals on life skills is challenging because:

- life skills education requires a participatory form of teaching which many teachers are not trained to deliver;
- most life skills curricula are not examined and consequently not highly prioritised by schools;
- evidence is still lacking on which life skills might reduce vulnerability to HIV infection and how to teach these skills in a classroom.

Why does it matter?

Life skills-based education for HIV prevention is an important approach for providing young people with the skills they need to reduce vulnerability to HIV infection.

This approach is useful in order to:

- teach young people practical skills such as how to use a condom;
- teach interpersonal skills such as how to negotiate condom use or to refuse sex;
- develop personal skills such as how to be more assertive or communicate better in relationships.

Studies have found that life skills-based education does not encourage sexual experimentation or increase sexual activity. On the contrary, evaluations of life skills programmes have demonstrated, in the context of HIV and sex education, that:

- it can delay the onset of sexual debut;
- among sexually active youth, it can increase condom use and decrease the number of casual sexual partners.

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What needs to be done?

Life skills programmes should be age-appropriate and introduce skills at different stages. For example:

Pre-puberty (aged 10 and under):

- the ability to express feelings and needs in a confident way;
- dealing with emotions, stress and conflict;
- understanding what it feels like to be different and that people are different to one another.

For early-adolescents (aged 10-14):

- communicating confidently about sexual feelings and HIV with peers, families and community members;
- critical thinking and problem-solving to make healthy decisions about sexuality, sexual expression and related behaviour;
- communicating clearly and effectively a desire to delay sexual debut or to refuse a sexual encounter;
- expressing empathy and support towards people with HIV or AIDS;
- maintaining a personal system of values independent of peer pressure.

For adolescents (aged 15-19):

- assessing risk and developing skills for negotiating for safer sex, including skills for the appropriate use of male and female condoms;
- identifying and using health services, including HIV testing and counselling as well as support to deal with substance abuse.

Life skills programmes will be most effective in influencing behaviour when they:

- **adopt goals, teaching methods and materials that are appropriate** to the age, sex and culture of the learners and their communities;
- **use participatory learning methods** such as role-playing and debates to practice communication, negotiation and refusal skills;
- **identify risk behaviours and protective factors** among those being targetted;
- **communicate clear and accurate messages** about risks of unprotected sex and methods of avoiding sex or using condoms and contraception;
- **address the issue of social pressures on sexual behaviour** and methods of avoiding and countering them;
- **are delivered by educators who are well-trained, motivated and supported** to deliver life skills education;
- **involve parents** in the development and delivery of consistent and coherent messages over time;
- **are part of a comprehensive approach** that includes policy development, community mobilisation and advocacy.

Key partners

Coordination with other HIV and AIDS implementing partners within the country is vital. Within the United Nations, UNICEF, UNESCO and UNFPA are the main agencies involved in life skills-based education for HIV prevention. Key partners also include:

- Relevant ministries (e.g., education, health, youth, social affairs)
- Youth Foundation, youth associations and anti-AIDS clubs, Clubs de Santé, World Organization of the Scout Movement, Family Health International
- School governing boards
- Teachers' unions, parent-teacher associations

Country example: South Africa

In 1998, the South African Ministry of Education mandated the implementation of a comprehensive life skills education programme in all secondary schools by 2005. A preliminary evaluation of results in the province of KwaZulu Natal demonstrated:

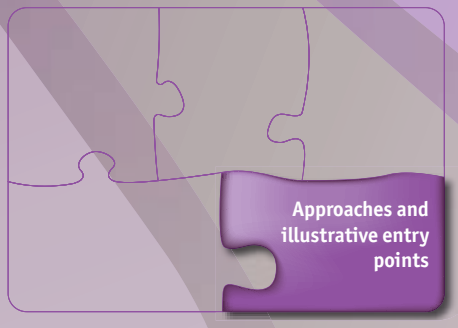
- gains in sexual and reproductive health-related knowledge, particularly knowledge of the ways in which HIV can be transmitted, knowledge of sexually transmitted infections other than HIV, and the number of contraceptive methods known;
- reported increased confidence in condom use as well as condom use at first sexual encounter;
- greater awareness by teachers of the need for a sustained and comprehensive programme.

Key resources

- WHO and UNICEF. 2003. *Skills for Health: Skills-based health education including life skills*. Geneva: WHO and UNICEF.
- Boler, T., and Aggleton, P. 2005. *Life Skills-based Education for HIV Prevention: A critical analysis*. London: ActionAid International/Save the Children.
- Jewkes, R. *et al.* 2007. *Evaluation of Stepping Stones: A gender transformative HIV prevention intervention*. Pretoria: MRC, South Africa.
- Mangrulkar, L. *et al.* 2001. Chapter II in *Life Skills Approach to Child and Adolescent Healthy Development*. Washington DC: American Health Organization.
- Population Council/Horizons. 2004. *Transitions to Adulthood in the Context of AIDS in South Africa: The impact of exposure to life-skills education on adolescent knowledge, skills, and behaviour*. Washington DC: Population Council.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

School health and HIV prevention



What is the issue?

School health can be an effective entry point for teaching about HIV and AIDS at schools, especially in contexts where teaching HIV through sex education is considered problematic. **School health is related to HIV vulnerability** in a number of ways:

- Health problems interfere with students' ability to come to school, to stay in school, or to make the most of their opportunity to learn.
- Ensuring good health at school-age can boost school enrolment and attendance, reduce the need for repetition and increase educational attainment.
- Good health practices can promote reproductive health and help reduce vulnerability to HIV infection.
- Enhancing overall health and nutritional status is also an important way to reduce vulnerability to HIV and sustain the health of those already infected.

Why does it matter?

School health programmes can be a critical means through which to reach school-age children and young people before they are sexually active. In addition, schools with school health programmes can be powerful agents for reaching parents and communities with HIV-related messages.

School health programmes are also essential to the realisation of Education for All (EFA) goals, by:

- encouraging more children and young people to enrol in school, reducing absenteeism and drop-out and enhancing pupils' learning ability;
- improving the quality of instruction through teacher training in skills-based methodologies;
- contributing to gender equality and equity in education by addressing a broad range of issues including sanitation facilities and safe learning environments.

Country example: Namibia

The Government of the Republic of Namibia has recognised the crucial role of school health and HIV & AIDS education as a means to achieve EFA in its National Plan of Action.

The Ministry of Basic Education, Sports and Culture and the Ministry of Higher Education, Training and Employment Creation established an HIV/AIDS policy and created customer service charters for primary, secondary and tertiary schools and institutions.

At the same time, the Ministry of Health and Social Services established a policy on school health promotion in conjunction with the Ministry of Basic Education, Sports and Culture. This compre-hensive approach is based on school health programmes covering junior secondary school curricula and policies to ensure that all learning takes place in a safe, healthy and supportive environ-ment with increased access to reproductive and other health services.

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What needs to be done?

School health programmes should be based on a whole school approach which:

- promotes healthy, safe and secure learning environments, including the prevention of sexual and physical violence;
- provides health education to develop the necessary knowledge, attitudes and skills to make informed decisions, reduce vulnerability and practice healthy behaviours (see Briefs on: *Curricula for HIV and AIDS Education* and *Life Skills-Based Education for HIV Prevention*);
- facilitates access to youth-friendly reproductive and sexual health services including sexually transmitted infection diagnosis, voluntary counselling and testing (VCT) for HIV, contraceptives (including male and female condoms), HIV care and treatment, and treatment of opportunistic infections such as tuberculosis;
- involves both education and health sectors throughout the programme cycle.

Experience shows that the most effective school health programmes include:

- **Comprehensive designs** that address policy development, health-promoting environmental change, skills-based health education and school-based health services;
- **Focus on building skills** of young people to develop a range of personal and inter-personal life skills that can help them adopt health-seeking behaviours;
- **Reach young people** before they become sexually active. This is crucial for helping to delay the initiation of sexual activity and to encourage protective behaviours upon sexual initiation.

The FRESH Approach

The FRESH (Focusing Resources on Effective School Health) interagency initiative was adopted at the World Education Forum in Dakar in 2000, and includes United Nations, international and non-governmental partners. FRESH promotes four key principles of school health:

- **School policies** to ensure a safe and healthy environment for educators and learners;
- **Water, sanitation and the environment**, including the provision of safe water and appropriate sanitation facilities in learning environments;
- **Skills-based heath education** promoting critical thinking, problem-solving and the development of health-promoting attitudes and behaviours;
- **School health and nutrition services** which provide and/or link students to necessary services to meet basic health and nutrition needs, including psychosocial support services for orphans and vulnerable children.

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Key partners

- Relevant ministries (e.g. education and health)
- Civil society organizations, including parent-teacher associations, community and religious groups, and other local associations
- International agencies, including FAO, UNESCO, UNFPA, UNICEF, WHO, WFP and the World Bank
- Other partners including Education International, Child-to-Child Foundation, Partnership for Child Development and Save the Children

Key resources

- UNESCO, UNICEF, WHO and World Bank. 2000. *Focusing Resources on Effective School Health: A FRESH start to enhancing the quality and equity of education*. Paris: UNESCO.
- UNESCO. *FRESH Toolkit*. Available at: www.unesco.org/education/fresh
- Whitman, C.V. *et al.* 2000. *Thematic Study on School Health and Nutrition, EFA 2000 Assessment*. Paris: UNESCO.
- WHO Information Series on School Health: http://www.who.int/school_youth_health/resources/information_series/en/index.html
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- Government of the Republic of Namibia. 2002. *EFA National Plan of Action 2002-2015*. Lusaka: Government of the Republic of Namibia.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

HIV and AIDS education for out-of-school young people

Approaches and illustrative entry points

What is the issue?

Worldwide, some **72 million school-age children are not attending school** (EFA Global Monitoring Report 2008), and slightly more than half of these are girls. In those countries worst affected by HIV and AIDS, the majority of 10-24 year olds are not in school. Numerous barriers inhibit their attendance, including:

- **economic hardship** impacting on the payment of fees associated with schooling (e.g. books, uniforms and tuition);
- **household obligations** including housework, child care, or work to supplement family income;
- **gender discrimination,** as a result of which families may see education for girls as less important than for boys (see Brief on: *Girls' Education and HIV Prevention*);
- **insufficient or inappropriate education,** due to a lack of schools, poor quality curricula, or a shortage of trained teachers;
- **poor infrastructure** (e.g. roads and transportation) inhibiting young people from getting to and from school quickly or safely;
- **national policies that prevent eligible learners from attending school** (e.g. preventing pregnant girls from continuing their education, or children without a birth certificate from school admission);
- **emergencies and social conflict** (e.g. natural disasters or wars) or **social marginalisation of certain groups** (e.g. street children, orphans or child soldiers).

Young people who do not attend school or who drop out prematurely miss many of the fundamentals of basic education – learning how to read, write, and do basic arithmetic. They are also disadvantaged as they miss the opportunity to learn and employ knowledge and life skills related to HIV in a stable classroom setting.

Why does it matter?

Out-of-school young people are at a disproportionately higher risk of HIV infection as they:

- lack access to vital health, sexual and reproductive health education, counselling and services often provided in school settings;
- miss the structure, protection and activities that school environments typically provide;
- may face stigma and discrimination that prevent them from adopting risk-reductive behaviours;
- may be more vulnerable to experimentation with alcohol and drug abuse, an important predictor of increased sexual experimentation and risk-taking;
- have lower social and economic status, increasing their vulnerability to coercive or abusive situations, including sexual exploitation, trafficking, violence or 'sugar daddy' practices where men exchange money or gifts for sexual favours from young women.

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What works?

Successful programmes that support the development and delivery of HIV education and services for out-of-school young people:

- **are based on the real, assessed needs of young people**, rather than on adults' perceptions;
- **actively involve young people themselves** as partners in the design, implementation and evaluation of activities;
- **use appropriate and realistic messages and materials** that acknowledge the challenges in young peoples' lives and are tailored to the particular circumstances of different groups;
- **are economically, physically and socially accessible to out-of-school young people** by reducing or eliminating costs, providing services in venues that are safe and non-intimidating (including where young people spend their work and leisure time), and at times appropriate for different lifestyles;
- **use a range of media** (e.g. print, radio, television and traditional media) **and information and communication technologies** to reach out-of-school young people;
- **rely on multiply entry points** (such as youth-friendly health counselling and services, peer and adult community educators, mobile prevention services) **and links with existing programmes that offer literacy, health, employment, and livelihood information and services**;
- **involve community leaders to add social credibility to information**;
- **use a wide variety of partnerships** across sectors and with partners that play a role in supporting out-of-school young people (e.g. community and youth leaders, educational planners, sports personalities, celebrities, religious leaders and media professionals);
- **build in-country capacity to monitor, evaluate and scale up successful programmes** based on experience and lessons learned.

Key partners

Under the UNAIDS division of labour, UNFPA is the lead organization for HIV prevention for young people outside school, with ILO, UNAIDS Secreteriat, UNESCO, UNICEF, UNODC and WHO as main partners. Key partners also include:

- Relevant ministries (e.g. education, health, social welfare, youth)
- Civil society organizations, including CARE, the Red Cross and Red Crescent societies, Save the Children, and others providing education, food and shelter for vulnerable young people
- Other international agencies, including the International Planned Parenthood Federation (IPPF) and its Member Associations and the World Bank.

Country example: Belize

In Belize, UNFPA is working with the government and civil society partners in an OPEC Fund-supported project to decrease HIV incidence among young people in especially difficult circumstances. For example, the project has trained youth peer educators to reach out to gang members and out-of-school young people. Lessons learned include the importance of innovative approaches to reach particularly vulnerable young people, and the need for ongoing, sustained efforts.

What needs to be done?

Ministries of education, civil society organizations and their development partners can support HIV and AIDS education for out-of school young people by:

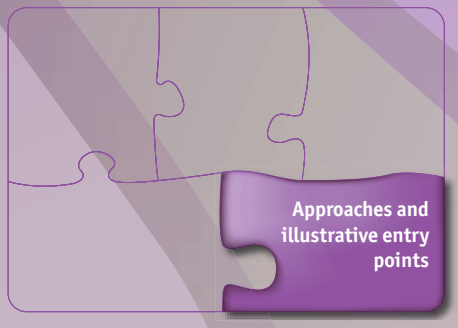
- **Supporting policies that encourage young people to stay in school** by abolishing school fees or providing financial assistance for school-related costs to poor families and orphans; using innovative curricula and methods to reach young people in rural areas; and supporting pregnant girls and married adolescents to return to school.
- **Providing out-of-school young people with accurate information and life skills-based education related to reproductive and sexual health and rights and HIV and AIDS.** This includes encouraging the delay of sexual debut, reducing the number of sexual partners and using condoms and other protective measures correctly and consistently.
- **Ensuring that out-of-school young people benefit from HIV and AIDS services and are effectively included in sexual health programmes.** This includes promoting youth-friendly and gender-responsive health services, including voluntary counselling and testing, early diagnosis and treatment of sexually transmitted infections, access to preventive commodities (such as male and female condoms; clean needles and syringes), and treatment for HIV, including antiretroviral therapy.
- **Addressing the particular vulnerability of out-of-school young people through a wide range of policies and programmes** that protect them from harm, expand their access to information and services and support their personal development.

Key resources

- UNESCO. 2006. *Synergies between Formal and Non-formal Education: An overview of good practice*. CD-Rom. Paris: UNESCO.
- UNFPA/FHI. 2006. *Peer Education Toolkit.* New York: UNFPA.
- P.A.U. Education/UNESCO. 2006. *Street Children and HIV & AIDS: Methodological guide for facilitators.* Barcelona, Spain: P.A.U. Education.
- WHO *et al.* 2006. *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*. Geneva: WHO.
- WHO *et al.* 2004. *Protecting Young People from HIV and AIDS: The role of health services.* Geneva: WHO.
- FHI. 2004. *Reaching Out-of-School Youth with Reproductive Health and HIV/AIDS Information and Services*. Youth Issues Paper 4, YouthNet. Arlington: FHI.

The English and Arabic editions of the EDUCAIDS Briefs were produced with financial support from the OPEC Fund for International Development

Drug use prevention in the context of HIV and AIDS education



What is the issue?

There is a clear **interrelationship between drug use and vulnerability to HIV infection**:

- Social exclusion, exposure to violence and lack of educational opportunities increase vulnerability to substance misuse and HIV infection.
- Mind-altering substances, including legal substances such as alcohol, have the ability to reduce inhibitions and may impact on judgement and decision-making relating to unprotected sex or needle-sharing.

Injecting drug use is a major mode of HIV infection in regions such as Asia, Europe, Latin America and North America.

- Since the beginning of the AIDS epidemic, approximately five million drug users have become infected with HIV, mainly through the sharing of contaminated injection equipment and through unsafe sexual practices while under the influence of drugs.
- Young people are particularly vulnerable to drug abuse and HIV infection and need to be the target of educational efforts.

Formal and non-formal educational programmes can be used to educate children and young people about drug use, its harmful effects, and ways of reducing potentially negative consequences. Any comprehensive HIV and AIDS education curriculum needs to address the links between HIV infection and the misuse of drugs.

Why does it matter?

Whether directly through injecting drug use, or indirectly through unprotected sexual activity under the influence, drug use and misuse have been implicated in a sizeable proportion of HIV and other sexually transmitted infections.

Tackling the relationship between drugs and HIV through education is important because:

- Adolescence is a time when many health-promoting behaviours are formed and education can be used to influence these behaviours;
- Drugs education in and out of schools can reach young people before they have experimented with alcohol and illicit drugs or become sexually active, thus reducing their risk of becoming infected with HIV.
- Drugs education can prevent the use of drugs and help minimise harm among those who may already be using drugs.
- Vulnerable young people face a number of challenges such as poverty, violence, social exclusion, and unemployment. Education can be used to help young people develop the resilience skills they need to resist peer pressure to take drugs and to have unprotected sex.
- Harm reduction strategies are important to reduce the risk of contracting HIV for those young people who are already taking drugs. Harm reduction approaches focus on people who are already taking drugs with the aim of reducing drug-related harm (such as sharing needles or unprotected sex) through the provision of accessible treatment and prevention services.

What needs to be done?

Education is an integral component of drug use prevention and treatment. Specific and targeted educational interventions can reduce vulnerability to drug use and HIV infection by:

- providing relevant information on locally prevalent drugs and substances, including on the potential harmful effects associated with their use;
- helping children and young people in formal and non-formal education settings to build the knowledge, attitudes and skills for health-promoting behaviours;
- discouraging the initial use of drugs among children and young people;
- reducing the risks of exposure to drugs within living and learning environments (e.g. by creating drug-free zones and having non-smoking policies in educational settings);
- tackling stigma and discrimination encountered by drug users, people living with HIV and their dependents/families in their living, working and learning environments;
- ensuring access to Education for All by targeting drug users and their families to acquire basic literacy and numeracy skills;
- supporting young people who are taking drugs to set realistic goals in order to change behaviour and reduce the risk of harming themselves.

Comprehensive responses to preventing HIV amongst injecting drug users should consist of the full range of treatment options (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes) as well as access to HIV prevention, treatment, care and support services. Such an approach must be based on promoting, protecting and respecting the human rights of drug users.[1]

1 UNAIDS. 2005. *Intensifying HIV Prevention. UNAIDS Policy Position Paper*. Geneva: UNAIDS.

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What works?

The success of drug use prevention programmes is dependent on their ability to achieve learning outcomes, influence environmental factors and forge collaborative partnerships.

Essential components may include:

- information, education and life-skills training about drug use and misuse and safe sexual behaviour in the context of health education programmes;
- access to voluntary counselling and testing services;
- peer education, support networks and outreach programmes, targeting children and young people "where they are", including in formal and non-formal educational settings and in their own communities;
- interactive communication tools such as art and drama;
- sustainable livelihood programmes for out-of-school young people which encourage vocational education and training in marketable skills, apprenticeship and entrepreneurship development, and which facilitate job placement and income generation. Building sustainable livelihoods is not merely for the purpose of survival but are an essential part of the rehabilitation process of drug users;
- development of functional literacy and numeracy as well as more advanced basic education skills among young people and adults who have dropped out of the education system;
- mobilisation of local communities, drug-user support groups, networks of people living with HIV and families to engage in programmatic activities;
- harm reduction through condom distribution and needle and syringe exchange programmes targeting drug users and their sexual partners. These can be important entry points for the provision of, or referrals to, counselling and drug dependence treatment programmes;
- development of local networks for referral to ensure that service provision reflects the social and care needs of drug users and other socially excluded populations;
- low threshold and other drug dependence treatment services to assist drug users to reduce and recover from drug use in a sustainable manner, providing support in achieving the highest level of physical, mental and social well-being;
- working with vulnerable groups such as sex workers, street inhabitants, prisoners and sexual minorities exposed to drug use and trafficking.

In all cases, services must be **anonymous, accessible, confidential, and sensitive to individual needs** and **youth-friendly.** For example, drop-in centres can provide a safe and comfortable place to receive counselling, education and life-skills training.

Key resources

- UNAIDS. 2005. *Joint UNAIDS Statement on HIV Prevention and Care Strategies for Drug Users*. Geneva: UNAIDS.
- UNAIDS. 2002. *Preventing the Transmission of HIV among Drug Users*. A Position paper of the United Nations system. Geneva: UNAIDS.
- UNESCO. 2007. *Another Way to Learn: Case studies*. Paris: UNESCO.
- UNESCO. 2002. *Dependence to Independence: Young people, drugs and marginalisation in Asia*. Paris: UNESCO.
- UNESCO. 2002. *Working Where the Risks Are: Drug abuse prevention programme for marginalised youth in Asia*. Paris: UNESCO.
- UNODC. 2003. *School-Based Education for Drug Abuse Prevention*. Vienna: UNODC.
- UNODC and Global Youth Network. 2002. *A Participatory Handbook for Youth Drug Abuse Prevention Programmes*. Vienna: UNODC.

Key partners

- Relevant ministries (e.g. culture, education, health, social welfare, justice)
- National drug control agency
- National AIDS Commission
- Community centres and social services
- Educational and training institutions
- International and local NGOs, especially those involved in providing support and services to drug-using populations
- Other international agencies such as UNODC, UNESCO and UNFPA

Regional example

Another Way to Learn is an initiative led by UNESCO that supports non-formal education projects in the Caribbean, Latin America, Africa and South Asia. The long-term goal of the initiative is to develop sustainable livelihoods for low-income, low-literate populations by addressing vulnerability to HIV and drug misuse a lack of education and social exclusion. Creative learning methodologies are used such as circus school, drama and art in order to communicate messages in an interactive and meaningful way.





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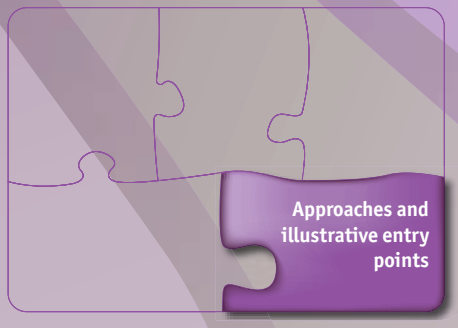
School feeding and HIV & AIDS



What is the issue?

As of 2006, there are more than 300 million chronically hungry children in the world. Hunger, poverty, education and HIV are interrelated.

- **In many countries, the epidemic contributes to, and is exacerbated by, a situation of malnutrition and food insecurity.**
- **Children who are hungry are less likely to enrol and attend school regularly. It is more difficult for hungry children to concentrate and learn while at school.**

School feeding is the provision of food to school children either 'on-site' in the form of a meal or a snack eaten in school during school hours or 'take-home' distributed to students for consumption at home. School feeding has been shown to have beneficial effects on:

- **child malnutrition and development:** providing nutritionally fortified meals at school helps to build children's immune systems, fight micronutrient deficiencies and prevent physical and mental stunting. For some, it may be the only meal they receive that day;
- **girls' education:** school feeding helps to bring more children into school and keep them there – this is particularly true of girls;
- **orphans and vulnerable children:** orphans and other vulnerable children are more likely to drop out of school. School meals can act as an incentive to keep vulnerable children in school;
- **emergency situations:** during emergencies, school feeding, even in makeshift schools, gives children access to resources they would not otherwise have access to, restoring continuity and a sense of normality in an unstable situation.

Why does it matter?

- School feeding is particularly crucial in the light of the growing number of orphans and children made vulnerable to HIV – many of whom lack access to even basic physical and social support, including good nutrition;
- School feeding helps to ensure that poor children get an education, which can have a positive and significant impact on HIV prevalence rates;
- School feeding also serves as an important entry point for broader, community-based HIV and AIDS work. For example, making contact with a student might provide an opportunity to support an entire family affected by HIV and AIDS, such as through take-home rations.

What needs to be done?

In the context of HIV and AIDS, the operating principles for effective school feeding programmes include:

- **integration:** programmes should be fully integrated into the overall development plans of schools and communities;
- **strategic focus:** programmes should target areas where they are likely to have the greatest impact. This includes areas experiencing food insecurity, high HIV prevalence, high levels of orphans, and low rates of school enrolment;
- **cost-effectiveness:** programmes should consider the cost-effectiveness of the food ration in terms of potential sustainability and eventual handover to local authorities;
- **partnership:** programmes should be set up in collaboration with all relevant stakeholders, including government, local authorities, donors, and NGOs. This will help to ensure that the work is both appropriate and sustainable;
- **participation:** the design, implementation and monitoring of programmes should actively involve a wide range of stakeholders.

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Country example: Zambia

Since January 2003, WFP programmes in Zambia have been targeting orphans, street children and other vulnerable children to increase their access to education, support families hosting vulnerable children and contribute to the maintenance of the nutritional status of these children. Children enrolled in the programme are served a hot, nutritious breakfast of fortified blended porridge at school. Additionally, their host families receive a monthly take-home ration of cereals as an incentive to keep the children in school and to assist with increased food needs at home. The family member who collects the take-home ration also attends a training session on food, nutrition and caring for the chronically ill and, when possible, on HIV and AIDS awareness.

Key resources

- WFP. 2004. *Getting Started: HIV Education in School Feeding Programs*. Rome: WFP.
- WFP. 2003. *Bringing Hope to a Generation: food aid to help educate orphans and other vulnerable children*. Rome: WFP
- IFPRI. 2006. *Child Vulnerability and AIDS: Case Studies from Southern Africa*. Washington DC: International Food Policy Research Institute
- Regional Centre for Quality of Health Care. 2003. *Nutrition and HIV/AIDS: A Training Manual*. Kampala: RCQHC.

Key partners

Under the UNAIDS division of labour, WFP is the lead organization for dietary and nutrition support, with UNESCO, UNICEF and WHO as main partners. Key partners also include:

- Relevant ministries (e.g. education)
- Civil society organizations, including NGOs active in schools and communities
- Parent-teacher associations

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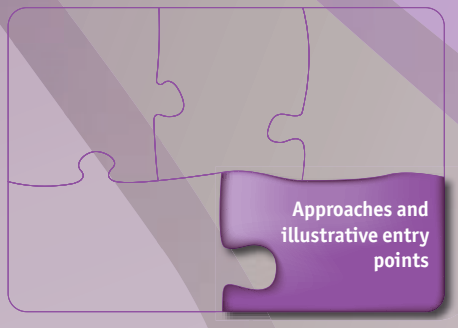
HIV and AIDS treatment education



What is the issue?

There is a widespread recognition that **antiretroviral therapy (ART) is an essential component of comprehensive responses to the epidemic,** which include HIV prevention, treatment, care, and impact mitigation. **Treatment education supports efforts to move toward universal access to treatment and is part of comprehensive HIV education**.

The WHO/UNAIDS '3 by 5' initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), other global and national initiatives, as well as significant reductions in cost have **expanded access to ART.** Over two million people in low and middle income countries are living longer and better lives as a result.

The success of programmes to scale up and ensure universal access to treatment will require **educating and preparing communities and individuals** about issues related to ART.

Treatment education informs and engages individuals and communities about:

- **voluntary counselling and testing** (VCT) to know their HIV status, a prerequisite for treatment programmes;
- **ART enrolment criteria**, with an emphasis on the right to equitable treatment access, including gender equity;
- **ART and drug regimens,** where to access treatment, how the drugs must be taken, potential side effects, possible interactions with other drugs, options for alternative treatments and how treatments may affect men and women differently;
- **the importance of adherence**, as well as how communities and individuals can support people with HIV to take the drugs as instructed by health professionals;
- **treatment costs**, including drugs, laboratory tests for monitoring, and provider fees;
- **the importance of continued protective behaviours**, and in this regard the need to strengthen and expand existing prevention efforts (see Brief on: *HIV Prevention with and for People Living with HIV*).

Why does it matter?

Treatment education programmes in a range of contexts and settings have contributed to:

- **increased awareness of available treatment and prevention services** and greater demand for and use of these services;
- **reduced HIV- and AIDS-related stigma** as HIV testing and treatment become part of a routine response by public health services to a chronic manageable illness;
- **a safer environment** where individuals feel more comfortable being tested for HIV and more aware of their status;
- **improved health-seeking behaviour**, including wider uptake of VCT, diagnosis and treatment of sexually transmitted infections (STIs) and opportunistic infections, and support for the overall health, nutritional and other needs of people with HIV;
- **better adherence to ART regimens**, leading to improved health outcomes and prevention of the development of drug-resistant strains;
- **expanded prevention education with and for people living with HIV**, including couple counselling, family support, and the promotion of risk reduction strategies (see Brief on: *HIV Prevention with and for People Living with HIV*)

In addition, experience indicates that treatment education can contribute to the creation of an environment conducive to successful prevention by:

- **dispelling myths**, filling knowledge gaps, and providing accurate information on HIV and AIDS;
- **engaging community members, educators, health workers and others** to become active partners in addressing HIV prevention, care and treatment needs;
- **building capacity for people with HIV** through their involvement in the development, planning, implementation and evaluation of treatment education;
- **promoting dialogue and partnerships** among treatment providers, NGOs, local and national governments, international agencies, the private sector and local groups of people living with HIV, to enhance prevention, care and support activities, and to generate more effective local responses.

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What needs to be done?

The **education sector can be a mass communication and distribution network** for information on treatment and can **build important problem-solving and negotiation skills among educators and learners** by integrating treatment education into:

- **health and life skills-based education** in formal and non-formal educational settings;
- **adult, employee and community education programmes;**
- **citizenship and rights education**;
- ministry of education **sectoral training for staff**;
- **traditional and local media** activities (e.g. interactive community theatre, radio, print and television);
- activities of **anti-AIDS clubs, student groups, peer education networks and groups of people with HIV** (e.g. support groups or post-test clubs).

Treatment education strategies will be most effective when implemented along with other interventions that aim to:

- **combat stigma and discrimination** which continue to present a major barrier to treatment access (see Brief on: *Addressing HIV-Related Stigma and Discrimination*);
- **mobilise political will and commitment** to improve sustained access to ART and reductions in cost of treatment (see Brief on: *Advocacy for a Comprehensive Education Sector Response*);
- **ensure multisectoral responses** among governments and local authorities, international agencies, NGOs, the private sector and groups of people with HIV.

Key partners

- Relevant ministries (e.g. education, health, human rights, social welfare, women's affairs)
- Networks of people with HIV, including the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS (ICW), and other national and local associations
- Civil society organizations, including HIV i-Base, NAM, the International HIV/AIDS Alliance, the International Treatment Preparedness Coalition, and the Treatment Action Campaign
- International agencies including ILO, UNAIDS, UNESCO and WHO

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Involving people with HIV in treatment education

The involvement of people with HIV in all aspects of the design, implementation and evaluation of treatment education is key to programme performance and sustainability. As positive role models, they can provide counselling and information about treatment, based on their own experiences, and combat stigma and discrimination through advocacy activities in their communities. It is important that people with HIV are adequately supported to develop HIV and AIDS knowledge, communication, organization and management skills, and that they are compensated for their work.

Country example: South Africa

'Beat It! Your Guide to Better Living with HIV/AIDS', a weekly television series in South Africa, aims to combat fear and denial of HIV and AIDS by promoting accurate knowledge and information on a variety of HIV-related subjects, in turn empowering people to take charge of their own health. Episodes cover a variety of subjects, including dealing with death and loss, HIV and disability, tuberculosis and HIV, gender and HIV, among others. At a recent UNESCO and WHO Consultation, Siyayinqoba, Beat It's Programme Director, explained that the series '*is about making good decisions and creating environments in which those decisions can be made in a safe space*'.

Source: UNESCO/WHO. 2006 *HIV and AIDS Treatment Education*. Technical Consultation Report. Paris: UNESCO.

Key resources

- UNAIDS IATT on Education. 2006. *HIV and AIDS Treatment Education: A Critical Component of Efforts to Ensure Universal Access to Prevention, Treatment and Care*. Paris: UNESCO.
- UNESCO/WHO. 2006 *HIV and AIDS Treatment Education*. Technical Consultation Report. Paris: UNESCO.
- IFRC. 2006. *ART Training Toolkit*. Geneva: IFRC.
- International HIV/AIDS Alliance. 2006. *Community Engagement for Antiretroviral Treatment – Trainer's manual – Participatory Tools and Activities for Civil society Organizations Working with People with HIV*. Brighton, UK: International HIV/AIDS Alliance.
- SAfAIDS. 2005. *Women's Treatment Literacy Toolkit for People with HIV*. Harare: SAfAIDS.

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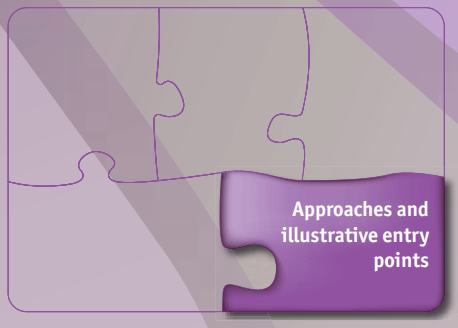
Communication and media in the education sector response to HIV & AIDS



What is the issue?

Communication and mass media are essential tools for raising awareness and educating in the general population, and, in particular, young people on means of prevention and available services for treatment, care and support. Communication and media can shape people's attitudes and contribute to social and behavioural change and include:

- **Information and communication technologies** (ICTs): applying new technologies such as the internet and interactive computer programmes to communicate messages;
- **Behaviour change communication** (BCC): using a range of communication strategies to change individuals' behaviour;
- **Social change communication** (SCC): using communications and mobilisation to support communities to change the underlying drivers of HIV risk and vulnerability.

The main challenges in using media and communication for HIV are:

- ensuring that messages from different forms of media and other educational efforts are consistent with one another. Failure to do so can create confusion for young people. In addition, it is important to ensure that the messages given in HIV and AIDS education in school do not contradict the messages given through the media;
- ensuring that journalists and media experts provide accurate and consistent messages on HIV. Inaccurate or conflicting messages can further stigmatise people with HIV and AIDS;
- positioning media communications within a rights-based framework and thus ensuring that people living with HIV or socially excluded groups are respected and treated without discrimination;
- ensuring participation and commitment from the people and communities in which change is expected;
- educating and supporting media producers, journalists and other key players in developing their capacity to deliver effective and accurate messages.

Why does it matter?

Communication and media strategies are important for:

- disseminating HIV and AIDS messages to raise knowledge and awareness on means of prevention and transmission and available services such as voluntary counselling and testing (VCT), treatment, care and support;
- increasing visibility of HIV and AIDS, thereby helping to reduce silence and fear to talk about HIV and AIDS and to know one's status;
- promoting behaviour change, including safer sex practices among adults and young people;
- facilitating access to services such as VCT and informing people about where and how to access services for prevention, treatment, care and support;
- reducing stigma and discrimination by deconstructing myths about HIV and AIDS, challenging attitudes that marginalise and socially exclude key populations and people living with HIV;
- challenging gender inequality and gender stereotypes.

Communication strategies are also powerful means to address the social drivers of the epidemic such as gender inequality, lack of human rights and HIV-related stigma and discrimination. These strategies are called social change communication and are important because they:

- allow communities to analyse for themselves how HIV has impacted on their community and what steps they can reduce the spread and impact of the epidemic;
- rely on participation of community members to change their own behaviours;
- focus on change at the level of the community rather than the individual, thus taking into account the wider cultural and peer influences which affect human behaviour.

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What needs to be done?

In order for mass media and communication to change behaviour, the messages need to be tailored to the specific target audience. Messages need to be culturally appropriate (see Brief on *Providing Culturally Sensitive Education on HIV and AIDS*), gender-sensitive and age-appropriate, as well as scientifically accurate.

- Communications should be targeted at people in communities who can be channels of information, such as teachers and traditional healers;
- Target audiences should be clearly identified so that their specific needs can be addressed appropriately;
- Media producers, journalists and other key stakeholders of the communication sector must be supported to develop their knowledge and capacity to deliver messages on HIV and AIDS;
- Networks and partnerships should be developed and nurtured between and among print and electronic media organizations, training institutions, and professionals;
- Communication for behavioural and social change projects and campaigns must be carefully planned, implemented and monitored with the participation of relevant stakeholders.

Ministries of education can effectively participate in and support national HIV and AIDS communication and media activities by:

- tailoring messages to the needs of young people;
- devising dissemination strategies as well as implementing project activities;
- sharing relevant policies to the public;
- supporting capacity-building of media and the communication sector in the area of effective learning methodologies.

Successful communication approaches which change underlying community beliefs and attitudes (such as social change communication) include[1]

- **Community participation and ownership:** communication programmes need to incorporate community participation and commitment from the start in order to ensure that the messages are suitable for the target audience and that the target audience participates in the communication process and contents.
- **Language and cultural relevance:** the communication process needs to be based on the specific culture and language of the target audience in order to increase legitimacy and relevance (see Brief on: *Providing Culturally Sensitive Education on HIV and AIDS*).
- **Generation of local content:** Communities already have strong local knowledge and community-based communication approaches can strengthen local knowledge and promote exchanges in equal terms.
- **The use of appropriate technology:** communication strategies should use technology which people can easily access and own.
- **Network and convergence:** social change communication programmes promote dialogue and debate, not only within the community, but also through networking more broadly. Networking contributes to strengthening the process and exchange of knowledge.

1 http://www.communicationforsocialchange.org/

Country example: South Africa

Soul Buddyz is an innovative multi-media health promotion and social change project about HIV and AIDS in South Africa. Through edutainment (education-entertainment) and the use of different types of mass media (TV, radio, print materials), the programme uses television to reach out to young people. The television programme tells the story of a group of friends and charts how they deal with HIV in their everyday lives. This dramatisation helps to make HIV a real issue which young people can easily relate to. Accompanying the television programme is a set of in-school activities such as teacher training, curriculum materials and anti-AIDS clubs.

Key partners

- Relevant ministries (education, information and communication, health, culture)
- United Nations (all UNAIDS Cosponsors and the UNAIDS Secretariat)
- National AIDS Commission
- Civil Society (NGOs, faith-based organizations)
- Private sector (MTV, L'Oréal)
- Journalists and media professionals
- School governing bodies and parent-teacher associations
- Donors

Key resources

- UNAIDS. 2005. *Getting the Message Across: The mass media and the response to AIDS*. Geneva: UNAIDS.
- UNAIDS. 1999. *Communications Framework for HIV/AIDS*. Geneva: UNAIDS.
- UNESCO, 2006. *Innovative Practices of Youth Participation in Media*. Paris: UNESCO.
- UNESCO. 2000. *Media & HIV/AIDS in East and Southern Africa: A resource book*. Paris: UNESCO.
- UNFPA. 2003. *Preventing HIV/AIDS among Adolescents through Integrated Communication Programming*. New York: UNFPA.
- Program for Appropriate Technology in Health (PATH) and Family Health International (FHI). 2002. *Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences*. Washington, DC: PATH.

Internet portals and links

- PANOS
  www.panos.org.uk
- UNESCO HIV/AIDS and ICT
  http://portal.unesco.org/ci/en/ev.php-URL_ID=23984&URL_DO=DO_TOPIC&URL_SECTION=201.html
- African Broadcast Media Partnership Against HIV/AIDS (ABMP)
  http://www.broadcasthivafrica.org/
- Journalist resource site on HIV/AIDS
  http://www.globalhealthreporting.org/
- MTV 'Staying Alive' website
  http://www.staying-alive.org/

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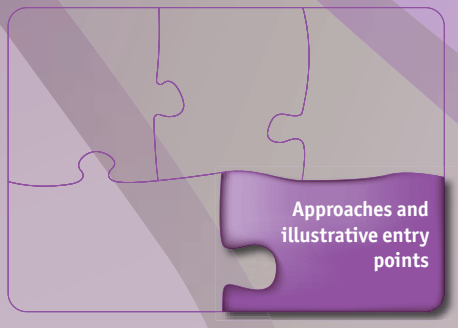
HIV prevention with and for people living with HIV



What is the issue?

Programme experience demonstrates that **prevention with and for people with HIV**, sometimes known as **positive prevention, is an essential component of comprehensive HIV and AIDS responses**.

Prevention with and for people with HIV **supports people with HIV to take effective steps to**:

- protect their sexual and overall health;
- avoid practices that could put them at risk of contracting sexually transmitted infections (STIs) and other opportunistic infections (e.g. tuberculosis);
- delay the weakening of the immune system and the onset of AIDS-related illnesses;
- protect themselves from reinfection;
- avoid transmitting HIV to their partners.

What needs to be done?

Guiding principles for **prevention with and for people with HIV** include that **people with HIV should be**:

- **fully involved in programme planning, design, implementation and evaluation** (see Brief on: *Promoting the Greater Involvement of People Living with HIV in Education Sector Responses*).
- **provided with information and practical support** to adopt risk-reductive behaviours and exercise their basic rights to privacy, confidentiality, informed consent and freedom from discrimination.

Additionally, such **programmes should**:

- **challenge stigma and discrimination** that pose significant barriers to information and services;
- **empower and support vulnerable groups,** as HIV is often fuelled by inequalities in power due to gender, sexuality, lifestyle and poverty;
- **deliver messages that are sensitive** to ethnicity, local culture and traditions, sexual orientation, age, language, and other issues, **delivered in a variety of settings and sustained over time**;
- **promote access to means of prevention** (e. g. condoms, clean needles) for everyone, regardless of their HIV status;
- **work not only with people living with HIV**, but also with those who may influence their behaviours and options (e.g. friends, family, partners, colleagues and outreach workers);
- **approach prevention education as a shared responsibility of all** – regardless of their HIV status.

Why does it matter?

Until recently, prevention education measures have focused primarily on helping uninfected persons adopt and maintain risk-reductive behaviours. They have often failed to address the distinct prevention needs of people living with HIV – who may or may not be aware of their HIV status.

Meeting the particular prevention needs of people with HIV is important because:

- people with HIV have the right to health and well-being, including a healthy sexual life;
- HIV and AIDS prevention, treatment, care and support are interrelated.

Interventions with and for people with HIV have also demonstrated a greater impact on the epidemic than prevention activities uniquely among individuals assumed to be uninfected, at equivalent levels of cost, time and resources.

These interventions also contribute to reduced HIV- and AIDS-related stigma and discrimination by supporting expanded HIV prevention information and services for all.

Positive prevention has recently emerged as **a programmatic strategy** used by a number of development partners. These include the U.S. Centers for Disease Control and Prevention (CDC), which acknowledged in 2003 that **opportunities had been missed in directing prevention messages towards people with HIV. The CDC recognises the importance of positive prevention across the continuum of strategies**, from helping people find out their HIV status, through increased access to voluntary counselling and testing (VCT), to enabling people who know they have HIV to reduce the risk of onward HIV transmission.

WHO and UNAIDS have also included positive prevention in a list of core interventions to promote universal access to HIV prevention, treatment, care and support.

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What works?

The selection of strategies will depend on the specific needs of people living with HIV in the programme area, the local social and cultural context, and the availability of financial, material and human resources, but may include a combination of the following:

- **Individual-focused health promotion** including:
  - → VCT;
  - → promotion of early detection of HIV infection through informed consent for testing;
  - → information and education on HIV and AIDS;
  - → information on risk-reduction strategies during sex, drug use, pregnancy, childbirth and breastfeeding;
  - → post-test and ongoing counselling;
  - → support for disclosure and partner notification;
  - → counselling for serodiscordant couples (when one person has HIV and the other does not).
- **Scaling up, targeting and improving service and commodity delivery** to ensure the:
  - → availability of voluntary counselling and testing;
  - → availability and distribution of condoms and lubricants at antiretroviral therapy (ART) delivery and other community service sites;
  - → elimination of stigma and discrimination among providers and other staff at treatment centres;
  - → provision of services to reduce mother-to-child transmission of HIV;
  - → provision of ART.
- **Community mobilisation by:**
  - → addressing gender-based violence;
  - → facilitating the establishment of post-test and other peer support groups;
  - → implementing focused and strategic communication campaigns;
  - → training people living with HIV as peer outreach workers (see Brief on: *Promoting the Greater Involvement of People Living with HIV in Education Sector Responses*).
- **Advocacy, policy change and community awareness** by:
  - → involving people living with HIV at all levels of programme implementation;
  - → conducting advocacy for positive prevention;
  - → conducting legal reviews and promoting legislative reform;
  - → supporting expanded and equitable access to ART.
- **Expanded HIV and AIDS education for all** – regardless of their HIV status (known or unknown) to promote risk-reductive behaviours and improved dialogue.

Country example: Mozambique

Kindlimuka, a non-profit association of people living with HIV and AIDS in Mozambique, has been carrying out prevention, care and advocacy initiatives since 1996. With support from UNICEF, Kindlimuka provides testimonials, conducts participatory learning programmes on HIV in schools, and trains peer educators. Due to the success of these programmes, similar activities have been replicated by other associations across the country.

Source: UNICEF www.unicef.org/mozambique

Key partners

- Relevant ministries (e.g. education, health, social welfare)
- Networks of people living with HIV, including the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS (ICW), and other national and local associations
- Civil society organizations, including the International HIV/AIDS Alliance and the International Federation of the Red Cross and Red Crescent Societies (IFRC)
- International agencies including the UNAIDS Secretariat, UNFPA, WHO and UNESCO

Key resources

- CDC. 2003. *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. 199(10), No. 3, pp. 141-150 (92 ref). Atlanta: CDC.
- Global HIV Prevention Working Group. 2004. *HIV Prevention in the Era of Expanded Treatment Access*. www.hivpolicy.org
- International HIV/AIDS Alliance. 2003. *Positive Prevention: Prevention strategies for people with HIV/AIDS*. Brighton: International HIV/AIDS Alliance.
- Janssen, R.S. *et al.* 2001. The Serostatus Approach to Fighting the Epidemic: Prevention Strategies for Infected Individuals. *American Journal of Public Health*, 91(7), pp. 1019-1024.
- NAPWA. 2003. *Principles of HIV Prevention with Positives*. Silver Spring: NAPWA.

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