Towards an AIDS-Free Generation

The Global Initiative on HIV/AIDS and Education

UNAIDS
Joint United Nations Programme on HIV/AIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
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Briefs for decision-makers

TOWARDS AN AIDS-FREE GENERATION

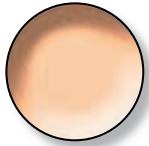## The Global Initiative on HIV/AIDS and Education

UNAIDS

Policy planning, management and resources

- Education and HIV/AIDS: a situation analysis
- Coordination mechanisms on HIV/AIDS and education at country level
- Projection models for HIV/AIDS prevention education
- Planning for human capacity in education in the context of HIV/AIDS
- Financing HIV/AIDS interventions in education
- Advocacy for HIV/AIDS prevention education

Still under consideration:

- *Monitoring and evaluation*
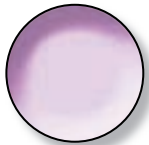
Education and communication: materials and methods

- Curricula for HIV/AIDS prevention education
- Teacher education for HIV prevention
- Quality education and HIV/AIDS
- Tertiary education and HIV/AIDS
- ARV Treatment education

Still under consideration:

- *Life skills education for HIV/AIDS*
- *Primary education*
- *The impact of sex and HIV/AIDS Education on behaviour*

Social, legal & service environment

- School feeding and HIV/AIDS
- Workplace policies on HIV and AIDS in education and training institutions
- Human rights, education and HIV/AIDS
- Fighting HIV/AIDS related stigma and discrimination

Still under consideration:

- *School health*
- *Education, culture and HIV/AIDS*

Key populations

- Focused HIV prevention programmes for key populations
- Education for orphans and children made vulnerable to HIV/AIDS
- HIV prevention education among out-of-school young people
- Girls' education and HIV prevention
- Refugees, internally displaced persons and HIV prevention education
- Drug use and HIV prevention education
- HIV prevention education and minorities
- Promoting the greater involvement of people living with HIV and AIDS in prevention education
- Prevention with and for people living with HIV and AIDS

Terminology & sources

- Acronyms
- Key partners

Still under consideration:

- *Information and research resources*
- *Guidelines on HIV-related language*
- *Official commitments and declarations of the United Nations*
- *Glossary*

TOWARDS AN AIDS-FREE GENERATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE GLOBAL INITIATIVE ON HIV/AIDS AND EDUCATION?

- The Cosponsoring Organizations of UNAIDS launched the Global Initiative on HIV/AIDS and Education in March 2004. This initiative aims to radically **enhance national responses against the epidemic by helping governments to implement comprehensive, nation-wide education programmes for young people**.
- The partners in the Global Initiative are united by a commitment to implement **a jointly developed framework on HIV/AIDS and Education**.
- The Global Initiative is designed:
- To complement and link with the **"3 by 5" Initiative to scale up treatment** against AIDS
- To be part of the broader **prevention effort spearheaded by UNAIDS**
- To facilitate the implementation of the so-called **"Three ones"** at the country level:

    One agreed HIV/AIDS Action Framework that provides 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

WHY IS THE GLOBAL INITIATIVE NECESSARY?

- **The epidemic is as unrelenting as it is devastating** – there are about 14.000 new infections a day and almost half of them are in the age group 15-24.
- **There is no cure** – and no cure is currently in sight. There is no vaccine – and no vaccine is in sight. Scaling up of treatments is essential and important – enabling people living with HIV and AIDS to continue living as caring parents, productive breadwinners and active citizens.
- **Treatments alone do not stop the epidemic**. Over the last several years, some 4-5 million new people have become infected with HIV – increasing the number who will be needing life long treatments in the future. To stop the epidemic and reduce its impact new infections must be prevented.
- **The sheer number of new infections** – with the epidemic accelerating in new areas and with additional millions adversely affected as children, kin and colleagues – **underlines the desperate need for education** to reduce the spread and social impacts of the epidemic.

Education is one of the most effective approaches to prevent HIV transmission and to mitigate the impact of the epidemic

- Educational institutions branch out further into communities and reach more young people than any other government-supported institutions
- Quality education influences not only the acquisition of knowledge but the development of constructive attitudes, skills and behaviours needed to develop appropriate personal and societal responses to the epidemic

WHAT IS PREVENTION EDUCATION?

HIV prevention education consists in the development of the awareness, knowledge, skills, attitudes and values that will reduce new infections and mitigate the impacts of HIV, including the impacts on the education sector.
It encompasses access to care, counselling and treatment education as well as preserving and enhancing the core functions of the education system through better planning and management. It aims to support decision-makers ranging from authorities deciding on national strategies to individuals deciding on life-styles.

WHAT ARE THE GOALS OF THE GLOBAL INITIATIVE?

The Global Initiative on HIV/AIDS and Education aims to support countries as they develop comprehensive education sector-based responses to HIV and AIDS, with a focus on children and young people, especially those who are most vulnerable.
As part of the overall UNAIDS prevention strategy, and in concert with all relevant development partners, **it will contribute to the realization of existing goals** set by the international community, notably:

(Continued)

- **The Dakar Framework for Action on Education for All** (April 2000):

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

- **The Millennium Development Goals** (Sept. 2000):

"To have halted by 2015 and begun to reverse the spread of HIV/AIDS" (Goal 6, Target 7)

- **The Declaration of Commitment of the United Nation General Assembly Special Session (UNGASS) on HIV/AIDS** (June 2001):

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce *by 2005* HIV prevalence among young men and women *aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.*

52. By 2005, ensure: that a wide range of prevention programmes *which take account of local circumstances, ethics and cultural values,* is available in all countries, particularly the most affected countries, including information, education and communication, *in languages most understood by communities and respectful of cultures,* aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, *including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections.*

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, *including peer education and youth-specific HIV education,* and services necessary to develop the life skills *required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers.*

Though achievements have been falling short of the commitments, **the goal of the Global Initiative is to reach an AIDS-free generation in less than a generation.**

WHAT ARE THE OBJECTIVES OF THE INITIATIVE?

The three main objectives of the Initiative rest on the premise that to reach children and young people with education about HIV and AIDS one must take a life-cycle perspective, socially embedding efforts to limit risk and vulnerability wherever young people are found: in school, after school, out of school.

1. **Support governments as they prepare a comprehensive educational response to HIV infection and AIDS, aimed both at risk and vulnerability reduction**, by:

- Enhancing capacity among education personnel to develop and implement responses

- Ensuring that appropriate, age-specific curriculum are developed, implemented, and available in all learning environments

- Monitoring to assess progress and to keep track of evolving needs and resources

2. **Mitigate the impact of HIV/AIDS on education in selected countries**, by:

- Developing planning and projection models to assess impact of the epidemic

- Assessing unmet needs, and ensuring that the Initiative is appropriately embedded in other development programmes and initiatives, notably Fast-track Initiatives, Poverty Reduction Strategic Papers, and Education for All plans

- Assisting in locating and securing funding to expand existing programmes and to develop and sustain new interventions

3. **Address structural causes of vulnerability in and around the learning environment** in close collaboration and partnership with development institutions and stakeholders by:

- Ensuring links between school health, school feeding programmes and HIV prevention education

- Targeting key populations with prevention education: girls, out-of-school young people, marginalized groups, minorities, refugees, etc.

- Developing or reinforcing attention to workplace issues for the benefit of education personnel and in the interest of educational institutions

- Ensuring that treatment, care and support are intimately linked to prevention efforts
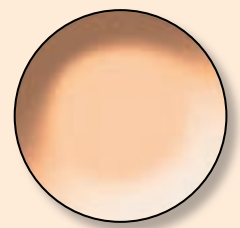
For decision support, a generic programme will be developed that is *simple and standardized,* yet *comprehensive and sensitive* to the particulars of each country and *applicable and adaptable* to each community.

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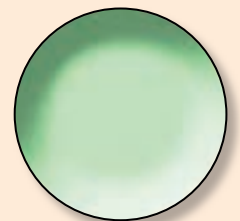
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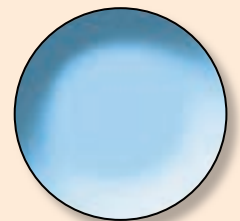- Monitoring and evaluation

Policy planning, management and resources
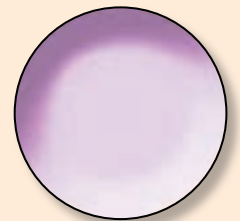
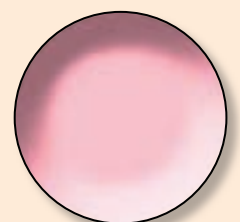Education and communication: materials and methods

Social, legal & service environment

Key populations

Terminology & sources

Joint United Nations Programme on HIV/AIDS

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UNESCO

EDUCATION AND HIV/AIDS: A SITUATION ANALYSIS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Millennium Development Goal 2 is focused on education with the aim being to *"Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling".* One of the greatest challenges in many developing countries to achieving this goal are the likely impacts of the HIV and AIDS epidemic on the education system and society. Basic facts on the relation between HIV/AIDS and education are outlined below.

OVERVIEW OF THE GLOBAL AIDS EPIDEMIC

- In just over two decades since the first cases of HIV infection were reported, **AIDS has become the most devastating epidemic in human history**.
- Globally some **39.4 million people** (between 35.9 – 44.3 million) **are living with HIV** (2004).
- **Numbers of new infections continue to rise**. In 2004:
- 4.9 million people became newly infected with HIV globally (more than 13 000 each day)
- nearly 3 million people became newly infected in sub-Saharan Africa
- 3 million people died of AIDS bringing the total number of people who died of AIDS since 1981 to over 20 million
- **Prevention efforts remain small-scale** and ARV treatment reach only a small percentage of people living with HIV and AIDS.
- Countries in Eastern Europe and East Asia are now experiencing the fastest growing HIV epidemic in the world. Large populous countries like China, India and Indonesia are of particular concern – even a slight increase in prevalence levels result in large numbers of people living with HIV.
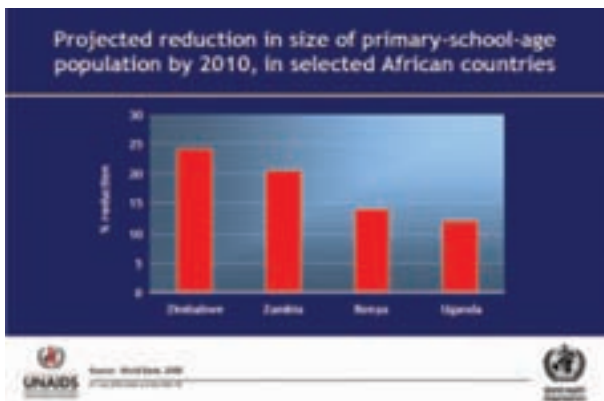
INCREASED FEMINISATION OF THE EPIDEMIC

Every year the number and proportion of women living with HIV increases.
- **Globally more than half of all adults who are infected are women**. In Africa the proportion is reaching 60%.
- In Sub-Saharan Africa 75% of young people infected are **women and girls**.
- **Gender power imbalances and inter-generational sex are important factors, along with biological factors**, that place girls at higher risk than boys. In sub-Saharan Africa, girls are having sex at an earlier age than boys and their sexual partners tend to be older.
- **Knowledge and information and access to services are the first lines of defence for young people**. The percentage of girls who have access to information is very low in most regions.
- **Women living with HIV or AIDS often experience greater stigma and discrimination** because of gender inequality.

Projected reduction in size of primary-school-age population by 2010, in selected African countries

Young people (15-24 years old) living with HIV, by region, end 2003

Sub-Saharan Africa 62%
Asia 22%
Eastern Europe & Central Asia 6%
High-income countries 2%
North Africa & Middle East 1%
Latin America & Caribbean 7%

Total: 10 million

Source: UNAIDS/UNICEF/WHO, 2004
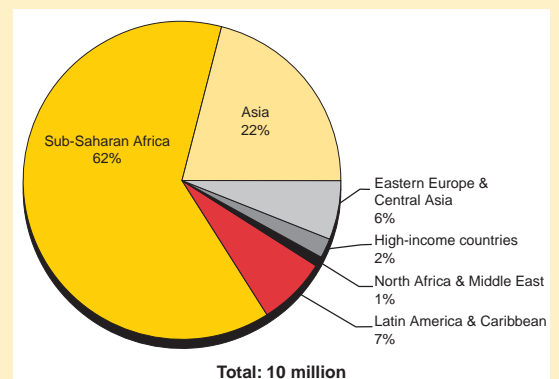
YOUNG PEOPLE AT RISK

Today's youth generation is the largest in history - nearly half of the global population is less than 25 years old. **Young people (aged 15 to 24) are both the most at risk** - globally accounting for half of all new HIV infections worldwide – **and the greatest hope for turning the tide of infections** - if they are given the tools and support to do so.

- More than 6000 young people contract the virus each day.
- 62% of all infected young people worldwide live in sub-Saharan Africa.
- A variety of factors place young people at the centre of HIV vulnerability including lack of information, education and services; the risks many are forced to take in order to survive; and the risks that accompany adolescent experimentation and curiosity including unsafe sex, drug injecting with contaminated equipment.

IMPACT ON SOCIETIES

- HIV and AIDS hinder human development
- High prevalence countries in sub-Saharan Africa are loosing on average 1 – 2 % of their annual economic growth.
- In many countries the impact of the epidemic on households is devastating – in Zambia for example, per capita Gross Domestic Product shrank by more than 20% between 1980 and 1999. Over the same period average daily calorie intake per person fell from 2273 to 1934 highlighting the impact of AIDS on households (loss of income occurs as individuals fall sick or die, and as household expenditures rise to meet increasing medical and related costs).
- Many Southern African countries are facing a human-capacity crisis as skilled staff essential for governments to deliver vital public services are lost because of illness and death.
- Average life expectancy has declined in 38 countries. In seven African countries where HIV prevalence in adults exceeds 20%, 13 years of average life expectancy have been lost as a result of AIDS mortality.

IMPACT ON EDUCATION

HIV and AIDS are significant obstacles to children achieving universal access to primary education by 2015. UNESCO estimates that 55 nations are unlikely to reach universal primary enrolment by 2015 – 28 of these are among the 45 most AIDS-affected countries.

- A decline in school enrolment is one of the most visible effects of the epidemic – in South Africa for example the number of pupils enrolling in the first year of primary school in 2001 in parts of KwaZulu-Natal province was 20% lower than in 1998.
- Many AIDS-affected families may withdraw children from school - a survey in three South African provinces reported that more than 40% of primary care givers took time off work or school to care for an HIV-infected family member. Almost 10% of households removed a girl from school compared to 5% for boys thus reinforcing gender inequities.
- Children orphaned or otherwise made vulnerable by AIDS may not attend school because they have to look after the household, care for younger siblings or because they cannot afford the fees.
- Quality of education may also suffer as more teachers become ill and die – a study in Zimbabwe found that 19% of male teachers and almost 29% of female teachers were living with HIV. In Southern Africa, AIDS related deaths among teachers rose by over 40% in 2000-2001.
- Inexperienced and under-qualified teachers and increased class sizes reduce quality of student-teacher contact. In rural areas where schools are dependent on only one or two teachers, a teacher's illness or death is especially devastating.
- An estimated US$1 billion per year is the net additional cost to offset the impact of AIDS (i.e. the loss and absenteeism of teachers and incentives to keep orphans and vulnerable children in school)
- HIV and AIDS weaken the quality of training and education as trained teachers are lost to the education system as a result of the epidemic.
- In Kenya, Uganda, Swaziland, Zambia and Zimbabwe, the epidemic is expected to significantly contribute to future shortages of primary teachers. In Swaziland for example an additional 7,000 teachers will need to be trained by 2020 to compensate for AIDS deaths.

KEY RESOURCES

- UNAIDS/WHO, *AIDS Epidemic Update*, UNAIDS, WHO, 2004
- UNAIDS
- HIV Impact on Education Clearinghouse (http://hivaidsclearinghouse.unesco.org/ev_en.php)
- UNESCO, *Education: A vaccine for HIV/AIDS*, In: *The new courier*, UNESCO, 2004
- Global Campaign for Education, *Learning to survive: How education for all would save millions of young people from HIV/AIDS*, Global Campaign for Education, 2004
- Kelly M.J., *Planning for education in the context of HIV/AIDS*, Series on fundamentals of educational planning, n° 66, Paris, UNESCO/IIEP, 2000

COORDINATION MECHANISMS ON EDUCATION AND HIV/AIDS AT COUNTRY LEVEL

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

Responses to the HIV/AIDS epidemic have continued to grow in intensity, but also in complexity. In particular:

- **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.

- **The flow of resources is increasing**, and with it too, the diversity of funding sources and of requirements for reporting and monitoring.

The need for coordination has therefore never been greater, if one is to ensure the most effective and efficient use of available financial and technical resources and to pool experience and expertise. It is a need that applies as much to coordination of the overall response as it does to coordination within specific sectors, especially those sectors that have much to contribute towards an effective response to HIV and AIDS. Education is one such sector, and one, where the impact of HIV and AIDS is being acutely felt in heavily affected countries.

WHAT NEEDS TO BE DONE?

It is important to establish institutional mechanisms for coordination and partnership, through which different actors will engage in the education sector response to HIV/AIDS. Mechanisms will facilitate dialogue, consultation and collaboration, and will aim to foster collective efforts, joint responsibility and mutual trust.

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/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 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

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WHAT NEEDS TO BE DONE? (Continued)

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 and evaluation

In the education sector:

Coordination of the planning, implementation and monitoring of the response to HIV and AIDS at country level should be undertaken by the Ministry of Education with key educational players in a 'Working Group on HIV/AIDS and Education'. The coordination role in the education sector should be informed and supported through active engagement in the multisectoral national coordinating authority.

This Working Group may benefit strongly from broad-based representation. Partners to be invited include relevant NGOs, bilateral agencies as well as the various UN 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

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WHAT NEEDS TO BE DONE? (Continued)

AIDS Council consisting of all relevant ministries as in Indonesia)

- To ensure coordination between the UN agencies, the Working Group could be UN driven (secretariat), but chaired by the Ministry of Education

The Working Group can serve to:

a. Scale up the response of the Ministry of Education and partners in the country by:

- **Providing evidence-based advocacy** in areas where the Ministry of Education and key partners are not, or not sufficiently, responding to HIV and AIDS

- **Supporting strategic planning as well as the development of a comprehensive sectorial strategic plan and of policies**

- **Offer strategic and technical advice** on how to:
- Integrate HIV/AIDS in the school curriculum and into teacher training
- Relate HIV/AIDS to a wider health education and sexual health education
- Strengthen the education sector's response in terms of care, support, and treatment of learners living with and affected by HIV and AIDS
- Deal with the impact of HIV and AIDS on the education sector
- Reach out-of-school youth through preventive education and related services
- Link to health services in general and the UNAIDS/WHO "3 by 5" Initiative in particular

b. Improve information sharing and analysis on:

- **Ministerial strategies and policies** related to education and HIV and AIDS

- **Pilot, regional, and nationwide HIV/AIDS projects and activities** being implemented by the Ministry of Education

- **Capacity building techniques** within Ministries of Education for scaling up the response to HIV and AIDS

- **Identified gaps in the response to HIV/AIDS** by the education sector

- **Key indicators** on the extent to which the UNGASS Declaration of Commitment on HIV/AIDS and "Education for All" goals are being reached

c. Enhance collaboration by:

- **Holding regular technical and financial meetings** between agencies, sharing information and developing plans for the future

- **Actively involving donors** in information meetings

- **Working towards an agreed approach to education and HIV/AIDS** among partners by integrating and testing current approaches such as reproductive health, life skills and HIV preventive education

- **Creating appropriate linkages** between schools, out of school youth and youth-friendly sexual health services

WHAT WORKS?

To ensure the best use of resources in support of national needs and priorities on HIV and AIDS, governments, donors, UNAIDS and civil society organizations now advocate in support of **three principles that are key to ensuring effective coordination of national responses to HIV and AIDS**, called the "Three Ones":

- *One agreed HIV/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*

The "Three Ones" are fundamental elements for sustainable, effective, long-term responses, including: support for national leadership and ownership, inclusion and participation of those who are most vulnerable in policy making, mutual accountability for all national and international partners, not least bilateral donors as well as the UN system.

HOW TO IMPROVE UN COORDINATION AT COUNTRY LEVEL?

Prevention Education can benefit from a number of key UN coordination mechanisms and technical resources that already exist at the country level. These include:

- *The UN Resident Coordinator system*: The UN Resident Coordinator system provides leadership for a strong and coordinated UN system response on HIV/AIDS that can assist in incorporating HIV/AIDS prevention education into the UN system's development frameworks – the *Common Country Assessment* (CCA) and *United Nations Development Assistance Framework* (UNDAF).

- *The UN Theme Group on HIV/AIDS*: The UN Theme Group is the major instrument for UN coordination and leadership on HIV/AIDS at the country level. It 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.

- *UN Technical Working Group (UNTWG)*: To assist the UN Theme Group in defining the UN system's policies and strategies, there is usually a UN Technical Working Group (UN TWG). It normally consists of the respective UN agencies' programme officers or focal points for HIV/AIDS-specific or HIV/AIDS-related programmes.

PROJECTION MODELS FOR HIV PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

How is an education system likely to develop? How will it respond to different interventions? These are the key questions projection models are used to answer.

Often many factors interact to produce the final outcome, and when these interactions are complex, projection models are particularly useful.

For example, future enrolment rates be may affected by the number of children born, distance to school, the economic situation of parents, the number of orphans, availability of teachers etc. – all of which may change over time. Enrolment rates may also change as a consequence of introducing school feeding programmes, reducing school fees, changing attitudes towards male and female learners, etc. Projections are a key tool in assessing such changes.

To make projections, a model of how the education system works is needed. The model allows you to review how a system will unfold over time. It also enables you to judge:

- **What will happen if no action is taken**
- **What can result from different interventions**
- **What interventions will have the greatest effects**

Hence one important use of projections is "what-if analysis": evaluating what will occur if a proposed policy change were implemented. By experimenting with a model, it is possible to assess the effects of actions before decisions are taken. Models are therefore useful at many different stages of policy-making: analysis, planning, policy-making, management, monitoring and evaluation.

WHY DOES IT MATTER?

Projection models are widely used in analysing the potential course of HIV/AIDS epidemic as well as its likely impacts, including its effects on the education system.

Most of the important decisions about the epidemic require knowledge about its current course, including its impacts on education, such as declining enrolments or shortfalls of teachers.

Likewise it is important to assess the potential effects of policy measures such as improved prevention, expanded treatments, revenue loss or reduced discrimination.

For HIV prevention, **projections can be used to assess a broad variety of issues**, such as:

- **The total number of people living with HIV and AIDS**, including children and young people, both now and in the future
- **The effects of the epidemic on subgroups of children and young people**, such as out-of-school young people and orphans and children made vulnerable to HIV/AIDS
- **The secondary effects of the epidemic** on economic growth, development and public finance
- **The effects of different social conditions on the epidemic**, such as poverty and malnutrition
- **The impacts of specific educational measures**, such as providing school meals, ensuring better teacher training and improving curricula
- **The impacts of behaviour change**, such as postponing sexual activity or increasing recourse to voluntary counselling and testing (VCT)
- **The cost of policy interventions**, such as providing treatments, funding retirement for sick teachers, training of teacher replacements, etc.

WHAT NEEDS TO BE DONE?

Projections and scenarios

- The validity and usefulness of a projection model depend on the assumptions made and how closely they correspond to real conditions, as well as on the quality of the data available.

- A projection model becomes more realistic the more factors are taken into account. But including more variables also makes it more complex and it increases the demands for different data.

- To develop credible plans for action, each country needs to design projection models with information specific to its national context. How they are constructed should be public to ensure transparency and accountability.

- Projections are used not only for simple forecasts, but to identify uncertainties. Different assumptions about future developments (e.g. about changes in birth rate) can become part of alternative scenarios. Such scenarios can prepare policy makers to address different possible futures.

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WHAT NEEDS TO BE DONE? (Continued)

What goes into projection models for education systems?

- **Demographic variables**, such as the total number of children by age and sex, migration between rural and urban areas, etc.
- **Economic quantities**, such as GNP, debt, grants and loans, budget allocations to education, domestic revenues
- **Socio-cultural factors** that have an impact on school enrolment and performance, such as traditions, gender roles, minority status or diseases
- **Political and institutional variables**, such as the degree of decentralization and capacity

With projection models, the availability of relevant data is the main challenge. To address this, it is vital to:

- Improve the country's Education Management Information System (EMIS), with special attention to the local level, and to regularly collect non-expensive qualitative information
- Produce and collect relevant information on the factors that can modify the impact of HIV/AIDS on pupils and teachers
- Develop transparency of information
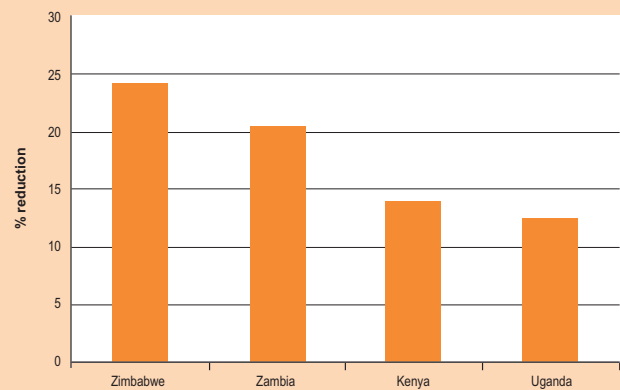
WHAT WORKS?

Some projection models for assessing the impacts of HIV/AIDS on education have been developed. Their suitability depends on the context and factors, such as the availability and reliability of data. Moreover, projection models can be modified and adapted, depending on the information accessible. Ultimately, there will be a trade-off between what questions you want to address and the data available to answer them.

Two examples of models are:

- **EDSIDA**: This has been developed by the Partnership for Child Development Team in cooperation with the World Bank. Its objective is to assess the consequences of the epidemic on teachers, mainly as a heuristic devise for raising awareness – including among policy makers – of the impact of HIV/AIDS, without providing specific data for planning purposes. The model projects the number of teachers in a country and the cumulative loss due to infections. It enables the additional costs of training and absenteeism to be calculated, as well as a pupil/teacher ratio.

- **IIEP**: The objective of this model is to assess the evolution of enrolments by grade and cycle and the resulting needs for teachers as well as physical and financial resources in the context of HIV/AIDS. It takes into account the impact of the epidemic on pupils and teachers, explores possible futures and allows the assessment of responses to changes in the educational system. The model is oriented towards planning for staff and physical and financial resources, based on assumptions about schools, such as facilities, equipment and teaching conditions. It allows simulation of the impact of different responses – such as changing organizational conditions and class size – that are essential for improving quality of education.

COUNTRY EXAMPLE: ZIMBABWE, ZAMBIA, KENYA AND UGANDA

A projection model was used to assess the reduction in the number of children of primary school age in four African countries by 2010.

Projected reduction in size of primary-school-age population by 2010, in selected African countries

Sources: World Bank, 2000

KEY PARTNERS

- Ministry of Education : Planning Department, Human resources Department, educational statistics service, District Education Offices
- National Statistics Institute, National Population Bureau, National Census Bureau (if not in the National Statistics Institute)
- Ministry of Health, Ministry of Social Welfare
- Relevant research institutions and universities
- UNAIDS
- International Institute for Educational Planning/UNESCO
- Partnership for Child Development
- The World Bank educational statistics

KEY RESOURCES

- Bennel P., Hyde K., Swainson N., *The Impact of the HIV/AIDS Epidemic on the Education Sector in Sub-Saharan Africa*, Centre for International Education, University of Sussex Institute of Education, 2002
- Croutch L., *Turbulence or Orderly Change? Teacher Supply and Demand in the Age of AIDS*, Pretoria, Department of Education, 2001
- UNAIDS Reference Group on Estimates, Modelling and Projections, "Improved methods and assumptions for estimation of the HIV/AIDS epidemic and its impact", *AIDS,* 16(9):W1-W14, 2002
- Boler T., *Approaches to examining the impact of HIV/AIDS on teachers*, UK Working Group on Education and HIV/AIDS, 2004
- "Projecting the impact of AIDS in the education systems: accelerating education sector response to HIV/AIDS in Africa": Sub-regional seminar on HIV/AIDS education (http://www.schoolsandhealth.org/Gabon%20Seminar/technical%20presentations/ModelPresentation.ppt)

PLANNING FOR HUMAN CAPACITY IN EDUCATION IN THE CONTEXT OF HIV AND AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

HIV and AIDS present a growing development challenge. The effects of the epidemic weaken the human and material capacity of the very institutions most needed to combat it – notably the education system. HIV and AIDS severely reduce the capacity of sectors to provide essential social services. Illness and death strike men and women during their most productive years, including educational policy makers, administrators and teachers.

In high-prevalence countries, rates of absenteeism, disease and death among key personnel strain capacity of the system to train replacements and make finding new recruits harder. Low individual performance and high turnover in the education sector will progressively undermine its planning, management and administrative capacity. They will also dramatically increase the costs of maintaining education services, as the expected working life of a trained teacher, for example, drops from thirty years to twenty or less, while the training costs do not diminish.

In consequence, **planning to deal with the effects of HIV/AIDS on social services, notably education, is a key task in all countries where the epidemic is not under control**.

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 up to 100 children.

Teachers and other key educational personnel are not easily replaced. For example, in Zambia and South Africa, the entire output of teacher training colleges will not be enough to make up for those lost to HIV and AIDS. When teachers are lost, schools fail and whole communities suffer. When ministries lose key staff, the whole education system suffers.

Damage to the education system tends to reduce demand for education, thus **increasing vulnerability of young people**. Out of school youth are less likely to have access to the information and education they need to adopt positive preventive behaviours, and being out of school in itself increases vulnerability to HIV and AIDS (*see brief on 'HIV Prevention Education Among Out-of-School Young People'*).

The potential impacts of the epidemic encompass:

- **Workplace issues** related to training, recruitment, retention, productivity, practices and procedures

- **Operations** of the education sector, including education and support

WHAT NEEDS TO BE DONE?

To effectively cope with HIV and AIDS, the education sector has to organize:

1. **A rapid response**:

- Stabilizing the sector's existing capacity in the short-term and introducing measures to replace losses by new categories of personnel such as volunteers and retired people

2. **A long-term strategic response**:

- **Prolonging life and health of education personnel** by promoting access to treatment and care and combating stigma and discrimination related to HIV and AIDS

- **Coping with the loss of human capacity due to HIV and AIDS** by fully integrating the impact of the epidemic into government planning, budgeting and monitoring tools and activities

- **Improving quality and performance of the education sector**, including by the use of innovative means of educational management and delivery, such as new information and communication technologies

WHAT WORKS?

Action to develop and retain the human capacity to preserve the key roles of the education sector involve cross-sectoral work to develop:

• Strong political will and commitment at all levels

• Adequate knowledge based on a diagnosis of the impact of the epidemic on the education sector. This must include information on changes in actual and projected impact on absenteeism, morbidity and performance of education personnel due to HIV and AIDS, and the development and maintenance of effective monitoring, review and evaluation mechanisms

• Dedicated financial resources to implement initiatives

• Capacity building for educational managers and professionals on new management, analysis, training and workplace issues related to HIV and AIDS, including responsive institutional systems and ways to secure additional internal and external resources

• Specific workplace programmes (*see brief on 'Workplace Policies on HIV and AIDS in Education and Training Institutions'*)

• Effective integration of HIV/AIDS components into national planning, not only for education, but also for other sectors that affect education

COUNTRY EXAMPLE: MALAWI

A study supported by UNDP found that the Ministry of Education, Science and Technology (MoEST) is operating with very high levels of staff vacancies - 52% among primary teachers and 77% among secondary teachers due to AIDS and out migration. Recommendations include:

• 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 with skills that are difficult to replace

• Exploring the possibility of utilizing UN volunteers for short-term replacements of critical capacities

• Developing critical skills by increasing the Government's scholarships fund

KEY RESOURCES

• Southern Africa Capacity Initiative (SACI), March 2004

• UNDP, *Supporting National HIV/AIDS Responses*, New York, UNDP, 2004

• Government of Malawi, UNDP, *Impact of HIV/AIDS on Human Resources in the Malawi Public Sector*, New York, UNDP, 2002

• Loewenson, R., Whiteside, A., *HIV/AIDS: Implications for Poverty Reduction*, New York, UNDP, 2001

• UNAIDS, WHO, *AIDS Epidemic Update* UNAIDS/WHO, Geneva, 2004

KEY PARTNERS

• Ministries of Education, of Planning and Development, of Finance, and of Social Welfare

• National AIDS Council

• Teachers' unions

• School governing boards

• International donor community, NGOs

FINANCING HIV/AIDS INTERVENTIONS IN EDUCATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

The impact of HIV and AIDS brings both new and additional costs to achieving Education For All (EFA):

• Additional costs due to the impact on the supply and quality of education. The epidemic increases absenteeism due to illness, treatment seeking and caring for sick relatives as well as the number of deaths among teachers and education staff. The costs include:

- Cover for absent staff

- Recruitment and training to replace staff

- Death benefits, including funeral costs

• Additional costs due to the impact on the demand for education. The epidemic increases the number of orphans and vulnerable children (OVC) who are less able to attend and stay in school. By 2010, there may be over 18 million orphans in sub-Saharan Africa, some 15% of the school-age population. The costs include those for:

- Support to enable OVC to stay in school

- Removing financial barriers to education, for example abolishing school fees and covering school levies for OVC

• New costs to ensure prevention, care and support for staff and students. Both groups need to be provided with the information and skills necessary to protect themselves and receive appropriate help. The costs include those for:

- Training teachers in prevention approaches

- Providing teaching materials

- Supporting peer education

- Providing access to information, voluntary counseling and testing and treatment

This extra expenditure comes at a time when, due to the social and economic impact of HIV and AIDS, all levels of society, from families to governments, may be experiencing reduced levels of income.

WHY DOES IT MATTER?

It has been recently estimated that, due to HIV and AIDS, an additional US$ 975 million will be needed every year to achieve Education for All globally. This covers costs related to teachers, school programmes and orphans and vulnerable children.

WHAT NEEDS TO BE DONE?

To estimate the effect of HIV and AIDS on the education sector, planners can use tools and models to quantify the impact and the resources required to mitigate it. The key steps include:

• Projecting the impact of HIV and AIDS on the supply of education. Using data - on the recruitment of new teachers and levels of retirement and voluntary departures, plus the rates of mortality and HIV prevalence - planners can estimate the total number of teachers, the proportion who are infected and the number who are dying or absent each year.

• Projecting the impact of HIV and AIDS on the demand for education. Using data - on age-specific fertility rates, the estimated number of school-aged children and the proportion that have lost one or more parent due to AIDS, plus the probability of vertical transmission and the survival probabilities of children who are infected - planners can project the proportion of OVC in the school age population.

• Estimating the additional cost. Education planners can use the above projections together with costs – for training teachers, teacher absenteeism, funeral grants, death benefits, prevention and treatment programmes and enrolling and keeping OVC in schools - to estimate the additional costs to the sector due to HIV and AIDS.

It is also important to estimate the "recovery" costs for education – those involved in addressing the past financial investments that have been undone by the epidemic.

COUNTRY EXAMPLE: MOZAMBIQUE

Mozambique: Impacts by 2010

Projections	
Number of orphans (in 2010)	734,081
Number of teacher deaths (during 2002-2010)	53,640
Costs of training teachers (cumulative to 2010)	US$ 1.3 m
Costs of absenteeism, (cumulative to 2010)	US$ 2.2 m

Further figures suggest that, in 2010 alone, it will cost US$ 35 million to enroll and keep orphans in school. Overall, the projections indicate that the impact of HIV and AIDS may severely affect the country's ability to meet EFA goals.

KEY PARTNERS

At the country level, the costs of responding to the impact of HIV and AIDS on education should be included in national budgets and discussed with development partners through the UN Development Assistance Framework (UNDAF), Poverty Reduction Strategy Papers (PRSPs), EFA plans and other planning instruments.

At the global level, there are a number of key institutions that can be approached to provide resources. These include:

- **Bilateral donors**: UNAIDS estimates that, in 2003, donor countries committed about US$ 3.6 billion to assist low and middle income countries to respond to HIV and AIDS, including in the education sector.

- **EFA Fast Track Initiative (FTI)**: A global partnership of donors, agencies and countries to support the goal of universal primary school completion by 2015. In the first 12months of operation, FTI has helped increase ODA to the first 12 countries by 17%, aiming to fill the gap between the current level of support for education and the costs related to achieving EFA, including those associated with HIV and AIDS. In addition, the Education Program Development Fund has mobilized $5.8m in 2005 to support preparation of sector plans, and US$ 255 million over 2004-2007 for a Catalytic Fund to assist countries that are having difficulties accessing ODA from other sources.

(Continued)

- **Foundations**: In 2002, the largest 15 American foundations that support international programmes made a commitment of US$ 228.9 million for HIV and AIDS globally, with 60% allocated to work outside of the USA.

- **Global Fund to Fight AIDS, Tuberculosis and Malaria**: This was created to find innovative ways to disburse funds to fight the three diseases. By mid 2004, US$ 3 billion had been approved for 331 grants for 128 countries, with 56% allocated to HIV and AIDS. US$ 232 million had been disbursed. In each country, funds are accessed through the Country Coordinating Mechanism (CCM).

- **International nongovernmental organizations (NGOs)**: In 2002, international NGOs, combined with bilateral donors, contributed approximately US$ 95.5 million to the HIV/AIDS response.

- **UN agencies**: Twenty-nine UN agencies are engaged in response to HIV and AIDS. Ten are UNAIDS Cosponsors and allocate specific funding to the epidemic.

- **US President's Emergency Plan For AIDS Relief (PEPFAR)**: This has committed US$ 15 billion to action on HIV and AIDS. Of this, about US$ 9 billion is for 12 African countries, plus Guyana and Haiti. The programme began disbursing funds in 2004, with a total of US$ 2.4 billion allocated for the first year.

- **World Bank**: Since 2000, the World Bank, through its Africa Multi-Country AIDS Programme (MAP), has committed US$ 1.07 billion for 28 countries and 2 sub-regional projects. The Caribbean MAP provides US$ 155 million to 14 countries. In 2003, the World Bank approved US$ 2.3 billion in education projects, half focused on basic education and all eligible to support HIV and AIDS responses.

KEY RESOURCES

- UNESCO, *EFA Global Monitoring Report*, Paris, UNESCO, 2003
- The World Bank, *Modeling the Impact of HIV/AIDS on Education Systems: A Training Manual*, Washington D.C., The World Bank, 2002
- The World Bank, *Education and HIV/AIDS. A Window of Hope*, Washington, World Bank, 2003
- Bruns, B., Mingat, A., Rakotomalala, R. (ed.), *Achieving Universal Primary Education by 2015 – a chance for every child*, Washington D.C., World Bank, 2003

ADVOCACY FOR HIV PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

The purpose of advocacy is to make key decision makers aware of a certain problem or issue, and of how they can take action on the required scale to address it.

More than two decades after the start of the HIV/AIDS pandemic, millions of children and young people still lack access to HIV prevention and sex education.

Many people living with or affected by HIV and AIDS – including those that learn or work in the education sector – are denied their fundamental human right to adequate health care, education and other services.

Advocacy is a first step in the process to remedy to this situation. It ensures that both policy makers as well as the general public are kept informed of the problems, of their urgency and of the options for response.

WHY DOES IT MATTER?

HIV and AIDS requires advocacy on an unprecedented scale and is vital for HIV prevention education.

Advocacy is vital because prevention education has to challenge complex, sensitive and ingrained social patterns such as gender relations, sexual behaviour, customs and traditions, **while at the same time providing practical, action-orientated guidance and solutions for behaviour and social change**.

Advocacy is vital also because effective HIV prevention education requires extensive partnerships among a broad range of stakeholders whose composition varies from country to country and whose interests often diverge. These include those both directly and indirectly involved in the education sector.

As the epidemic escalates, **there is an ever-increasing need for consistent and continuous communication of key information and targeted messages**.

WHAT NEEDS TO BE DONE?

To achieve comprehensive HIV prevention education, advocacy needs to be carried out at different levels:

- **Regional level**, with regional networks of governments, UN agencies and universities. For example, in the SADC region, an HIV/AIDS Strategic Framework and Action plan was developed by governments in 2003-2007 and a UN Regional Directors Group on HIV/AIDS established to support national HIV/AIDS responses in Eastern and Southern Africa.

- **National level**, with ministers, civil servants, opinion leaders (politicians, religious leaders, artists, entertainment and sports celebrities), UN

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

agencies, donors, companies, news organizations and international 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. For example, with trainee teachers, the work should focus on ensuring that they have both adequate knowledge and the right skills and attitudes to address HIV and AIDS-related issues in the classroom.

- **School level**, with school directors, head teachers, administrators and teachers. For example, with directors, the work should focus on emphasizing a school's institutional responsibility to take action on HIV and AIDS prevention – to support learners and staff and also to engage with and set a positive example to the local community.

- **Family level**, with parents, grandparents, siblings and members of the extended family. For example, with parents (through Parent-Teacher Associations), the work should focus on seeking their approval and endorsement of HIV prevention education - by emphasizing the positive benefits to their children.

- **Community level**, with religious groups, local leaders, health workers, NGOs and groups of people living with HIV and AIDS. For example, with local leaders, the work should focus on emphasizing the positive benefits of HIV prevention education, not only to children and young people in school, but to the broader community and its future.

Advocacy at all levels needs to be supported by appropriate technical support and capacity building on key skills. These key skills include strategic planning, message development and public speaking. It also involves working in non traditional

WHAT WORKS?

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

A coordination mechanism, involving all key partners, both within and outside of 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 detail 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 for prevention education should be:

• Short, positive and powerful

• Simple, in culturally appropriate language

• Realistic and relevant to the target audience

• Backed up by facts and figures

Those who deliver messages should be not only knowledgeable, but also have legitimacy with the target audience.

When planning an advocacy campaign on HIV prevention education, it is important to be prepared to respond to potential critics. For example, data should be at hand that demonstrates that, if carried out in a participatory and culturally sensitive and youth-friendly manner, HIV prevention does not lead to the earlier onset of sexual activity (UNAIDS, 1999).

COUNTRY EXAMPLE: UGANDA

Uganda adopted a multisectoral approach on advocacy for HIV prevention early on in the epidemic. The programme was established under the auspices of the national AIDS Commission and 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/AIDS were broadcast widely while the Islamic Medical Association of Uganda supported community education programmes on HIV/AIDS, including condom distribution.

KEY PARTNERS

• Ministries of Education

• UNAIDS agencies, especially UNESCO, UNICEF, the World Bank, UNFPA, WHO, UNDP and ILO

• Teacher training institutions

• Teachers' unions

• Parent-teacher associations

• Student groups and associations

• National AIDS Programs

• National and international NGOs

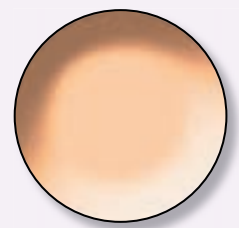• Opinion leaders, including journalists

KEY RESOURCES

• UNESCO Asia-Pacific Regional Bureau for Education, *Education and HIV/AIDS: An Advocacy Toolkit for Ministries of Education,* UNESCO Bangkok, 2003

• Interagency Task Team for HIV/AIDS and Education, *HIV/AIDS and Education: A Strategic Approach*, Paris, IIEP Publications, 2002 (http://www.unesdoc.unesco.org)

• Carr-Hill R., Katabaro K.J., Katahoire A.R., Oulai D., *The Impact of HIV/AIDS on Education and Institutionalizing Preventive Education*, Paris, IIEP, 2002 (http://www.unesdoc.unesco.org)

• The World Bank, UNICEF, *Ensuring Education Access for Orphans and Vulnerable Children: A Training Module*, The World Bank, 2002 (http://www.schoolsandhealth.org)

• The World Bank, *Education and HIV/AIDS. A Window of Hope*, World Bank, 2003

Education, materials & methods

- Curricula for HIV/AIDS prevention education
- Teacher education for HIV prevention
- Quality education and HIV/AIDS
- Tertiary education and HIV/AIDS
- ARV Treatment education

Still under consideration:

- *Life skills education for HIV/AIDS*
- *Primary education*
- *The impact of sex and HIV/AIDS Education on behaviour*

Policy planning, management and resources
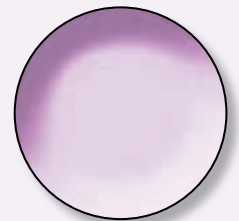
Education and communication: materials and methods

Social, legal & service environment

Key populations

Terminology & sources

Joint United Nations Programme on HIV/AIDS

UNAIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
UNODC·ILO·UNESCO·WHO·WORLD BANK

UNESCO

CURRICULA FOR HIV PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

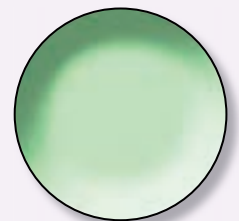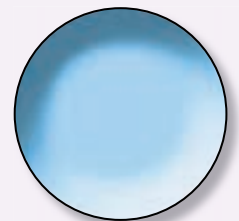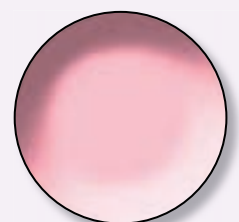Many countries include HIV prevention education in their curricula and develop effective teaching materials. However, **recent evaluations of HIV prevention education in school settings highlight a number of common shortcomings**:

- Within already crowded curricula, HIV/AIDS education gets little or no attention

- When it is part of the curriculum, HIV/AIDS is not covered comprehensively

- Teaching and learning material is poor or not available

- Learning of facts is generally emphasized over acquiring attitudes and adopting safe behaviours

- Teaching methods are not appropriate, notably to take into account factors such as gender inequalities, socio-cultural context and life skills education

- Teachers are not adequately trained or supported to provide effective HIV prevention education

- No specific or relevant assessment of learning outcomes, including acquired skills, is carried out

Overall, these weaknesses mean that **HIV/AIDS is often not covered in a meaningful and relevant way**, and with sensitive but vital issues often missed out.

In some cases, HIV/AIDS is simply not taught at all.

WHY DOES IT MATTER?

It is imperative that HIV prevention education be incorporated into the curricula of schools because:

- **Schools are embedded in all communities**, with the potential to reach more children and young people than any other institution

- **Schools often do serve as community hubs and centers for outreach**, providing opportunities for individuals and a wide range of groups to participate in HIV prevention education efforts

- **Teachers are an invaluable resource for education and information**, often motivated and willing to contribute to HIV prevention

Life skills education is central to HIV prevention education. It refers to an interactive teaching and learning, which enable learners to develop the knowledge, attitudes and skills to adopt healthy and safe behaviours. To take care of themselves and others, children and young people need to learn how their body functions, know what promotes well-being and good health and be empowered to develop beneficial social relations.

(Continued)

WHY DOES IT MATTER? (Continued)

It is vital that HIV prevention education starts at an early age in primary school and be sustained through secondary school:

- Early learning targeted for children aged 10–14, usually before sexual activity begins, can have an important impact on the spread of HIV within a rising generation

- In many countries heavily affected by HIV and AIDS, most children do not go on to secondary school and the only opportunity to reach them is at primary level

- Behavioural studies show that young people are more likely to adopt safer sexual practices if they receive good quality, gender sensitive, learner-centered reproductive health education *before* starting sexual activity

- To be effective, prevention education needs to be continued and repeated throughout schooling

- Special programmes must be established to reach out-of-school youth

As a group not yet infected with HIV, children and young people present a "window of opportunity" that it is vital not to miss.

WHAT NEEDS TO BE DONE?

To achieve national coverage of effective HIV prevention education programmes, **a two-fold approach is needed**, combining:

- **Local level innovation and experimentation**, by implementing existing best practice of HIV prevention education programmes in schools and teacher training institutions

- **Top-down insertion of HIV prevention education into official curricula**

Overall:

- **Curricula need to provide strong requirements as well as clear and practical stipulations** to ensure that HIV prevention education is actually implemented in schools

- **Adequate time needs to be allocated** to HIV education

- **Systematic assessment of learning outcomes should be undertaken**

- **Life skills education must be age-appropriate, culturally sensitive, and start before the onset of sexual activity**. It should include self-respect and respect for others, assertiveness, critical thinking and communication

- **HIV prevention education should be comprehensive**, providing options for prevention covering:

  - Relationships and sexuality

  - Gender issues and inequalities

  - Stigma and discrimination

- **HIV prevention education should be introduced when young children are starting to develop their values and behaviours**

- **HIV prevention education would be strengthened if it were made an "examinable" subject** within the curriculum

KEY PARTNERS

- Ministries of Education and other Ministries, including Health, Sports, Youth and Culture

- Textbook authors and publishers

- Teacher training institutes

- Schools governing boards

- NGOs and other civil society organizations

- UNESCO, UNICEF, UNFPA

WHAT WORKS?

For effective HIV prevention education, knowledge alone is not enough. Experience and evaluations have shown that, **to be effective, curricula and programmes should**:

- **Actively involve young people, community leaders and other representatives of civil society** in the development, adaptation and implementation of initiatives

- **Provide demonstrations of and practice in skills of communication, negotiation and individual decision-making**

- **Use teaching methods that help learners to personalize information**, especially about risk and vulnerability

- **Last long enough** to be comprehensive and complete important learning activities

- **Select, train and use teachers or peers** who actually believe in the importance of the work

- **Specifically address behaviours that put people at risk**

Governments can take a lead by:

- **Setting standards for the content** and minimum duration of HIV prevention programmes

- **Providing practical examples of good, simple and comprehensive HIV education programmes**, with instructions for teachers, activity sheets for learners

- **Developing tools to adapt and implement curricula in local contexts**

KEY RESOURCES

- HIV/AIDS Curriculum Clearinghouse

- UNICEF, *Life Skills Education With a Focus on HIV/AIDS*: Eastern and Southern Africa Region, Nairobi, UNICEF/ESARO, 2003

- Boler T., *The Sound of Silence. Difficulties in communicating on HIV/AIDS in schools, London*, ActionAid, 2003

- The World Bank, *Education and HIV/AIDS: A Sourcebook of HIV/AIDS prevention Programs*, Washington D.C., The World Bank, 2003

TEACHER EDUCATION FOR HIV PREVENTION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Education ranks among the most effective and cost-effective means of preventing HIV transmission and infection. In order to have an impact, **teachers must be provided with appropriate HIV-related knowledge, skills and resources, and supported by institutions and communities in their work with their colleagues and students.**

Teacher education programmes, administered through universities and teacher training institutions, and complemented by continuing professional development, **are key to preparing teachers to address HIV and AIDS in their own lives and in the lives of those they instruct and mentor**. They are part of a comprehensive response by the education sector to prevent and to mitigate the effects of HIV and AIDS on teachers and students, institutions and communities.

WHY DOES IT MATTER?

Educational institutions reach further into communities around the world than any other institutions. Teachers are strategically placed to develop students' HIV/AIDS-related knowledge and life skills and to combat stigma and discrimination against people living with HIV and AIDS. This should start in primary school and continue through secondary education and university.

Teacher education programmes equip teachers who teach in both formal and non-formal educational settings **with the skills, instructional methods and resources to provide effective HIV prevention education**.

These programmes support teachers to:

- **Gain confidence and comfort in discussing sensitive issues** such as sexuality, health behaviours, gender issues, diseases, culture and morality
- **Establish conducive learning environments** that promote the adoption of safe and healthy behaviours and skills related to HIV/AIDS prevention, care and support
- **Develop participatory and interactive teaching materials for HIV/AIDS education programmes**
- **Encourage other teachers to incorporate HIV/AIDS issues** into their curricula and learning materials and into professional discussions they may have with other colleagues and community members
- **Advocate for workplace policies and guidelines** supporting HIV education (*see brief on 'Workplace Policies on HIV and AIDS in Education and Training Institutions'*)
- **Strengthen parental support of HIV education** through participation in parent/teacher associations, teachers' and family welfare groups

WHEN IS IT NEEDED?

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

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

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

WHAT NEEDS TO BE DONE?

Effective teacher education programmes for HIV education **should**:

- **Address teachers' own vulnerability to HIV infection and AIDS** and acknowledge how HIV and AIDS have affected teachers and their institutions as well as the education system
- **Provide guidance on and practice in inter-active and participatory methodologies** including role playing, debates and life skills education (*see brief on 'Life Skills Education for HIV Prevention'*)

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **Develop counselling and support skills for teachers**, including how to work with students, colleagues and other teachers affected or living with HIV/AIDS
- **Supply learning materials that are appropriate** to the age, gender and culture of students and their communities (*see briefs on 'Curricula for HIV Prevention Education' and 'Building Culturally Sensitive Education on HIV and AIDS'*)
- **Use information and communication technologies** (ICTs) as well as distance learning programmes **effectively**
- **Involve communities, including people living with HIV**, to share knowledge, build support and encourage dialogue
- **Provide incentives and motivation for continuing professional development** through the provision of continuing education credits or certification to teachers
- **Be reinforced by ongoing encouragement** through peer coaching and support groups or mentoring with 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 impacts of teacher education programmes on HIV education. Additional studies should document:

- Which training approaches and modes of delivery lead to effective learning and skills outcomes for teachers
- The effect of refresher courses and in-service training on teachers' HIV/AIDS-related knowledge, attitudes and skills
- Relevant indicators to monitor and evaluate teacher education programmes on HIV and AIDS

COUNTRY EXAMPLE: ZIMBABWE

In Zimbabwe, where the HIV prevalence is estimated at 24.6% of the adult population, the Ministry of Education and Culture and UNICEF have been training national, regional and district education officers and teachers in participatory methods and in HIV/AIDS curriculum development since the mid-1990s. Pre-service training is based on an AIDS education curriculum established in nearly 30 colleges while in-service training uses a cascade model - training trainers at the central level, who then train the next level, and so on down to the local level.
An evaluation of the project concluded that teacher education requires detailed planning and close monitoring using "hands-on participatory training for teachers" and establishing a "close link…between in-service training and pre-service training, and between training and materials."

KEY PARTNERS

- Education International
- UNESCO, ILO, UNAIDS
- InWENT
- Ministries of Education and other relevant Ministries
- Teacher training centres
- Teacher associations
- World Confederation of Teachers
- NGOs

KEY RESOURCES

- Gallant M., Maticka-Tyndale E., "School-based HIV Prevention Programmes for African Youth", *Social Science and Medicine,* 58 (7), 2004, 1337-51
- Education International, WHO, Education Development Center Inc., *Training and Resource Manual on School Health and HIV/AIDS Prevention,* WHO, 2001
- O'Donoghue J., "Zimbabwe's AIDS Action Programme for Schools: A Case Study", *Promotion and Education,* 3(2), 1996, 7-12
- James-Traore T.A., Finger W., Daileader Rudland C., Savariaud S., *Teacher Training: Essential for School-based Reproductive Health and HIV/AIDS Education*, Arlington, Family Health International (FHI), Youthnet Program, 2004
- UNESCO, *Teacher Training Manual on HIV/AIDS Preventive Education in the School Setting,* UNESCO/ Asia and Pacific Regional Bureau for Education, 2005

QUALITY EDUCATION AND HIV/AIDS

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

Quality education is a basic human right. It provides children with invaluable tools to fight poverty and to promote social progress. It increases life skills such as self-confidence, social and negotiation skills, and their earning power.

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 educational outcomes both for present and for future generations.

Due to the magnitude of the HIV/AIDS epidemic, the quality of educational systems has been challenged, potentially threatening progress 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 are 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, teenager, adult) in her/his learning environment (formal or nonformal)
- **The level of the system** that creates and supports the learning experience

Both dimensions must tailor their responses taking the HIV/AIDS pandemic into account.
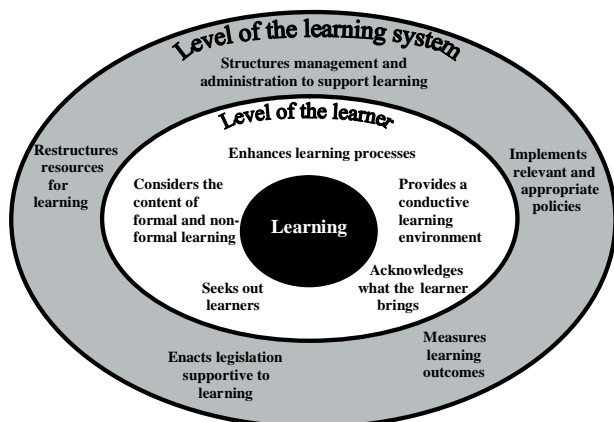
A Framework for Considering HIV/AIDS and Quality Education

WHAT NEEDS TO BE DONE AT THE LEVEL OF THE LEARNER?

- **Seek out learners** from households affected by HIV/AIDS, and assist them, their families and their communities to support learning and fulfill 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 the learning materials, ensuring they are culturally appropriate and gender responsive, age specific, contain accurate HIV/AIDS information, and include education that teaches how to protect and respect oneself and others (*see brief on 'Life Skills Education for HIV Prevention'*)

- **Emphasize inclusion, participation and dialogue** that addresses HIV/AIDS-related stigma and discrimination from classmates, teachers, parents and communities

- **Provide a safe learning environment** which prohibits all forms of violence, provides adequate hygiene and sanitation facilities, and ensures access to health and nutrition services

WHAT NEEDS TO BE DONE AT THE LEVEL OF LEARNING SYSTEMS?

- **Promote open and transparent mechanisms within the educational system and establish a legislative framework** to support and encourage a dialogue on HIV/AIDS and the right of all to have access to education
- **Implement educational programmes** that make schools safe and supportive of the learner and ensure access to education
- **Mobilize resources to meet the increasing human and financial demands caused by HIV/AIDS** to ensure the provision of Education for All (EFA)
- **Measure educational achievement** related to knowledge, attitudes, skills and behaviors and work towards a system of education that does not discriminate or stigmatize those affected or infected by HIV/AIDS

WHAT WORKS?

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

- **Support individuals and communities to "break the silence" on the impact of the HIV epidemic** on daily lives and institutions, including education systems, while improving community awareness of the value of education
- **Ensure the involment 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/AIDS and education programmes for their children
- **Improve access to school for all learners** through reducing or eliminating annual 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 men and women's vulnerability to HIV. This includes strategies that seek to empower women while also involving men
- **Develop and implement workplace policies** that are responsive to HIV/AIDS for teachers, administrators and other school staff including codes of practice and guidelines (*see brief on 'Fighting Stigma and Discrimination'*)
- **Develop teacher training programmes** on HIV/AIDS and related issues (gender, human rights, sexual and reproductive health, life skills and communication skills)
- **Measure learning outcomes in terms of acquisition and use of knowledge, skills or competencies, values and behaviours about HIV/AIDS** and use the results for the implementation and assessment of educational policies, programmes and practices

(Continued)

WHAT WORKS? (Continued)

- **Expand access to antiretroviral (ARV) treatment and treatment education** including information on obtaining and adhering to treatment, and the role of stigma and discrimination and gender inequality (*see brief on 'ARV Treatment Education'*)
- **Develop actions to minimize the impact of the pandemic on the education system**, and the role of the school and system in care and treatment, in education plans, including national EFA plans

COUNTRY EXAMPLE: ETHOPIA

In settings highly impacted by HIV/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 recent study in Ethiopia found that schools that began and ended the day earlier than usual and scheduled breaks during harvest time had improvements in students' continuation and achievement rates.

KEY PARTNERS

- Academy for Educational Development
- Education International
- Ministries of Education and relevant Ministries
- Parent-teacher associations
- School governing boards
- Teacher training institutions
- UNESCO
- UNICEF
- USAID
- World Bank

KEY RESOURCES

- UNAIDS Inter-Agency Task Team (IATT) on HIV/AIDS and Education, *Quality Education and HIV/AIDS*, Paris, UNESCO, 2004
- UNICEF, *Quality Education for All: From a girl's point of view*, UNICEF, 2002
- Coombe C., "Mitigating the Impact of HIV/AIDS on Education Supply, Demand and Quality", in Cornia G.A. (Ed.), *AIDS, public policy and child well-being*, Florence, UNICEF-IRC, 2002
- UNICEF, *Defining Quality in Education*, New York, UNICEF, 2000
- Verwimp P., "Measuring the quality of education at two levels: A case study of primary schools in rural Ethiopia," *International Review of Education*, 45(2), 1999, 167-196

TERTIARY EDUCATION AND HIV/AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Prevention education programmes in tertiary institutions are vital because:

- **They educate and train already sexually active young adults,** unlike most of the school system

- **Many are involved in high-risk sexual behaviour** despite the fact that HIV/AIDS awareness among students and staff is fairly widespread

- There is growing evidence that **students and higher education staff are getting infected or affected by HIV/AIDS** in many countries where the epidemic is growing

- **Increased HIV/AIDS-related morbidity and mortality is undermining the core functions of tertiary institutions** to train future leaders, professionals and experts and to fulfil their educational, research and informational functions necessary for economic and social development

WHY DOES IT MATTER?

High levels of HIV/AIDS-related illnesses and deaths affect tertiary institutions at various levels because they impact on:

- **The demand for tertiary education** by reducing the number of students in these institutions. As parents fall sick, they become more reliant on their children's economic contribution or unable to afford school fess.

- **The supply of highly trained and experienced teachers**: high levels of morbidity and mortality in teaching staff are affecting the ability to provide educational services

- **The quality of education** because of teacher absenteeism and attrition as they fall sick or die

- **Human capacity development** by undermining the heavy educational and financial investments made in tertiary education

Most tertiary institutions have not assessed the full effect of the epidemic and responses are slow in coming:

- **Few tertiary institutions have developed any formal policy guidelines to tackle HIV and AIDS**

- **Most tertiary institutions have not mainstreamed HIV and AIDS into their teaching programmes** and many teachers would be ill equipped to teach the topic if it were

- **Tertiary institutions have not started to deal with the replacement and training costs** of those leaving university

WHAT NEEDS TO BE DONE?

To effectively deal with the epidemic, tertiary institution governing boards should provide leadership in the battle against HIV/AIDS and elaborate consistent and efficient strategies with a long term perspective that:

Acknowledge the need for an institutional response

- **Recognize that HIV and AIDS undermine the quality and quantity of the educational and training services** that tertiary institutions offer

- **Recognize that the epidemic calls for a drastic, concerted and well-coordinated response**

- **Target both students, teachers and non teaching staff**

- **Are both inward-looking** (protects the institution's own functioning) **and outward-looking** (serve the needs of an AIDS-affected society)

Set new mechanisms to strengthen their capacity to establish an HIV/AIDS strategy

- **Identify focal units for dealing with HIV and AIDS** across the institution

- **Set collegial and collaborative procedures *at every stage of the response*** (design, planning, implementation, monitoring and evaluation)

- **Set aside resources** to build their internal capacity to deal with HIV and AIDS

- **Quantify and document their direct and indirect losses** due to HIV/AIDS-related morbidity and mortality both among their students, teachers and non teaching staff

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **Support university HIV/AIDS research programmes**

Aim at developing prevention, care and treatment for students and staff

- **Mainstream HIV education into teaching and training programmes** for students and staff
- **Develop information, counselling and care services** that are effectively used by students and staff
- **Refer to treatment delivery programmes**
- **Bolster individual responsibility** to help students, teachers or administrative staff to develop a lifestyle in which they do not put themselves or others at risk of infection and/or social exclusion
- **Improve the learning environment** with the aim of decreasing the vulnerability of specific groups

Mitigate the impact of the epidemic on the tertiary education system

- **Protect social and human rights** of students, teachers or administrative staff infected/affected by the disease through the establishment of codes of conduct *(See brief on 'Human Rights, Education and HIV/AIDS')*
- **Establish an HIV/AIDS workplace policy** *(see brief on 'Workplace Policies on HIV and AIDS in Education and Training Institutions')*

WHAT WORKS?

Many factors contribute to the success of responses to HIV and AIDS in tertiary institutions. These include:

- **Sensitive and strong institutional leadership** that keeps track of institutional focus on HIV/AIDS
- **Collecting, sharing and keeping up to date evidence-based data on the vulnerability of the tertiary education sector to HIV and AIDS,** including quantifying its impact on performance and productivity
- **Dedicated HIV/AIDS management structures** at national, district and institution level with clear mandates and lines of communication
- **Additional financial resources** dedicated to implement and sustain HIV/AIDS initiatives
- **Effective monitoring, review and evaluation mechanisms to assess achievements and failures**

COUNTRY EXAMPLE: KENYA

A study conducted in 2000 revealed that the University of Nairobi was losing about two of its members every week, which translates into about 100 people per annum, to AIDS related illnesses. The loss of manpower has particularly been more acute among senior academics and administrators, whose training takes huge financial resources and time.

(Continued)

COUNTRY EXAMPLE: KENYA (Continued)

There has also been an increase in the level of morbidity within the university resulting in considerable strain on the meager human and financial resources allocated to health care.

Through its Vice-Chancellor, the University of Nairobi recognized the devastating effects of HIV and AIDS on its personnel, finances and academic programmes. It has since intensified research activities and launched campaigns that seek to intensify HIV/AIDS awareness within the university, to establish voluntary counselling and testing (VCT) services on campus and to intensify the distribution of condoms among both its students and staff members.

KEY PARTNERS

- Ministry of Education, Ministry of Planning and Development, Ministry of Finance
- National AIDS Council
- University Associations, Student associations, National Teacher unions and associations
- University governing boards
- University Research Committees and Centres
- Campus Health Centres
- Mobile Task Team on the impact of HIV/AIDS on Education
- ADEA Working Group on Higher education
- HEARD (Health Economics and HIV/AIDS Research Division), University of KwaZulu-Natal
- UNAIDS
- UNESCO
- WORLD BANK

KEY RESOURCES

- Association of African Universities (AAU), *An HIV/AIDS Toolkit for Higher Education Institutions in Africa,* Johannesburg, AAU, 2004
- Chetty D., *Institutionalizing the response to HIV/AIDS in the South African University System,* South African Vice Chancellors Association (SAUVCA), 2001
- Katjavivi P. H., Otaala B., *African Higher Education Institutions Responding to the HIV/AIDS Pandemic*, Mauritius, Vice Chancellors and Presidents of African Universities (COREVIP), 2003
- Kelly, M., *Crafting the Response of a University to HIV/AIDS,* Lusaka, University of Zambia, 2002
- Kelly M., *Planning for Education in the Context of HIV/AIDS*, Paris, UNESCO/IIEP, 2000
- Higher Education Against HIV/AIDS (South Africa)
- International Network for Higher Education in Africa
- Association of Commonwealth Universities

ARV TREATMENT EDUCATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

There is a common recognition that:

- **ARV treatment is an essential component of care and support for people living with HIV**

- **Treatment programmes have the potential to offer powerful synergies with HIV prevention efforts**

There is increasing momentum to scale-up access to antiretroviral (ARV) treatment, through national and local efforts, with the support of international and bilateral initiatives such as the WHO/UNAIDS "3 by 5" initiative, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Clinton Foundation Initiative, and through expanded funding for treatment from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

Alongside these initiatives, **there is a critical need to develop ways of educating and preparing communities and individuals about issues related to ARV treatment.**

What is treatment education?

Treatment education engages communities and individuals to learn about ARV treatment by providing information on:

- **Voluntary counseling and testing** (VCT) to know one's HIV status through informed consent and a confidential testing process

- **ARV treatment enrollment criteria**, with an emphasis on the right to equitable treatment access on the basis of medical criteria

- **ARV treatments and drug regimens** (how the drugs must be taken and adhered to, how they work, possible treatment side effects, possible interactions with other drugs, options for alternative treatments and how treatments may affect men and women differently)

- **Treatment costs**, drugs, laboratory tests for monitoring, provider fees, etc.

- **Importance of continued STI/HIV related protective behaviours**, health monitoring and support from the health services (*see brief on 'Prevention With and For People Living With HIV and AIDS'*)

WHY DOES IT MATTER?

Treatment education is an essential component of comprehensive responses to HIV/AIDS**:**

- **It promotes treatment adherence**, leading to improved health outcomes and preventing the development of drug-resistant strains

- **It encourages health-seeking behaviour**, including VCT, diagnosis and treatment of sexually transmitted infections (STI), treatment of opportunistic infections, and other elements of HIV and AIDS prevention and care

- **It promotes a safer environment** where individuals feel more comfortable being tested for HIV and aware of their status

- **It improves awareness of available treatment and prevention services** and creates the demand for, and use of, these services

- **It supports prevention education with and for people living with HIV and AIDS**, including couple counselling, family support, and the promotion of risk reduction strategies *(see brief on 'Prevention With and For People Living With HIV and AIDS)*

- **It contributes to reducing HIV and AIDS related stigma** as HIV testing and treatment become part of a routine response to a chronic manageable illness by public health services

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

- **It dispels myths**, fills knowledge gaps and provides accurate information on HIV/AIDS

- **It engages community members, educators, health workers and others** to become active partners in addressing HIV prevention, care and treatment needs

- **It builds capacity for people with HIV** through their involvement in the development, planning, implementation and evaluation of treatment education

- **It promotes dialogue and partnerships** between treatment providers, NGOs, local and national governments, international agencies, private sector, local groups of people living with HIV and AIDS in order to improve equity of access to ARV treatment, bolster efforts to reduce stigma and discrimination and promote the sustainability of local initiatives to provide HIV prevention, treatment and care

WHAT NEEDS TO BE DONE?

Treatment education strategies will depend both on context, and the availability of financial, material and human resources. They should aim to:

- **Integrate treatment education into existing community-based structures and services**, including in health clinics, schools and other non-formal education settings
- **Encourage the incorporation of culturally appropriate messages** about ARV treatment, HIV prevention and health seeking **in traditional and local media** (interactive community theatre, exhibitions, radio, print, television)
- **Support treatment education initiatives implemented by groups of people with HIV** (such as support groups or post-test clubs) *(see box below)*

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

- **Mobilize political will and commitment** to improve access to ARV treatment and reductions in cost of treatment *(see brief on 'Advocacy for HIV Prevention Education')*
- **Enhance coordination of treatment education activities** among treatment providers, NGOs, governments and local authorities, international agencies, private sector and local groups of people with HIV and AIDS
- **Ensure that the provision of ARV is sustained over time**
- **Combat stigma and discrimination**, which continues to represent a major barrier to treatment access *(see brief on 'Fighting HIV and AIDS Related Stigma and Discrimination')*

INVOLVING PEOPLE LIVING WITH HIV AND AIDS IN TREATMENT EDUCATION

The involvement of people living with HIV and AIDS 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 counseling 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 living with HIV and AIDS are adequately supported and trained in empowerment, communication and presentation skills, and HIV/AIDS information and compensated for their work financially, materially, technically, and/or psychologically *(see brief on 'Promoting the Greater Involvement of People Living With HIV and AIDS in Prevention Education')*.

COUNTRY EXAMPLE: INDIA

The Committed Communities Development Trust's CHILD (Children of HIV-positive Individuals Living in Dignity) Project in Mumbai, India, implements a comprehensive HIV/AIDS programme addressing issues of care, support and prevention, through a family based approach.

Programme evaluations concluded that ARV treatment for children should be planned with their families. They also stated that treatment should be reinforced by psychosocial support to help children cope with their illness and by life skills education to help them maintain healthy lifestyles. This helps them to resist negative pressures, interact effectively, and avoid risk-taking behaviour.

KEY PARTNERS

- Christian Aid
- Global Network of People Living with HIV/AIDS
- International Community of Women Living with HIV/AIDS (ICW)
- International HIV/AIDS Alliance
- International Treatment Preparedness Coalition
- Ministries of Education and relevant Ministries
- Regional, national and local groups of people with HIV, including support groups, post-test clubs etc.
- Treatment Action Campaign (TAC)
- UNAIDS
- UNESCO
- WHO

KEY RESOURCES

- UNESCO, "An AIDS-free Generation in Less than a Generation: UNESCO's and UNAIDS' Global Initiative on HIV/AIDS and Education", UNESCO/IIEP, 2004
- International HIV/AIDS Alliance, *Improving Access to HIV/AIDS-related Treatment*, International HIV/AIDS Alliance, 2002
- Mills S., "The Serostatus Approach to HIV Prevention and Care: Cautions and Caveats", *American Journal of Public Health,* 92 (3), 2002, 331-332
- WHO, *Safe and Effective Use of Anti-retroviral Treatments in Adults with Particular Reference to Resource Limited Settings*, Geneva, WHO, 2001
- International HIV/AIDS Alliance, *Care, Involvement and Action: Mobilising and Supporting Community Responses to HIV/AIDS,* International HIV/AIDS Alliance, 2000

Social, legal & service environment

- School feeding and HIV/AIDS
- Workplace policies on HIV and AIDS in education and training institutions
- Human rights, education and HIV/AIDS
- Fighting HIV/AIDS related stigma and discrimination

Still under consideration:

- *School health*
- *Education, culture and HIV/AIDS*

Policy planning, management and resources
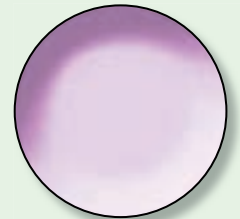
Education and communication: materials and methods

Social, legal & service environment

Key populations

Terminology & sources

Joint United Nations Programme on HIV/AIDS

UNAIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
UNODC·ILO·UNESCO·WHO·WORLD BANK

UNESCO

SCHOOL FEEDING AND HIV/AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

"School feeding" refers to the provision of meals to children in school. It can include a mid-morning drink or snack, a hot lunch or rations of food to be taken home to families.

There are 300 million chronically hungry children in the world, 100 million of whom do not attend school. There are many reasons why school feeding is important:

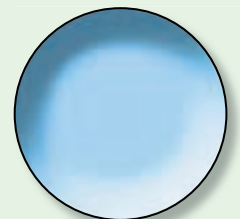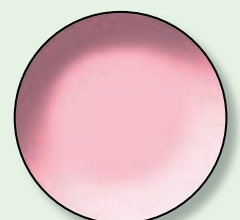- **Education:** School feeding attracts poor, hungry children to school, helps to keep them there and enables them to get an education. When meals are offered, school enrollment and attendance rates can increase significantly. Also, when adequately fed, a student's ability to concentrate, learn and achieve is dramatically improved.
- **Child development:** Providing 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 that they receive that day.
- **Child malnutrition:** Giving take home rations to encourage girls' school attendance can have a long-term effect on reducing child malnutrition. A study by the International Food Policy Research Institute concluded that 44% of the reduction in child malnutrition between 1970 and 1995 is attributable to increases in women's education.
- **Orphans and Vulnerable Children**: Orphans and other vulnerable children are more likely to not enroll in school; enroll late; attend school irregularly; or drop out of school earlier than other children. Family take home rations for this group helps to ensure their enrollment and attendance.
- **Emergency situations:** During emergencies, school feeding, even in makeshift schools, provides a critical source of both nutrition and social stability.

WHY DOES IT MATTER?

- **School feeding is vital in the context of HIV/AIDS**: in many countries, the epidemic both contributes to, and is exacerbated by, a situation of malnutrition and food insecurity.

- **Food is often the main need of poor families affected by HIV and AIDS**. The epidemic can decrease a family's labour force and, as such, reduces income available for basic necessities such as food. Children are often taken out of school to care for the chronically ill or earn needed income.

- **School feeding is particularly crucial in the light of the growing number of orphans and children made vulnerable to HIV and AIDS** – many of whom lack access to even basic physical and social support, including good nutrition.

- **School feeding ensures that poor children get an education, which can have a positive and significant impact on HIV prevalence rates**. For example, young rural Ugandans with secondary education are three times less likely than those with no education to be living with HIV.

- **School feeding can enhance HIV prevention education by attracting children, especially girls,**

(Continued)

WHY DOES IT MATTER? (Continued)

to school. This provides a critical entry point to prevention efforts – by both enabling children to access HIV/AIDS-related information, counseling and life skills, and also by improving their overall integration and socialization. Combined, these empower children, enabling them to take command of their lives and make good decisions, including about how to reduce their vulnerability to HIV.

- **School feeding also serves as an important entry point for broader, community-based HIV/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/AIDS, the operating principles for effective school feeding programmes include:
- **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.

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **Participation:** The design, implementation and monitoring of programmes should actively involve:
  - Teachers and school boards
  - Children and young people
  - Parents and parent-teacher associations
  - Other key community members
- **Integration:** Programmes should be fully integrated into the overall development plans of schools and communities. They should complement other interventions, both those relating to HIV prevention (e.g. life skills teaching) and other subjects (e.g. de-worming, potable water, latrines, nutrition).
- **Strategic focus:** Programmes should target areas where they are likely to have the greatest impact. This includes:
  - Food insecurity
  - High HIV prevalence
  - High levels of orphans
  - Low rates of school enrollment
  - Gender inequality
- **Cost effectiveness:** Programmes should consider the cost-effectiveness of the food ration – in terms of potential sustainability and eventual hand-over to local authorities.
- **Access to all:** Programmes should provide food to *all* children in a school – both for nutritional reasons and to combat the potential stigma caused by isolating specific children, including orphans and vulnerable children.

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 the same children. Children enrolled in the programme are served a hot, nutritious breakfast of fortified blended porridge at school. Additionally, their host families/guardians 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.

There are two groups of targeted beneficiaries. Some of the beneficiaries are street children, others are children who attend community schools, which provide a basic education using a shorter curriculum, without fees. The street children attend a one-hour daily training session comprised of life-skills training, HIV/AIDS awareness, health and hygiene training. Those children in community schools undergo the same sensitization, but on a monthly basis. For both programmes, the family member who collects the take-home ration also attends a training session on food, nutrition, caring for the chronically ill, or HIV/AIDS awareness.

KEY PARTNERS

- World Food Program (WFP)
- Ministries of Education
- UNAIDS co-sponsors, especially UNESCO, WHO, World Bank and UNICEF
- Parent-teacher Associations
- NGOs active in schools and communities

KEY RESOURCES?

- WFP, *Programming in the Era of AIDS: WFP's Response to HIV/AIDS*, Rome, WFP, 2003
- WFP, *Widening the 'Window of Hope': Using food Aid's To Improve Access to Education for Orphans and Vulnerable Children*, Rome, WFP, 2003
- WFP, *Getting Started: HIV Education in School Feeding Programs*, Rome, WFP, 2004
- WFP, *Literature Review: Impact of Education Levels on HIV/AIDS Prevalence Rates*, Rome, WFP, 2004
- UNICEF, UNAIDS and USAID, *Children on the Brink 2004: A joint report of new orphans estimates and framework of action*, USAID, 2004
- UNICEF, *Africa's Orphaned Generation*, UNICEF, 2003

WORKPLACE POLICIES ON HIV AND AIDS IN EDUCATION AND TRAINING INSTITUTIONS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

- Education sector workers, support staff, teachers and school administrators remain a vulnerable category of a nation's workforce in many countries hardest hit by the HIV/AIDS epidemic.
- Some human resource policies within the education system can create situations that often increase vulnerability (for example the deployment and transfer of teachers increases mobility and distance from the family network).
- Moreover, in worst affected countries, the HIV/AIDS epidemic is weakening governments' capacity to plan and deliver ongoing basic educational and social services. Several countries are reporting vacant posts in Ministries of Education and among regional or district officers.
- Usually, prevalence rates are highest among non-teaching support staff at all levels, but teachers and head-teachers are also at risk.

WHY DOES IT MATTER?

Mortality rates and absenteeism of teachers and other education sector waorkers significantly impact on education systems.

- Mortality and absenteeism represent two significant destabilising factors in countries where there are chronic shortages of trained teachers and education staff to meet EFA goals, particularly in rural and remote areas. Replacing such personnel places an additional burden on under-resourced education systems.
- Professional capacity following the onset of AIDS is lost as a result of long-term absence for illness, attendance at funerals and care of sick relatives. This may be aggravated by teachers' attempts to stay in their jobs to avoid stigmatisation if they take sick leave, loss of income or unemployment.
- Even a marginal rate of incapacity and absence will impact on class size, which is already excessive in many developing countries. Combined with a more systemic deterioration of teaching conditions due to low pay, poor teaching and learning conditions, and resulting low morale, AIDS-related professional incapacity adds to the challenges faced by learning environments. This impacts on the quality of national systems, and could influence enrolment ratios particularly for and among already fragile poorer families, girls and orphans.
- Teachers seeking better medical treatment may transfer from rural to urban areas, exacerbating an already unbalanced deployment of qualified teachers in rural and remote areas. The urban/rural divide in educational quality and access is likely to grow in such circumstances.

Stigma and secrecy further undermine the learning environment.

(Continued)

WHY DOES IT MATTER? (Continued)

- While there is not widespread evidence of overt discrimination against teachers or other education sector workers living with HIV and AIDS, there is some evidence that a climate of secrecy resulting from fear of stigma and discrimination, in and out of school, inhibits a healthy teaching and learning environment and contributes to low impact of many school-based prevention education programmes. This is a reflection of the stigma and secrecy that exists in the wider society whereas schools have a role to play in reversing negative attitudes.
- Myths and prejudice, combined with hierarchical power relations, contribute to vulnerability and infection.

WHAT NEEDS TO BE DONE?

An education workplace policy containing the following components should be developed:

- **Recognition of HIV/AIDS as a workplace issue**: All schools or institutions need to treat HIV and AIDS as a challenge to quality education; this entails much more than the prevention role of education
- **Guiding principles**: the basic principles of such a policy would, for instance include non-discrimination and respect for the rights and responsibilities of teachers, non-teaching staff, students, parents and other relevant stakeholders in relation to HIV/AIDS prevention, care and support
- **Basic facts on HIV/AIDS and transmission**: what is HIV, what is AIDS, how is it transmitted, who is vulnerable, behaviour change and the importance of prevention measures to avoid risk and infection

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **Stigma and discrimination**: provisions on why it is important not to stigmatize and discriminate against fellow workers or learners, what constitutes stigma and discrimination and what sanctions should be applied to those who behave in this way (*see brief on 'Fighting HIV/AIDS Related Stigma and Discrimination'*)
- **Gender and HIV/AIDS**: provisions on power relations, reproductive rights, definition of and means to prevent and deal with sexual harassment and learner abuse
- **Prevention education and training**: curricula and pedagogical training on how to prevent infection, educate for behaviour change, develop life skills and counter stigmatisation, and practical prevention measures such as condom distribution. Such education should rely on existing training structures and programmes provided they cover all teachers and other workers (*see brief on 'Teacher Education for HIV Prevention'*)
- **Employment conditions**: non-discriminatory conditions for entry to employment, voluntary testing, confidentiality and counselling, care and support through human resources development measures, including appropriate deployment and transfer policies, sick leave provisions and cover, class sizes and workload adapted to the school environment, education on and access to treatment for HIV/AIDS and opportunistic diseases

- **Healthy work environment**: the conditions necessary for a healthy and safe teaching and learning environment, including resources and how to use them, facilities, healthy living, hygiene and safety kits (*see brief on 'School Health, Learning Outcomes and HIV Prevention'*)
- **Workplace care, support and treatment**: solidarity, care and support should guide the response to HIV/AIDS in the workplace. Schools should be an entry point for voluntary, confidential counselling and testing (VCCT), and other means of care, support and treatment including anti-retroviral treatment (ART)
- **Social dialogue and workplace roles**: means to develop a workplace policy based on social dialogue and partnership between employers/managers, teachers and workers, roles, rights and responsibilities of public authorities, private school managers, head-teachers, teachers and support staff, learners, parents and other education stakeholders
- **Community outreach**: importance and ways to reach out to the local community through the involvement of local political, religious, business and youth leaders or centres and the informal economy through community-based organisations (CBOs), faith-based organisations (FBOs) and other NGOs

WHAT WORKS?

An effective and comprehensive policy for education sector workplaces will be most successful when developed:

- **In partnership**: public and private education authorities need to work with education sector workers and their representative organisations (associations and unions) to develop comprehensive workplace policies on HIV/AIDS within the education sector, consistent with a national framework on overall education policies and structures, especially in schools, training sites, tertiary institutions and non-formal education centres as appropriate.
- **In accordance with principles of social dialogue** advocated by the International Labour Office (ILO) – widespread sharing of information, consultation and negotiation – on the content, implementation, assessment and revision of the policy between the education authorities, public and private, and the education sector workforce, through its most representative organisations (associations or unions). The policy needs to follow closely the principles and content of the ILO's Code of Practice on HIV/AIDS and the world of work, suitably adapted to the specific needs of schools and other education institutions.

KEY PARTNERS

- Ministries of Education, Labour, Health and Social and Community Affairs
- District level education and local government officials
- Teachers/trainers, principals, training institution and education support staff
- Teachers' and education workers' organisations (associations or unions)   (Continued)

KEY PARTNERS? (Continued)

- Parent/teacher and student associations
- Community, religious and business leaders
- Non-formal education associations or networks - including community-based organisations (CBOs), faith-based organisations (FBOs) and other non-governmental organizations (NGOs)
- Education International and World Confederation of Teachers
- International Labour Organization (ILO)

KEY RESOURCES

- Bennell P., *The Impact of the AIDS epidemic on Schooling in Sub-Saharan Africa*, Background paper for the Biennial Meeting of the Association for the Development of Education in Africa, 2003
- EI/WHO/EDC, *Participatory Learning Activities from the EI/WHO Training and resource manual on school health and HIV and AIDS Prevention*, Geneva, 2004
- IOE, *Employers Handbook on HIV/AIDS: A guide for action*, Geneva, UNAIDS, 2002
- ILO, *Code of Practice on HIV/AIDS and the World of Work*, Geneva, 2001
- ILO, *Implementing the ILO Code of Practice on HIV/AIDS and the world of work: an education and training manual*, Geneva, ILO, 2002
- Ministry of Education, Youth and Culture, Government of Jamaica, *National Policy for HIV/AIDS Management in Schools*, 2004
- Ministry of Education, Republic of Zambia, *HIV/AIDS Guidelines for Educators*, Ministry of Education, Republic of Zambia, 2003

HUMAN RIGHTS, EDUCATION AND HIV/AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

An effective international response to the HIV/AIDS epidemic must be grounded in respect for all internationally-agreed civil, cultural, economic, political and social rights. **The protection and promotion of human rights are essential to preventing the spread of HIV and to mitigating the social and economic impact of the epidemic** because they are keys to:

- **Reducing the vulnerability to HIV of key population groups including women and children.** These groups may be vulnerable because of unequal legal status or because they are unable to exercise civil, political, economic, social and cultural rights (*see briefs in section 4 on Key populations*).

- **Empowering individuals and communities** to respond to the epidemic. **When human rights are protected, civil society organizations working on HIV/AIDS are able to respond to the epidemic more effectively, fewer people become infected, and** people living with HIV/AIDS **and their communities can better cope with the epidemic and its impact.**

- **Lessening the dramatic impact of the epidemic** on those infected and affected by HIV. Stigmatization, discrimination and human rights abuses reduce the capacity of those infected and affected to cope with HIV and AIDS.

Human rights principles related to HIV and AIDS are found in all major existing international instruments and are legally binding. States have commitments to:

- **Ensure respect, protection and fulfillment of the human rights of people infected with, affected by or vulnerable to HIV**

- **Create the social and economic conditions to enable individuals and communities to exercise prevention, treatment and care options** when they are available

- **Address the needs of particularly vulnerable populations** (*see briefs in section 4 on Key populations*)

WHY DOES IT MATTER?

Lack of respect for human rights has a negative impact on education, in particular on:

- **Access to and demand for education: increased poverty and need for caregivers can result in reduced enrolments;** children infected or affected may be denied access to education

- **Supply of education**: teachers and staff infected or affected may be denied their right to employment because of stigma and discrimination, or access may be reduced by increased teacher absenteeism and other disruptions, in particular when teachers, staff, students and families do not have the right to access treatment and care

Education is the most effective way to help people understand and protect their own rights, to understand the nature of HIV and AIDS and thus to decrease vulnerability to HIV/AIDS.

(Continued)

WHY DOES IT MATTER? (Continued)

The commitments made by States to act on HIV and AIDS in the education sector relate to:

- **Availability**: The governments should ensure that free and compulsory education is available to all school-age children

- **Accessibility**: The governments should ensure and secure access to education for all without any discrimination

- **Acceptability**: The governments should set minimum standards of quality education and be able to provide education of particular relevance to HIV infected and affected young people

- **Adaptability**: The governments should adapt education to the best interests of each child. The needs and interests of the HIV infected or affected students must be considered

(*As stated by the Special Rapporteur on the Right to Education of the UN High Commission on Human Rights*)

WHAT NEEDS TO BE DONE?

States have commitments to protect, fulfil and ensure social, economic and cultural rights of all students, teachers and staff affected by or living with HIV/AIDS.

Government must ensure that all students and staff enjoy their rights to:

- Confidentiality regarding their HIV status
- Employment (concerning adults)
- Education
- Equal access to career advancement
- Equal access to training programmes
- Equal access to health care, STD care, distribution of condoms
- Provident and pension funds
- Appropriate and widely accessible information about HIV/AIDS issues, and how to protect themselves
- Access to free/affordable confidential and voluntary HIV testing, and counselling
- Develop peer education programmes

To this end, they should:

- **Develop, implement and enforce professional and ethical codes of conduct as well as workplace policies** in accordance with human rights principles (*see brief on 'Workplace Policies on HIV and AIDS in Education and Training Institutions'*)
- **Develop information, counselling, prevention and care services** that are available and accessible and can be effectively used by students and staff
- **Include life-skills, health and reproductive health components in education programmes**
- **Provide legal support and services to educate teachers, students and staff affected by HIV/AIDS** about their rights, enforce those rights, and develop expertise in HIV-related legal issues
- **Work to change discriminatory and stigmatizing attitudes** through education, training, and media campaigns (*see brief on 'Fighting HIV/AIDS Related Stigma and Discrimination'*)
- **Set up monitoring and enforcement mechanisms** to guarantee that HIV-related human rights are protected

WHAT WORKS?

For any approach to be successful, it is essential to:

- Integrate HIV/AIDS-related human rights into institutional strategies and programmes of various sectors at local and national levels
- Address factors such as gender and power relations, religion, sexual orientation, culture and race
- Ensure full participation of people living with HIV and vulnerable groups

(Continued)

WHAT WORKS? (Continued)

- Integrate HIV/AIDS-related human rights into training and education materials, including into programmes designed specifically to change discriminatory attitudes and behaviours

When combined, these factors strongly enhance the protection of individuals and communities from discrimination, inequality and exclusion, and reinforce their likelihood of accessing prevention, care and treatment services.

KEY PARTNERS

- Governments, Ministries, national human rights institutions, ombudsmen, United Nations agencies and bodies, non-governmental organizations and civil society partners.
- UNAIDS Global Reference Group on HIV/AIDS and Human Rights
- ICASO/International Council of AIDS Service Organizations and regional secretariats: Asia Pacific Council of AIDS Service Organizations (APCASO) ; Consejo Latinoamericano y del Caribe de Organizaciones No Gubernamentales con Servicio en VIH/SIDA (LACCASO)
- Canadian HIV/AIDS Legal Network
- Francois-Xavier Bagnoud Centre for Health and Human Rights
- AIDS Law Project, South Africa
- AIDS Litigation Project
- Lawyers Collective HIV/AIDS Unit/India

KEY RESOURCES

- UNAIDS, *The UNAIDS Guide to the United Nations Human Rights Machinery for AIDS service organizations, people living with HIV/AIDS, and others working in the area of HIV/AIDS and Human Rights*, Geneva, UNAIDS, 1997
- ICASO, *Advocacy Guide to the Declaration of Commitment on HIV/AIDS,* Ottawa, ICASO, 2001
- ICASO, *An Advocates Guide on HIV/AIDS and Human Rights,* Ottawa, ICASO, 1999
- ICASO, *NGO Summary of the International Guidelines on HIV/AIDS and Human Rights*, Ottawa, ICASO, 1999
- UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact,* Geneva, UNAIDS, 1999
- UNAIDS, *An overview of HIV/AIDS-related stigma and discrimination*, Geneva, UNAIDS, 2002
- UNESCO, UNAIDS, *HIV/AIDS and Human Rights: Young People in Action Kit*, UNESCO, UNAIDS, 2001

FIGHTING HIV/AIDS RELATED STIGMA AND DISCRIMINATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Stigma and discrimination related to HIV/AIDS are significant obstacles to the prevention of new infections, and to the provision of HIV care, support and treatment.

Stigma and discrimination can also exacerbate the negative impacts of the HIV epidemic on individuals, families, communities and nations. They can lead to violations of human rights and in turn threaten countries' efforts to promote quality education and achieve Education for All (EFA) goals by 2015.

Stigma can be underpinned by numerous factors such as:

• Misconceptions about HIV transmission

• Prejudice against those living with HIV and AIDS

• Social fears and anxieties about sexuality, illness, and death

• Lack of treatment options

Discrimination then ensues when actions are directed against those stigmatised, often leading to violations of human rights and fundamental freedoms.

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 pupils, teachers and other education sector personnels 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 living 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 accomodation or campus residences

• Barred access to educational programmes, loans, bursaries, scholarships or grade advancement

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

• Refusal for employment or dismissal from work

• Required HIV testing as condition of employment or violations of confidentiality regarding their HIV status

(Continued)

WHY DOES IT MATTER? (Continued)

• Physical or verbal violence and harassment, ostracism and rejection

• Restriction on participation in educational events, access to higher positions, or training programmes

• Limited medical, financial or other support for affected family members

WHAT IS THE IMPACT OF STIGMA AND DISCRIMINATION?

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 dropouts

• Increased vulnerability of affected groups to child labour and exploitation in the case of interrupted schooling

• Diminished future income-earning opportunities due to lack of education or skills

• Hopelessness, fatalism, depression and reduced self-esteem and self-confidence

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

• Reduced productivity and motivation and increased absenteeism

(Continued)

WHAT IS THE IMPACT OF STIGMA AND DISCRIMINATION?
(Continued)

- 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
- Hopelessness, fatalism and depression and reduced self-esteem and self-confidence

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 surround and foster learning *(see brief on 'Quality Education and HIV/AIDS')*
- Provide clear messages about the principal modes of transmission of HIV, also challenging 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 Education for HIV Prevention'*)
- Provide teacher training on HIV/AIDS, gender, human rights and life skills and on effective communication

In the community:

- Involve people living with HIV in prevention education and care activities
- Support the establishment of anti-AIDS clubs and youth associations, and school campaigns against stigma and discrimination
- Involve parents in education programmes and school committees to improve their knowledge and attitudes about HIV/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 staffs' 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 partners have access to comprehensive health services including voluntary counselling and testing (VCT), and follow up care and treatment

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 lifeskills in the context of HIV/AIDS. A recent evaluation of the programme demonstrated:

- Improved support for childrens 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 special needs of children affected by HIV and AIDS

KEY PARTNERS

- Action Aid
- Global Network of People Living with HIV/AIDS
- International Council of AIDS Service Organizations (ICASO)
- International HIV/AIDS Alliance
- Ministries of Education and relevant Ministries
- National Association of People Living with AIDS (NAPWA)
- Parliamentarians
- Population Council
- Save the Children
- UNAIDS
- UNESCO
- UNICEF
- WHO

KEY RESOURCES

- UNESCO, *Living and Learning in a World with HIV/AIDS: HIV/AIDS in School*, Paris, UNESCO, 2004
- Thatun S., "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
- Aggleton P., Parker R., *A Conceptual Framework and Basis for Action: HIV/AIDS Stigma and Discrimination*, Geneva, UNAIDS, 2002
- Brown, L. et al., *Interventions to Reduce HIV/AIDS Stigma: What Have We Learned*, Population Council, 2001

Key populations

- Focused HIV prevention programmes for key populations
- Education for orphans and children made vulnerable to HIV/AIDS
- HIV prevention education among out-of-school young people
- Girls' education and HIV prevention
- Refugees, internally displaced persons and HIV prevention education
- Drug use and HIV prevention education
- HIV prevention education and minorities
- Promoting the greater involvement of people living with HIV and AIDS in prevention education
- Prevention with and for people living with HIV and AIDS

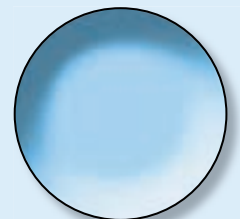Policy planning, management and resources
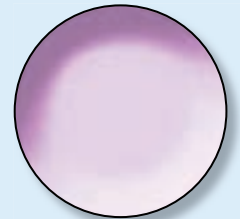
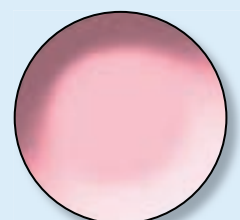Education and communication: materials and methods

Social, legal & service environment

Key populations

Terminology & sources

Joint United Nations Programme on HIV/AIDS

UNAIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
UNODC·ILO·UNESCO·WHO·WORLD BANK

UNESCO

FOCUSED HIV PREVENTION PROGRAMMES FOR KEY POPULATIONS
The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Focused prevention programmes are prevention efforts aiming to decrease the incidence of HIV and other sexually transmitted infections (STIs) **by reducing risky behaviour among key populations**, understood as members of groups critical to the dynamic of the HIV/AIDS epidemic.

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

WHY DOES IT MATTER?

There is growing recognition that focused prevention interventions that target key populations can have a dramatic impact on the epidemic, especially in low-prevalence countries.

These 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) increase the possibility of HIV infection. Since certain populations may more frequently engage in these practices, they represent an obvious target for limited prevention resources.

Key populations for focused HIV prevention 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 including casual sex, sex work, same-sex, shared injection equipment)
- **Rates of sexual partner change**
- **The likelihood of exposure to HIV** or opportunities to expose others to HIV

On the basis of these criteria, two key populations are always likely to be involved in focused prevention programmes:
- **Sex workers**
- **People living with HIV and AIDS**

Depending on local contexts and feasibility, focused prevention may also include:
- **Clients of sex workers**
- **People seeking treatment for STIs**

Additional populations may also be targeted wherever they are identified to be particularly vulnerable or at risk, such as:
- **Men who have sex with men** (MSM)
- **Injecting drug users** (IDUs)
- **Mobile populations**

WHAT NEEDS TO BE DONE?

Focused prevention involves the delivery of five key sets of interventions:

1. Individually focused health promotion to support protective behaviours including:
- Culturally appropriate Information, Education and Communication (IEC) on STIs, including HIV
- Development of communication, negoti-ation, and refusal skills
- Condom promotion
- Voluntary counseling 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 anti-retroviral treatment

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
- Facilitated group discussions on gender, sexuality, sexual health and related themes
- Establishment of safe and private meeting spaces for members of key populations

4. Structural and environmental interventions to create an enabling environment including:
- Inclusion of key populations in decision-making bodies related to HIV
- Awareness raising and anti-stigma educa-tion with the general population

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- Educational activities with those who shape community norms (e.g. police, outreach workers, cultural and religious leaders)
- Provision of legal services

5. Capacity strengthening of programme implementors in order to:

- Support for strategic planning, and resource mobilisation and management
- Facilitate networking and partnership building
- Assure quality, including STI diagnosis and treatment and AIDS care and support
- Strengthen monitoring and evaluation mechanisms

KEY PARTNERS

- Family Health International (FHI)
- Futures Group/POLICY Project
- International HIV/AIDS Alliance
- Marie Stopes International
- Ministry of Education and other relevant Ministries
- Population Council
- UNAIDS, UNESCO, WHO
- World Bank

WHAT WORKS?

1. **Focus on risk situations and target behaviours resulting in the largest number of infections**, referring to evidence-based studies where these exist

2. **Collect and analyse data on key populations and their environment** (size, characteristics, socio-cultural issues, geographic location, etc.)

3. **Undertake strategic planning for each key population** and determine HIV-related needs, the scale and range of existing HIV programmes and significant gaps and implementers

4. **Mobilise resources and participation** through advocacy targeting opinion leaders, and identify relevant partners (communities, NGOs, government agencies, private sector)

5. **Pilot culturally appropriate and gender responsive activities** among each key population and monitor results and lessons learned

6. **Build implementation capacity** to scale up and obtain good coverage of demonstrated effective programmes among key populations

7. **Expand prevention efforts to those who may not be readily identifiable** as part of a key population but may still engage in risk behaviours

8. **Address risk, stigma and discrimination**

9. **Develop resources to promote mainstreaming of prevention activities**, such as materials seeking to address gender and power dynamics encouraging HIV transmission

10. **Monitor and evaluate behaviour change** using, where possible, widely accepted indicators and good practice in social science

11. **Work closely with key populations** in the planning, implementation and evaluation of efforts

12. **Build a long-term risk and vulnerability reduction programme**

KEY RESOURCES

- Stanecki K., "Doing the Right Thing", Plenary Presentation, International AIDS Conference, Bangkok, 2004

- Family Health International, *Effective Prevention Strategies in Low Prevalence Settings*, FHI, 2001

- Ainsworth M., Overs M., *Confronting AIDS: Public Priorities in a Global Epidemic,* Washington D.C., The World Bank, 1999

- Evans C., *An International Review of the Rationale, Role and Evaluation of Community Development Approaches in Interventions to Reduce HIV Transmission in Sex Work*, New Delhi, Horizons Program, 1999

EDUCATION FOR ORPHANS AND CHILDREN MADE VULNERABLE TO HIV/AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

During 2001-2003 alone, the number of orphans attributed to AIDS globally increased from 11.5 to 15 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 are themselves at higher risk for becoming infected with HIV:

- They are frequently shunned by society, denied affection and left with few resources to fall back on
- Due to economic hardship and reduced parental care and protection, many of them drop out of school
- They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse

Studies show that, in many countries, **becoming an orphan or child made vulnerable to HIV and AIDS has a detrimental impact on education**:

- Data from 20 sub-Saharan 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, Zambia and Tanzania, orphans were less likely 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:

- **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 more relied upon to take care of siblings or sick family members
- **Family scepticism about the value of education**. Some families, particularly when facing the challenges of HIV and AIDS, doubt the usefulness and importance of education to their children's future
- **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
- **Stigma and trauma**. The loss of a family member or caregiver, plus the stigma attached to being an "AIDS orphan", causes severe emotional stress for children
- **Fear of HIV infection**. Many children, particularly girls, fear becoming infected with HIV through sexual abuse at school, or on their way to school

WHY DOES IT MATTER?

Education is a basic human right for all children, including orphans and vulnerable children. This is recognised in the *Convention on the Rights of the Child and 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 psychosocial development, as well as protecting them from child labour and providing a safe, structured environment in difficult times. A child who knows how to read, write, do basic arithmetic and use life skills, including those relating to HIV and AIDS, has a solid foundation for continued learning throughout their life.

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 the hidden costs (e.g. uniforms and books)
- **Expand the role of schools to provide care and support to orphans and vulnerable children** through measures such as building partnerships with social services and community networks
- **Protect orphans and vulnerable children by developing policies and practices** to reduce stigma and discrimination, and especially sexual 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

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

The EFA goals and framework are a vital resource. They help:
- Governments in affected countries to review their policies and strengthen their education response
- Implementing agencies to better plan, manage and evaluate their work
- Donors to assess their policy commitments and plan increased resource allocation
- The international community to attract new partners and place orphans and vulnerable children higher on agendas
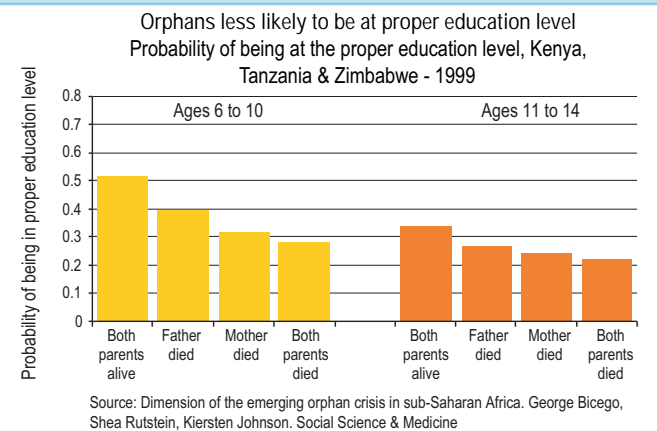
WHAT WORKS?

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

- **Work in partnership**: Schools and the education sector alone cannot do it all. Alliances between the Ministry of Education, the Ministry of Health and the Ministry of Social Welfare are critical. Also, civil society organizations, including faith-based organizations and community networks, have a special role, particularly where such groups are already involved in providing education, food and shelter for vulnerable children.
- **Use a rights-based approach**: This is vital at all stages, including decision-making, planning, implementation and advocacy. Decisions should be made in the best interests of the child and with the active participation of orphans and vulnerable children.
- **Incrementally revise existing social policy**: This should aim to achieve concrete measures to protect and promote the educational development of orphans and vulnerable children.
- **Ensure benefits to communities**: Strategies to improve access to education should target not only those orphaned by AIDS, but all vulnerable children. They also need to directly benefit schools and communities and support broader, system-wide reform.
- **Regularly upgrade responses to go to scale**: Programming should meet both the immediate needs and longer-term objectives for large-scale coverage. For example, in the short-term, the provision of school meals and abolition of fees might take precedence over curriculum reform.
- **Balance attention to care, support and prevention**: Responses need to vary according to the status of the epidemic and its impact. In emerging epidemics, greater attention may be needed for prevention, while fostering care and support for small numbers of orphans and vulnerable children. In more advanced epidemics, simultaneous efforts may be needed on all fronts.
- **Keep families together and involved**: Wherever possible, siblings need to be kept together and close to their families or in family-like environments. Education needs to reflect this by involving children and young people, plus their extended families and communities, in developing solutions to practical challenges.
- **Commit to monitoring and evaluation**: Training and support for a range of partners is required at school and community levels to enable local and national indicators to be used in policy making and reporting.

(Continued)

WHAT WORKS? (Continued)

Efforts need to be supported not only by adequate financial, human and technical resources, but 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, for example 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.

Orphans less likely to be at proper education level
Probability of being at the proper education level, Kenya, Tanzania & Zimbabwe - 1999

Source: Dimension of the emerging orphan crisis in sub-Saharan Africa. George Bicego, Shea Rutstein, Kiersten Johnson. Social Science & Medicine

KEY PARTNERS

- Government Ministries, including Health, Social Welfare and Culture
- International agencies and donors
- International NGOs
- National and local NGOs and other civil society groups, including faith based organizations
- The UNAIDS Inter-Agency Task Team on orphans and vulnerable children and Task Team on Education

KEY RESOURCES

- UNAIDS IATT on Education, *Framework for the Protection, Care and Support of OVC Living in a World with HIV and AIDS*, 2004
- UNAIDS IATT on Education, *The Role of Education in the Protection, Care and Support of OVC Living in a World with HIV and AIDS*, 2004
- UNAID, UNICEF and USAID, *Children on the Brink 2004: a joint report of new orphans estimates and a framework for action*, USAID, 2004
- International HIV/AIDS Alliance, *Building Blocks in Practice: Participatory Tools to Improve the Development and Care and Support for OVC*, International HIV/AIDS Alliance, 2004 (www.aidsalliance.org)
- International HIV/AIDS Alliance, *A Parrot on Your Shoulder: A Guide for People Starting to Work with OVC*, International HIV/AIDS Alliance, 2004 (www.aidsalliance.org)
- The World Bank, The Partnership for Child Development, UNICEF, UNAIDS, *Ensuring Education Access for OVC*, World Bank, 2002

HIV PREVENTION EDUCATION AMONG OUT-OF-SCHOOL YOUNG PEOPLE
The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

Schools branch out into more communities and reach more young people than any other institution and hence are crucial for protecting the young and preventing the spread of HIV. Most children and young people are HIV-free. To curb the epidemic, they must know how it spreads and act on this knowledge. Young people and their families have to learn to protect their health, provide and seek treatment and care, be protective of others and not to discriminate. **The highest priority is the age group between 10 and 24, in which about half of new infections take place**. Reaching and engaging them with HIV and AIDS prevention messages and services is essential to changing the course of the epidemic.

Many barriers prevent young people from attending schools, e.g.:

• Poverty, which implies inability to pay school fees and other school related costs

• Work traditions, which oblige children to supplement family resources

• Insufficient or inappropriate education due to lack of schools, poor quality curricula, risky school routes and no transportation, shortage of trained teachers, discriminatory behaviours (e.g. towards pregnant girls or AIDS orphans).

• Emergencies and social conflict (natural disasters, wars, refugees)

The result is that more than 115 million children have never been to school and many more, especially girls, drop out prematurely. In the most affected countries, the majority of the 10-24 year olds are not in school. Hence, the formal education system will have to be the hub of a much broader effort.

Moreover, **out-of-school young people are very diverse**, ranging from those integrated and working in rural areas to marginalized groups such as orphans, street children, refugees and victims of trafficking. **Since the groups are so different, efforts to reach them have to be targeted and messages tailored to their needs**.

WHY DOES IT MATTER?

Out-of-school young people are at a disproportionately higher risk to HIV. Among the reasons are:

• **Lack of access to the vital health, sexual and reproductive health education, counseling and services** often provided by schools

• **Absence of the structure, protection and activities the school environment provides**

Gender-related factors make out-of-school young people particularly vulnerable:

• **Unequal social status and economic rights disproportionately expose out-of-school girls** to sexual pressure, violence, trafficking as well as to "sugar daddies" or men seeking younger partners in the belief that they are HIV-free

• **Early marriage of young girls to older males**

• **Norms of masculinity: being out of school** contributes to boys and young men having early sexual initiation, premarital sex and multiple partners, as well as other attempts to prove their prowess and dominance, especially among their peers

WHAT NEEDS TO BE DONE?

HIV prevention education must address **the basic needs of out-of-school young people, link with programmes that offer literacy, health, employment and livelihood and be tailored to the particular circumstances of different groups**. Information and education must be buttressed by **life skills**, such as the capability to negotiate safe sex, and by youth-friendly health services, including access to condoms and harm reduction programmes such as drug substitution therapy or needle and syringe access. Programmes need to be flexible and to match the schedules and realities of out-of-school young people. Efforts should:

• **Enhance policies that encourage schooling and help keep young people in school**, e.g. by assisting poor families and orphans with school fees, books and uniforms; by innovative curricula and delivery to reach young people in rural areas; by empowering and encouraging pregnant girls and married adolescents to return to school.

• **Ensure that policies and programmes address the fact that the many out of school young people are**

WHAT NEEDS TO BE DONE? (Continued)

particularly vulnerable and require youth friendly and gender-responsive prevention approaches. Provide out-of-school young people with accurate information on reproductive and sexual health and rights, including on HIV/AIDS and with protective life skills to promote a healthy lifestyle. Health information and education should be offered to young people where they work and spend their free time, encourage delaying sexual debut, reducing the number of sexual partners, and correct and consistent condom use.

- **Ensure out-of-school young people benefit from HIV/AIDS services and are effectively included in sexual health programmes**. Provide young people, especially those who are sexually active, with access to youth-friendly health services, e.g. voluntary counseling and testing, early diagnosis and treatment of sexually transmitted infections, risk reduction by preventive commodities such as condoms (male and female) and clean needles and syringes, and anti-retroviral therapy.
- **Create a supportive and enabling environment for programmes**. Adopt policies and enact legislation to ensure that out-of school young people are protected from harm, supported through caring services, and have opportunities for personal development.

WHAT WORKS?

For all young people, it is essential that programmes:

- **Actively involve the young people themselves** as partners in the design, implementation and evaluation of activities
- **Are based on the real, assessed needs of the young people**, rather than on adults' perceptions
- **Use appropriate and realistic messages and materials** that acknowledge the challenges in young peoples' lives and do not demand a total change of lifestyles

Successful programmes have some or all of the following characteristics:

- **Use community settings**. Targeted community-based interventions to reach out-of-school young people where they spend their leisure and work time, such as in city centres, in sport areas or in factories.
- **Use media and new information and communication technologies**. HIV prevention messages on the radio, in print media, on television and on the Internet are excellent ways to reach out-of-school young people.
- **Link with existing services**. Multiple ways of delivery can be used to target and reach different groups of out-of-school young people (such as youth-friendly health counseling and services, peer and adult community educators, mobile prevention services).

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **Be economically, physically and socially accessible to young** people by reducing or eliminating costs, providing services in venues that are safe and non-intimidating, at times appropriate for different lifestyles.
- **Use a wide variety of partnerships** from sectors and with partners that play a role in supporting out-of-school young people, e.g. community and youth leaders, educational planners, sport personalities, celebrities, religious leaders and media professionals.
- **Build in-country capacity and scale up successful programmes**.

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. Lessons learned include the importance of innovative approaches to reach particularly vulnerable young people, and the need for on-going, sustained efforts. For example, the project has trained youth peer educators to reach out to gang members and out-of-school young people.

KEY PARTNERS

- Government Ministries, including Education, Health, Youth and Social Welfare
- International agencies and donors
- International Planned Parenthood Federation (IPPF) and its Member Associations
- International development NGOs, including the Red Cross and Red Crescent societies, Save the Children and CARE
- Local and national NGOs, civil society organizations, including young people's groups

KEY RESOURCES

- Family Health International, *Reaching Out-of-School Youth With Reproductive Health and HIV/AIDS* Information and Services, Youth Issues Paper 4, YouthNet, Family Health International, 2004
- Middleton-Lee S., Ireland E., *Effective Peer Education: Working with Children and Young People on Sexual and Reproductive Health and HIV/AIDS*, Save the Children UK, 2004
- UNAIDS et al., *Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*, WHO, 2004
- WHO et al., *Protecting Young People from HIV and AIDS: The Role of Health Services*, WHO, 2004

GIRLS' EDUCATION AND HIV PREVENTION

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

Free and compulsory education is a fundamental right for all children and young people, at least in the elementary stages. This right is enshrined in the 1948 Universal Declaration of Human Rights as well as in the 1959 Declaration on the Rights of the Child. The 2000 Dakar Framework for Action that reaffirmed this right was adopted to achieve Education for All (EFA).

Educating girls and young women can yield dramatic social benefits. Education not only provides girls with knowledge, but also gives them better and empowering life chances and choices. Educated girls tend to:

- Be better equipped to protect themselves against HIV and AIDS
- Postpone marriage and have fewer children – who, in turn, are more likely to survive and be better nourished and educated
- Be more productive at home and better paid in the workplace
- Have better access to formal employment
- Assume a more active role in social, economic and political decision-making throughout their lives

In practice, **almost 60 million girls around the world are still missing out on an education** despite UN targets. Besides **in most countries girls' attendance drops sharply after primary school**, resulting in 4.4 less years of education than boys by the age of 18.

Among the reasons for this disparity in education are:

- **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 discrimination**. Families may see education for girls as less important than for boys, while teachers may have lower expectations of girls as compared to boys. In families of limited resources education for boys is seen as a better investment.
- **Political frameworks**. Policies might prevent pregnant girls from continuing their education or 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.

(Continued)

WHAT IS THE ISSUE? (Continued)

- **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.
- **Lack of quality education**. The curriculum may be irrelevant to the reality of girls' lives and in some countries there may be a lack of female teachers to provide positive role models.
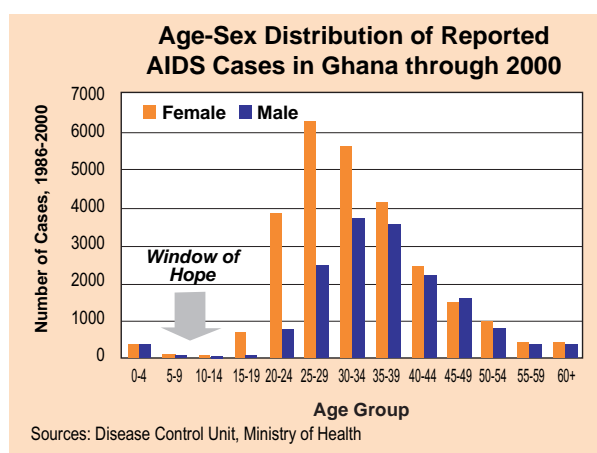
WHY DOES IT MATTER?

Girls and young women are disproportionately affected by HIV and AIDS, both directly and indirectly.

Worldwide, two thirds of young people living with HIV and AIDS are girls. In sub-Saharan Africa, young women aged 15-24 are three times as likely as their male peers to be infected and living with HIV. Meanwhile, girls in families affected by the epidemic are under more pressure than boys 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.

Girls' education and effective HIV prevention are inextricably linked. Schools and other educational initiatives provide a crucial entry point. They not only provide girls with knowledge about HIV/AIDS and reproductive health, but they also enable them to build the practical skills, attitudes and social networks needed to make good decisions about their lives, including how to protect themselves from HIV.

COUNTRY EXAMPLE: GHANA

Age-Sex Distribution of Reported AIDS Cases in Ghana through 2000

Sources: Disease Control Unit, Ministry of Health

WHAT NEEDS TO BE DONE?

For effective HIV prevention education 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, such as abolishing school fees
- **Ensuring that education provides a safe space**, for example by promoting "zero tolerance" to sexual abuse on school grounds
- **Ensuring quality education**, for example ensuring that gender sensitivity is included in classes for both boys and girls, and that the curriculum covers 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**, for example 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 education:

- **Is integrated into education for *all* girls and young women**, not just formal schooling, but other projects, such as literacy classes
- **Starts early**, with basic information 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
- **Addresses subjects relevant to girls' real lives**, including difficult situations, such as pressure from older men to have sex or pressure from families to earn money through transactional sex
- **Is culturally sensitive** and does not put girls at risk of shame or stigma
- **Is provided to both girls and boys** simultaneously to ensure that boys get the same messages about equality and the empowerment of women and that they understand the necessity of adopting protective behaviours (i.e. such as using condoms and respecting a woman's right to do so)
- **Takes an approach based on human rights**, building girls' self esteem and empowering them
- **Builds both knowledge and life skills**, such as how girls can negotiate safer sex
- **Aims to achieve not just awareness, but behaviour change**
- **Involves the broader community**, building understanding about why girls are particularly vulnerable to HIV and AIDS
- **Is carried out by gender-sensitive teachers and peers**, including some who are female
- Is linked to gender-sensitive services, such as family planning clinics

KEY RESOURCES

- UNICEF, *Strategies for Girls' Education*, UNICEF, 2004
- UNICEF, *Accelerating Progress in Girls' Education*, UNICEF, 2003
- UNICEF, *The State of the World's Children 2004: Girls, Education and Development*, UNICEF, 2003
- UNICEF, *Girls' Education, Making Investments Count*, UNICEF, 2003
- Interagency Gender Working Group and USAID, *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organisations*, USAID/IGWG, 2004

KEY PARTNERS

- Ministry of Education and other Ministries, such as for Health or Women's Affairs
- Educational policy makers and programme developers
- Schools governing boards and teachers
- NGOs and civil society organisations, including women's, young people's and human rights groups
- Parents and community members
- International initiatives on education, such as United Nations Girls' Education Initiative (UNGEI) and Fast-Track Initiative (FTI)
- Global Coalition on Women and AIDS

REFUGEES, INTERNALLY DISPLACED PERSONS AND HIV PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

Refugees and internally displaced persons (IDPs) are people fleeing conflict and persecution who often suffer from discrimination and difficulties in exercising their rights. By the end of 2003, there were 37 million refugees and IDPs worldwide. The majority of these were women and children. 35% were young people, aged 12-24 years.

Education is an integral component of a refugee or IDP's right to protection. However, in practice, **many such children and young people** (particularly girls) **lack the opportunity or resources to go to school**, especially at the secondary level. The unique situation of refugees requires more innovative approaches to prevention education. **Without such interventions they may be more exposed to HIV and sexual and gender based violence than host populations.**

WHY DOES IT MATTER?

Contrary to popular belief, such communities often have lower HIV prevalence than host populations. However, **refugees and IDPs can be particularly vulnerable to HIV and AIDS** due to a number of reasons:

- **Such communities are at high risk of sexual violence and exploitation** during conflict, flight and asylum context. This is particularly the case for women and children who might be neglected, sexually abused or subjected to military recruitment and sexual slavery.

- **Emergencies can lead to the breakdown of family ties, the weakening of community support and the reduction or cessation of public health services**, including those related to HIV and AIDS.

- **Refugees and IDPs are often excluded from the HIV/AIDS plans and programmes of host countries.**

- **NGOs and other agencies supporting refugees and IDPs often lack specific expertise and capacity** for HIV prevention education.

- In emergency situations, **HIV/AIDS and education have to compete with other humanitarian priorities**, including those focused on immediate survival.

Despite these challenges, **there are many reasons why it is both vital and possible to carry out HIV prevention education among refugees and IDPs**. These include that:

- **HIV prevention is an integral component of a refugee or IDP's right to protection**

- **Education**, both formal and non-formal, **is a critical strategy in the prevention of HIV among refugees and IDPs**

- **Refugees and IDPs can be a key resource for HIV prevention education**, including by impacting on behaviour change

- **Interventions with refugees and IDPs may also benefit the local population**, both directly and indirectly

WHAT NEEDS TO BE DONE?

To ensure that programmes for refugees and IDPs incorporate effective HIV prevention education, action is needed in a number of areas:

Policy and programme design and implementation:

- Develop national policies on HIV prevention education, as an essential component of overall refugee and IDP protection

- Develop and support advocacy, capacity building and monitoring strategies for HIV prevention education, using UNHCR's HIV/AIDS Strategic Plan

- Provide a similar type and level of HIV prevention education for refugees and IDPs as those for the host community

- Strengthen programmes – for refugees and IDPs, host populations and decision-makers – to raise awareness about rights and provide training on gender-based sexual violence

- Progressively increase and effectively target the allocation of funding and other resources to promote overall access to formal and non-formal education for young 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, age and gender-sensitive approaches, strategies and tools on HIV prevention education and sexuality for refugees and IDPs

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

Monitoring and evaluation:

- Measure progress by developing and monitoring indicators specific to HIV prevention education among refugees and IDPs
- Conduct research and evaluation of HIV prevention education as part of ongoing situation analyses of refugees and IDPs
- Recruit staff to support the above tasks, with appropriate knowledge and attitudes about HIV prevention education

Emergency setting measures:

- Ensure health services, including those relating to HIV/AIDS and reproductive health, are appropriate and supportive to young refugees and IDPs, especially for girls
- Use the guidelines of the UN Inter Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings to ensure the provision of minimum essential HIV/AIDS services, including condoms and other key prevention methods
- Ensure immediate and adequate care for cases of sexual violence among refugees and IDPs, including information and advice on HIV and AIDS
- Promote HIV voluntary counseling and testing (VCT) services for refugees and IDPs

Community mobilization:

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

KEY RESOURCES

- UNHCR, Agenda for Protection, Third Edition, Geneva, UNHCR, 2003

- UNHCR, Sexual and Gender-Based Violence Against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response, Geneva, UNHCR, 2003

- UNHCR, HIV/AIDS and Refugees: UNHCR's Strategic Plan 2002-2004, Geneva, UNHCR, 2002

- UNHCR, HIV/AIDS Education for Refugee Youth: The Window of Hope, Geneva, UNHCR, 2002

- UNAIDS, WHO, UNESCO, School Health Education to Prevent AIDS and STD: A Resource Package for Curriculum Planners, UNAIDS, WHO, UNESCO, 1994

- IRC, UNHCR, How-To Guide: Reproductive Health Education for Adolescents, N'zerekore, UNHCR, 1998

- Margaret Sinclair, Planning Education In and After Emergencies, Paris, IIEP-UNESCO, 2002.

KEY PARTNERS

- Governments

- UNHCR and other UN agencies

- Refugees, IDPs and their communities

- Implementing and operational partners, including the Red Cross and Red Crescent societies and other non-governmental organizations

- Donors

HIV RISK FACTORS FOR CONFLICT AND DISPLACED PERSONS CAMPS

Key Factors

- Area of origin HIV prevalence
- Surrounding host population HIV prevalence
- Length of time: conflict, existence of camp

Increased Risk

- Behavioural change
- Gender violence/transactional sex
- Reduction in resources and services (e.g. health, education, community services, protection, food)

Decreased Risk

- Reduction in mobility
- Reduction in accessibility
- Increase in resources and services in host country

Source: Disasters, September 2004, Vol. 28, issue 3, pp. 322-339(18): HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action. Paul B. Spiegel, UNHCR

DRUG USE AND HIV PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

- **Injecting drug use is a major mode for the transmission of HIV in many countries** of Asia, Europe, Latin America and North America. To date, more than **5 million drug users have become infected with HIV**, mainly through the sharing of contaminated injection equipment.

- **HIV/AIDS has a clear association with drug use.** Mind altering substances, such as legal and illegal drugs and alcohol, reduce inhibitions and responsible behaviour. They impact on a person's judgement and decision-making. In many cases, they **make the users more likely to take higher risks and become involved in harmful behaviours** (such as unsafe sex and drug injection with shared equipment).

- The interaction of drug use with high-risk sexual behaviour, the social nature of drug-injecting and the complex dynamics of sharing equipment present **a considerable challenge for the design of effective responses.**

WHY DOES IT MATTER?

HIV prevention education is an important element of a comprehensive strategy to reduce drug abuse and the spread of HIV. While precise figures can be difficult to obtain, research shows that:

Drug use increases risk behaviours and the speed with which the virus spreads:

- **Injecting drug users are disproportionately likely to be involved in the sex industry or to engage in high-risk sexual activity**. The number of people infected through unsafe sex while intoxicated is not known, but it is probably considerably higher than those infected with contaminated equipment.

- **HIV can spread through drug using populations with remarkable speed and can stabilize at very high rates**. In some regions more than 50 per cent of injecting drug users are infected with HIV.

Drug users are not the only ones at risk:

- **Drug-injecting contributes to an increased incidence of HIV infection through the transmission of the virus to the children of drug-injecting mothers**, and through sexual contact between drug injectors and non-injectors.

- **Young people are particularly vulnerable to drug abuse**. This is of particular concern as they represent more than half of all new infections worldwide.

It is necessary to educate and raise awareness of the risks associated with drug use, informing about the means of protection.

WHAT NEEDS TO BE DONE?

To ensure effective HIV prevention among active and potential drug users, **specific and targeted interventions are required**. These should focus on:

- **Discouraging the initial use of drugs**: The main purpose of any prevention education strategy should be to avoid the onset of drug use, especially among young people. Evidence shows that the later one starts to use drugs, the lower the possibility of becoming a frequent drug user and the lower the risk of HIV infection.

- **Avoiding the transition from non-injecting to injecting drug use.**

- **Reducing the risk of HIV infection** and promoting counselling, peer support throught drug users networks, the provision of needle exchange and availability of condoms.

- **Education programmes, whether formal or informal, should both provide relevant information and help students to gain the attitudes, life skills and empowerment** necessary to make good decisions, protect themselves and, where necessary, change their behaviour.

- **Education should necessarily cover a broad range of interventions** since many of the young people affected by drugs are marginalised and often outside of the school system *(see brief on 'HIV Prevention Education Among Out-of-School Young People')*.

- **HIV prevention is vital for all. Children and young people** are directly or indirectly affected by drug use - either using drugs themselves or being in families or communities where drugs are used. **The majority of drug users and injecting drug users are adults.**

WHAT WORKS?

Depending on the target audience (potential, active or injecting drug users), a comprehensive package of prevention and care interventions has been shown most effective. Most important is to find the right combination of interventions, appropriate for the specific circumstances (type of drug used, age group, cultural factors, gender, individual socio-economic conditions, poverty, etc.).

1. Such interventions could include for **potential drug users**:

- Information, education and life skills training and condom distribution
- Involving youth is a key aspect of the success of programmes targeted at that age group
- Support from local communities, drug users support groups and family involvement have been shown to be very important

2. For **non-injecting drug users**:

- Voluntary and confidential HIV testing and counselling, referrals to a variety of treatment
- Prevention efforts to avoid the transition from non-injecting drug to injecting drug use
- Prevention promoting the risk involved in drug use, the nature of support available and referrals to service providers

3. For **injecting drug users**:

- **Outreach**: This method aims to reach young people who are not reached by conventional services by going to where they are and making contact. Outreach workers can be users, ex-users or non-users.
- **Reduce risk of infection**: Concrete services to reduce infection via contaminated injecting equipment are essential. These are also used as entry points to offer injecting drug users counselling and drug dependence treatment options.
- **Voluntary HIV counselling and confidential testing**: Counselling before and after the test is vital to help youth understand the meaning of test results and, if the test is positive, next steps and consequences.
- **Drug dependence treatment services** can assist drug users once a trusting relationship has been established with outreach workers.
- **Anonymity, confidentiality and sensitivity** are important. Using active listening skills, clear language and being accessibly located, are also important for outreach workers to make contact with young injectors.
- **Youth friendly services**: Services can be delivered in a drop-in centre that must be a safe and comfortable place, located near to where injectors gather. Such services, if appropriate, can include counselling, education and life skills training, hygiene, referrals, access to clean injecting equipment, information, recreation and more.

COUNTRY EXAMPLE: BRAZIL

UNODC, in collaboration with the government and civil society organisations, has since the early 90s been implementing large-scale prevention education projects in Brazil, which address both drug use and HIV/AIDS. Lessons learned from these projects include:

- A fundamental element of prevention education is to **help young people to develop self-esteem** by stimulating them to assume responsibility for their own health
- **Extreme ideas** about the potential consequences of drug use **do not contribute to reducing consumption**
- **Modern interactive programmes and dynamic pedagogical instruments** (such as games, theatre, writing, videos, poster production, etc.) instead of traditional lectures **are more likely to attract youngsters' attention** to the drug problem
- **Evaluation of activities and impact studies** are important parts of any prevention programme
- The success of prevention education programmes depends on **policies that empower and incorporate youth into society**
- **Social responsibility is an important aspect to strengthen positive behaviour** among youth, helping them to establish objectives and responsibilities
- **Stimulating the organizational and occupational development of youth, as well as their community involvement**, increases their feeling of belonging to a social group

KEY PARTNERS

- Ministry of Education, Ministries of Social Welfare, of Health and of Sport and Culture
- National Drug Control Agency
- National AIDS Council
- Schools
- Community centres and social services
- International and local non-governmental organisations, especially those involved in providing support and services to drug using people

KEY RESOURCES

- UNODC
- WHO Substance Abuse
- American International Health Association
- American Foundation for AIDS Research (AMFAR)
- Centres for Disease Control and Prevention(CDC) (statistics on HIV/AIDS)

HIV PREVENTION EDUCATION AND MINORITIES

The Global Initiative on HIV/AIDS and Education

WHAT IS THE ISSUE?

The unrelenting expansion of the HIV/AIDS epidemic has heightened the importance of prevention programmes for the general population. However, infections do not spread evenly. Some minorities are disproportionately affected by HIV and AIDS, and targeted prevention programmes must be aimed at groups that are linguistically, culturally and physically isolated or marginalized. Targeted programmes are both effective and efficient. *(See brief on 'Focused HIV Prevention Programmes for Key Populations').*

Minorities generally encompass **ethnic, religious and linguistic communities, indigenous and tribal peoples, migrants and refugees, as well as sexual minorities.** For these people, linguistic, geographical, social and economic barriers can present formidable handicaps to access formal employment and public services such as education and healthcare. Stigma and discrimination can also result in voluntary refusal to integrate in the societies in which they live. For them, isolation and disempowerment can lead to exploitation.

Targeting minorities is difficult:

• Defining the groups that should be reached can be complex, as universally or even locally accepted definitions often do not exist

• Minorities are not homogenous and people can belong to several groups at the same time. Some members of minorities may face further marginalization due to age, poverty, disability, gender or other factors

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 the heightened vulnerability of minority groups to HIV infection**.

• **Poor infrastructure in many minority communities results in poor or no access to health-related information or services** for HIV and AIDS prevention care and support. Inadequate early diagnosis of HIV and treatment for AIDS allows the virus to spread.

• **When available, information and services are often not tailored, produced in the minority languages, or sufficiently sensitive to the specificities of minorities**, making them ineffective.

• **Minority groups may be excluded from school-based programmes on life skills, sexual and reproductive health, and from youth-friendly health services and other HIV prevention programmes.** Levels of schooling tend to be much lower among groups isolated by language or geography. Children of migrants, nomads and seasonal workers often have difficulties accessing formal education, and therefore school based HIV prevention.

• **Minorities are more likely victims of human and sex trafficking as well as drug abuse and hence are more exposed to HIV.** Women and children in the sex industry are particularly at risk. Hardship faced by young people in some minority groups influences the intake of injecting drugs (*see brief on 'Drug use and HIV Prevention Education'*).

(Continued)

WHAT DOES IT MATTER? (Continued)

• **The vulnerability of minorities, including homosexual men, to HIV is reinforced by stigma, discrimination and poverty,** which decreases the power they have over their own lives and health. Minorities may also be mis-portrayed in epidemiological statistics.

WHAT NEEDS TO BE DONE?

In order to communicate effectively with minorities, education and educators in general must welcome and respect diversity and reach out to them with relevant education of quality. Specifically related to prevention education, this means going beyond linguistic, geographical, social and economical barriers to provide appropriate, targeted, HIV/AIDS-related information and services. The following measures can help ensure that prevention education is understood and integrated by those most vulnerable and hardest to reach.

• **Ensure that indicators are adapted to reveal appropriate information about key groups** that can facilitate tailoring HIV prevention services to each group

- collect accurate data on HIV prevalence and modes of transmission in minorities with indicators on population distributions, economic activities, health, education, migration, religious and traditional activities and events

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- conduct research to assess the risk factors specific to each minority

• **Develop health care and services adapted to the target populations**

- Diversify and expand health care by providing diagnosis of HIV infections outside medical settings, and ensuring that prevention efforts include people living with HIV and their partners, and expanding prevention of mother-to-child transmission programmes to marginalized groups

• **Customize messages and tailor learning materials to minority groups**

- Design targeted prevention programmes that include the importance of knowing one's HIV status
- Involve minority groups in the development of prevention programmes and have materials developed directly in the language of communication by native speakers
- Develop 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, TV, etc…)
- Support peer education

• **Build partnerships and local capacity for HIV prevention education that involve minority populations**

- Identify unreached groups and develop direct and targeted interventions for them
- Secure the involvement of minority leaders in project management
- Identify and use the competencies of NGOs and community-based organizations (including religious groups) in mobilizing community leaders

• **Protect minority rights by new and adapted laws**

- Review the legislative framework to ensure equality of rights for minority groups
- Take specific measures to remedy and redress human rights abuses in minority populations
- Engage political leaders to publicly address the question of minority issues and the importance of the respect of human rights *(see brief on 'Human rights, Education and HIV/AIDS')*

KEY PARTNERS

• Institute for Cultural Research, Lao PDR
• Social Research Institute, Chiang Mai University, Thailand
• Yunnan Academy of Social Sciences, Yunnan Province, China
• Inter-Mountain Peoples Education and Culture in Thailand
• New Life Center Foundation, Chiang Mai, Thailand
• Radio Thailand Chiang Mai, Thailand
• Lao National Radio, Vientiane, Lao PDR
• Yunnan's People Broadcasting Station

WHAT WORKS?

• **Facilitating the development of advocacy by minority group representatives and minority group organizations**
• **Linking HIV prevention, care and support are linked to broad developmental issues** such as poverty reduction, expansion of access to education and communication
• **Basing policy on sound research** that develops understanding about behaviour, for example about gender roles, norms and values, livelihoods, community rules, and social behaviours and codes
• **Inclusive attitudes and policies** towards minority religions, behaviours or cultures. Cultures and religions are not static – they are alive, like the people that are part of them
• Ensuring sustainability through s**upport for local initiatives and capacity**

COUNTRY EXAMPLE: THAILAND, LAO PDR, CHINA

UNESCO Bangkok has initiated and implemented a number of HIV/AIDS and trafficking-related programmes that target hilltribe and ethnic minority populations across the Greater Mekong Sub-region. One of the projects is the **Radio Soap Opera Programme** in minority languages for the prevention of HIV/AIDS, trafficking in women and children and non-traditional drug use.

Each soap opera is written in the ethnic minority language by native authors/speakers. The story is derived from community research, based on real-life stories and on accurate and factual information. The story has to be culturally appropriate and sensitive. All the songs and music have to be traditional and, if possible, produced specifically for the soap opera programme.

UNESCO has chosen radio as the means of transmitting educational and preventive messages in minority languages, because it is the most cost-effective communication technology to reach a wide range of ethnic audiences within the broadcasting country as well as cross-border.

KEY RESOURCES

• Centers for Disease Control (CDC)
• NIAID (National Institute of Allergy and Infectious Diseases)
• Institute for Cultural Research, Lao PDR
• Social Research Institute, Chiang Mai University, Thailand
• Yunnan Academy of Social Sciences, Yunnan Province, China

PROMOTING THE GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV AND AIDS IN PREVENTION EDUCATION

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

People with HIV and AIDS have a critical role to play in designing, implementing and evaluating HIV/AIDS prevention, treatment and care programmes. The movement towards the "greater involvement of people with HIV and AIDS" (commonly called GIPA) in the full continuum of the HIV/AIDS response is based on the:

• Broad recognition of the important contribution that people living with HIV and AIDS can make in the response to the epidemic

• Creation of opportunities for their involvement and active participation in all aspects of the response

This contribution can be made at various levels (community, workplace, school, ministry, etc.) and across sectors, from the social and cultural to the economic and political.

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 **UN General Assembly on HIV/AIDS Special Session** (UNGASS) in 2001. It was further upheld in the Guiding Principles for the "3 by 5" initiative led by WHO/UNAIDS.

Numerous **networks of people 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 and 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 with HIV and AIDS.

WHY DOES IT MATTER?

There are numerous reasons why involving people with HIV and AIDS in prevention education is important for effective and ethical responses to the epidemic, including that it:

• **Educates people** about the existence and needs of people living with HIV and AIDS

• **Helps to break down the stereotypes** associated with HIV infection and related stigma and discrimination

• **Promotes a safer environment** where people will feel more comfortable being tested for HIV and aware of their status because they are encouraged and reassured by people who have already gone through this process

• **Supports people living with HIV and AIDS to actively work to prevent further HIV infections** through the adoption and maintenance of risk-reduction behaviours

• **Helps to educate people living with HIV** of the risk of "superinfection," or infection with other strains of the HIV virus, as well as with opportunistic infections

(Continued)

WHY DOES IT MATTER? (Continued)

• **Assists people living with HIV and AIDS in focusing on their individual health needs and on advocating for their rights** to make informed decisions regarding their health and healthcare

• **Engages people living with HIV and AIDS to take part in activities** such as counselling, training, medical care, and support groups

• **Gives people living with HIV and AIDS 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**

WHAT NEEDS TO BE DONE?

Address the obstacles people living with HIV and AIDS may face to their greater involvement by:

• **Encouraging people to know their HIV status** though increased access to HIV testing, treatment and care

(Continued)

WHAT NEEDS TO BE DONE? (Continued)

- **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 'Fighting HIV/AIDS Related Stigma and Discrimination')* at the community level by:
  - promoting tolerance
  - improving knowledge about HIV/AIDS
  - advocating for the legal and human rights of people living with HIV and AIDS among opinion leaders
- **Supporting the creation of networks or organizations of people with HIV and AIDS**
- **Strengthening the advocacy, leadership or counselling skills of people living with HIV and AIDS** in prevention, care and support activities
- **Making accessible the necessary material, financial and technical support** for their intervention and participation
- **Promoting the social recognition of people living with HIV and AIDS and their partners or families** associated with their participation in prevention programmes and projects

Comprehensive programmes to encourage the greater involvement of people living with HIV and AIDS in prevention education should also:

- **Support the expansion of services for people with HIV and AIDS** including medical care, counselling, training, support groups and positive living skills *(See brief on 'Prevention With and For People Living With HIV and AIDS')*
- **Promote culturally appropriate and gender responsive positive and non-discriminatory attitudes**, policies, and programmes supporting people living with HIV and AIDS
- **Build the capacity of people living with HIV and AIDS** for involvement through improved HIV and AIDS knowledge, communication, organisation and management skills

WHAT WORKS?

Experience has demonstrated a variety of effective ways to overcome obstacles to developing and implementing prevention initiatives with people living with HIV and AIDS:

- **Provide psychosocial and material support** to people living with HIV and AIDS with few resources such as peer counselling, financial compensation, food, drugs, medical care, travel reimbursement, child care and education programmes
- **Direct resources towards building the capacity of the coalitions and organizations** of people living with HIV and AIDS
- **Network with other organizations and services** to foster the involvement of people living with HIV and AIDS as well as linking these with other referral services

COUNTRY EXAMPLES

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 and AIDS, to influence behaviour change, improve knowledge, reduce stigma and discrimination, and enhance local and national HIV/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, Vietnam, Swaziland, Thailand and the Ukraine. Efforts in the Asia-Pacific region were implemented in collaboration with the Asia-Pacific Network for People Living with HIV and AIDS (APN+).

KEY PARTNERS

- Global Network of People Living with HIV/AIDS (GNP+)
- International Community of Women Living with HIV/AIDS (ICW)
- International HIV/AIDS Alliance www.aidsalliance.org
- International Federation of the Red Cross/Red Crescent Societies
- Ministry of Education and other relevant Ministries
- National Associations of People Living with HIV and AIDS
- UNAIDS, UNESCO, WHO

KEY RESOURCES

- Global HIV Prevention Working Group, *HIV Prevention in the Era of Expanded Treatment Access*, 2004
- National Association of People Living with HIV/AIDS (NAPWA), *Principles of HIV Prevention with Positives*, 2003
- Horizons, *Greater Involvement of PLHA in NGO Service Delivery: Findings from a Four Country Study*, Washington D.C., Population Council, 2002
- UNAIDS, *From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA)*, Geneva, UNAIDS, 1999

PREVENTION WITH AND FOR PEOPLE LIVING WITH HIV AND AIDS

The Global Initiative on HIV/AIDS and Education

UNAIDS

WHAT IS THE ISSUE?

Lessons learned from best practice show that **prevention with and for people living with HIV and AIDS**, sometimes also know as "positive prevention", **is an essential component of a comprehensive HIV prevention strategy**.

Prevention with and for people with HIV and AIDS **supports people with HIV and AIDS to take effective steps to**:
- Protect their sexual and general health
- Avoid practices that might put them at risk of contracting new sexually transmitted infections (STIs) and other "opportunistic infections" (such as tuberculosis)
- Delay the weakening of the immune system and the onset of AIDS-related illnesses
- Avoid transmitting HIV to other people

WHY DOES IT MATTER?

Until recently, prevention education messages have focused primarily on helping uninfected persons to adopt and maintain sexual behaviours to keep them uninfected. They have often failed to address the distinct prevention needs of people living with HIV and AIDS.

Prevention activities that meet the particular needs of people living with HIV and AIDS are important because:
- One positive person is always involved in each case of HIV transmission
- People living with HIV have the right to live well with HIV, including their sexual life
- HIV and AIDS prevention, treatment, care and support are all interrelated

Interventions with and for people with HIV and AIDS 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.

They also contribute to reduce HIV and AIDS related stigma and discrimination by generalizing HIV prevention to all.

Positive prevention has recently emerged as **a programmatic strategy** by the U.S. Centers for Disease Control and Prevention (CDC). In 2003, **the CDC acknowledged that there had been missed opportunities in directing prevention messages towards people with HIV and AIDS.**

In its document, *Advancing HIV Prevention: New Strategies for a Changing Epidemic Initiative*, **the CDC recognises the importance of positive prevention across the continuum of strategies**, from helping people find out their HIV status by increasing access to voluntary counselling and testing (VCT), to enabling people who know they have HIV to reduce the risk of onward HIV transmission.

WHAT NEEDS TO BE DONE?

Guiding principles for "prevention with and for people living with HIV/AIDS" acknowledges that **people living with HIV and AIDS should**:

- **Be fully involved in programme planning, design, implementation and evaluation** (*see brief on 'Promoting the Greater Involvement of People Living with HIV and AIDS in Prevention Education'*)
- **Be provided with information and practical support to negotiate** safer sex with their partners and have access to basic rights such as privacy, confidentiality, informed consent and freedom from discrimination

In addition, such **prevention programmes should**:

- **Be delivered in a variety of settings and sustained over time**
- **Support people with HIV and AIDS in exercising their rights** and **challenge stigma and discrimination** that can drive people underground and limit their access to information and services
- **Empower and support different groups** as HIV is often fuelled by inequalities in power due to gender, sexuality, lifestyle and poverty
- **Develop messages** sensitive to ethnicity, local culture and traditions, sex, sexual orientation, age, language, drug use, etc.
- **Work not only with people living with HIV**, but also with those who may be able to influence their behaviour and options (friends, family, partners, colleagues and outreach workers)
- **Approach prevention education as a shared responsibility requiring everyone to be involved**

WHAT WORKS?

The selection of strategies will depend on the specific needs of people living with HIV and AIDS 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:**
  – Voluntary counselling and testing
  – 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 pregnancy, childbirth and breastfeeding and sex
  – Post-test and ongoing counselling
  – Support for disclosure and partner notification
  – Counselling for sero-discordant 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
  – Provision of ARV treatment
  – Availability and distribution of condoms and lubricants at ARV treatment delivery sites and at 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

- **Community mobilisation** by:
  – Facilitating the establishment of post-test and other peer support groups
  – Implementing focused and strategic communication campaigns
  – Training people living with HIV and AIDS as peer outreach workers (*see brief on 'Promoting the Greater Involvement of People Living With HIV and AIDS in Prevention Education)*
  – Providing home-based care
  – Addressing gender-based violence

- **Advocacy, policy change and community awareness** by:
  – Involving people living with HIV and AIDS at all levels of programme implementation
  – Conducting advocacy for positive prevention
  – Conducting legal reviews and promoting legislative reform
  – Supporting advocacy for access to treatment

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 May 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.

KEY PARTNERS

- Global Network of People Living with HIV/AIDS (GNP+)
- International Community of Women Living with HIV/AIDS
- International HIV/AIDS Alliance
- International Federation of the Red Cross/Red Crescent Societies
- Ministries of Education and relevant Ministries
- National Association of People Living with HIV and AIDS
- Regional, national and local groups of people with HIV, including support groups, post-test clubs etc.
- UNAIDS, UNESCO, WHO
- U.S. Centers for Disease Control and Prevention
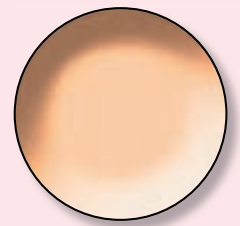
KEY RESOURCES

- Global HIV Prevention Working Group, *HIV Prevention in the Era of Expanded Treatment Access*, 2004
- National Association of People Living with HIV/AIDS (NAPWA), *Principles of HIV Prevention with Positives*, 2003
- International HIV/AIDS Alliance, *Positive Prevention: Prevention Strategies for People with HIV/AIDS*, Draft background paper, International HIV/AIDS Alliance, 2003
- Center for Disease Control and Prevention's initiative: "Advancing HIV Prevention: New Strategies for a Changing Epidemic," (http://www.cdc.gov/hiv/partners/ahp_program.htm)
- Janssen R.S. et al., "The Serostatus Approach to Fighting the Epidemic: Prevention Strategies for Infected Individuals," *American Journal of Public Health*, 91(7), 2001, 1019-1024
- King-Spooner S., "HIV prevention and the positive population," *International Journal of STD and AIDS*, 10(3), 1999
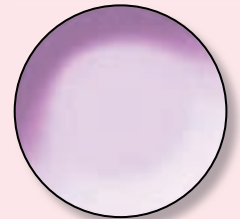
Terminology and sources

- Acronyms
- Key partners

Still under consideration:

- *Information and research resources*
- *Guidelines on HIV-related language*
- *Official commitments and declarations of the United Nations*
- *Glossary*

Joint United Nations Programme on HIV/AIDS

UNAIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
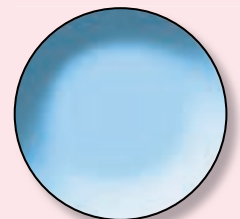UNODC·ILO·UNESCO·WHO·WORLD BANK

UNESCO

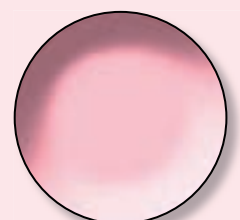Policy planning, management and resources

Education and communication: materials and methods

Social, legal & service environment

Key populations

Terminology & sources

ACRONYMS

The Global Initiative on HIV/AIDS and Education

UNAIDS

HIV/AIDS ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
API	AIDS Program Effort Index
ARV or ART	Anti-Retroviral (Treatment)
CBO	Community-based organization
CCM	Country Coordinating Mechanism
DoE	Department of Education
DoH	Department of Health
EFA	Education for All
FRESH	Focused Resources on Effective School Health
FTI	Fast Track Initiative
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technologies
IDP	Internally Displaced Person
IDU	Injecting Drug User, Intravenous Drug User
LSE	Life Skills Education
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Programme
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NAC	National AIDS Council
NAP	National AIDS Programme
NEP	Needle Exchange Programme
NGO	Non Governmental Organization
OVC	Orphans and Children made Vulnerable to HIV/AIDS
PLWHA/PLHA/PLWA	People/Persons Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VC(C)T	Voluntary (and Confidential) Counselling and Testing

ACRONYMS OF ORGANIZATIONS

AFS	Agence Française de Développement (French Development Agency)
CDC	Centers for Disease Control and Prevention (Atlanta, USA)
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
EDF	European Development Fund
EU	European Union
FBO	Faith-based Organization
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)
IATT	Inter Agency Task Team
IDRC	International Development Research Centre
IIEP	International Institute for Educational Planning
ILO	International Labour Organisation
MoE	Ministry of Education
MoEC	Ministry of Education and Culture
MoH	Ministry of Health
MoYS	Ministry of Youth and Sport
IPPF	International Planned Parenthood Foundation
NORAD	Norwegian Agency for Development Cooperation
OECD	Organisation for Economic Co-operation and Development
SCF	Save the Children Fund
SDC	Swiss Agency for Development and Cooperation
SIDA	Swedish International Development Cooperation Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UNTWG	United Nations Technical Working Group
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

The above list of acronyms is not exhaustive.

KEY PARTNERS

The Global Initiative on HIV/AIDS and Education

UNAIDS COSPONSORS

- **UNAIDS** - Joint United Nations Programme on HIV/AIDS (http://www.unaids.org)
- **UNHCR** - United Nations High Commissioner for Refugees (http://www.unhcr.ch)
- **UNICEF** - United Nations Children's Fund (http://www.unicef.org)
- **WFP** - World Food Programme (http://www.wfp.org)
- **UNDP** - United Nations Development Fund (http://www/undp.org)
- **UNFPA** - United Nations Population Fund (http://www.unfpa.org)
- **UNODC** - United Nations Office on Drugs and Crime (http://www.unodc.org)
- **ILO** - International Labour Organization (http://www.ilo.org)
- **UNESCO** - United Nations Educational, Scientific and Cultural Organization (http://www.unesco.org)
- **WHO** - World Health Organization (http://www.who.int)
- **World Bank** (http://www.worldbank.org)

MEMBERS OF THE UNAIDS IATT ON HIV/AIDS AND EDUCATION

- **AED** - Academy for Educational Development (http://www.aed.org)
- **Action Aid** (http://www.actionaid.org)
- **Aga Khan Foundation** (http://www.akdn.org/)
- **American Institutes for Research** (http://www.air.org)
- **CIDA** - Canadian International Development Agency (http://www.acdi-cida.gc.ca)
- **DFID -** UK Department for International Development (http://www.dfid.gov.uk)
- **Development Cooperation Ireland** (http://www.dfa.ie)
- **Education Development Center** (http://www.edc.org)
- **Education International** (http://www.ei-ie.org/)
- **European Commission** (http://www.eu.int)
- **Ford Foundation** (http://www.fordfound.org)
- **Nelson Mandela Foundation** (http://www.nelsonmandela.org)
- **Netherlands Ministry of Foreign Affairs** (http://www.minbuza.nl)
- **SIDA** - Swedish International Development Agency (http://www.sida.se)

MEMBERS OF THE UNAIDS IATT ON YOUNG PEOPLE AND HIV/AIDS

- **UNFPA -** United Nations Population Fund (http://www.unfpa.org)
- **ILO** - International Labour Organization (http://www.ilo.org)
- **UNAIDS Secretariat** (http://www.unaids.org)
- **UNESCO** - United Nations Educational, Scientific and Cultural Organization (http://www.unesco.org)
- **UNICEF -** United Nations Children's Fund (http://www.unicef.org)
- **UNODC** - United Nations Office on Drugs and Crime (http://www.unodc.org)
- **WHO -** World Health Organization (http://www.who.int)
- **World Bank** (http://www.worldbank.org)

NON GOVERNMENTAL ORGANIZATIONS AND DONORS

- **Advocates for Youth** (http://www.advocatesforyouth.org)
- **AFD -** Agence Française de Développement (French Development Agency) (http://www.afd.fr)
- **AIHA -** American International Health Association (http://www.aiha.com/english/health/hiv.htm)
- **AMFAR** - American Foundation for AIDS Research (http://www.amfar.org)
- **CARE** - (http://www.care.org)
- **CDC** - US Centers for Disease Control and Prevention (statistics on HIV/AIDS) (http://www.cdc.gov)
- **Christian Aid** (http://www.christianaid.org)
- **CTB -** Coopération Technique Belge (Belgian Technical Cooperation) (http://www.btcctb.org)
- **DANIDA -** Danish International Development Agency (http://www.um.dk/en/menu/DevelopmentPolicy/DanishDevelopmentPolicy/DanishDevelopmentPolicy)
- **EDF -** European Development Fund (http://europa.eu.int/scadplus/leg/en/lvb/r12102.htm)
- **FHI** - Family Health International (http://www.fhi.org/en/index.htm)
- **Gates Foundation** (http://www.gatesfoundation.org)
- **Global Campaign for Education** (http://www.campaignforeducation.org/news.html)
- **GNP+ -** Global Network of People Living with HIV/AIDS (http://www.gnpplus.net)
- **GTZ -** Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation) (http://www.gtz.de)
- **HEARD** - Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal (www.und.ac.za/und/heard)
- **IRDC -** International Research Development Centre (http://www.idrc.ca)
- **ICW -** International Community of Women Living with HIV/AIDS (http://www.icw.org)
- **ICASO** - International Council of AIDS Service Organizations (http://www.icaso.org)
- **International Federation of the Red Cross/Red Crescent Societies** (http://www.ifrc.org)
- **International HIV/AIDS Alliance** (http://www.aidsalliance.org)
- **International Youth Foundation** (http://www.iyfnet.org)
- **InWEnt** - Internationale Weiterbildung und Entwicklung (Capacity Building International, Germany) (http://www.inwent.org)
- **IPPF** - International Planned Parenthood Foundation (http://www.ippf.org)
- **International Youth Foundation** (http://www.iyfnet.org)
- **JICA -** Japan International Cooperation Agency (http://www.jica.go.jp)
- **Kaiser Family Foundation** (http://www.kff.org)
- **Marie Stopes International** (http://www.mariestopes.org.uk/)
- **Mobile Task Team on the impact of HIV/AIDS on Education** (http://www.mttaids.com/site/)
- **NAPWA** - National Association of People Living with AIDS (US) (http://www.napwa.org)
- **NORAD** - Norwegian Agency for Development Cooperation (http://www.norad.no)
- **OECD** - Organization for Economic Co-operation and Development (http://www.oecd.org)
- **Partnership for Child Development** (http://www.child-development.org)
- **Save the Children** (http://www.savethechildren.org)
- **SDC -** Swiss Agency for Development and Cooperation (http://www.sdc.admin.ch)
- **USAID** - US Agency for International Development (http://www.usaid.gov)
- **World Confederation of Teachers** (http://www.wctcsme.org/)
- **YouthNet** (http://www.youthnet.org)

OTHER UN PARTNERS

- **FAO** - Food and Agricultural Organization (http://www.fao.org)
- **IIEP/UNESCO** - International Institute for Educational Planning, UNESCO (http://www.unesco.org/iiep)
- **UNIFEM** - United Nations Development Fund for Women (http://www.unifem.org)
- **UNODC Global Youth Network** (http://www.unodc.org/youthnet/youthnet_links.html)
- **WHO Substance Abuse** (http://who.int/substance_abuse/)
- **OHCHR** - Office of the United Nations High Commissioner for Human Rights (http://www.ohcr.org)

The key partners here listed do not constitute an exhaustive list.