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2011-2012 Education Sector HIV and AIDS Global Progress Survey



Progression, Regression or Stagnation?

2011-2012 Education Sector HIV and AIDS
Global Progress Survey
Progression, Regression or Stagnation?

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This report, *2011-2012 Education Sector HIV and AIDS Global Progress Survey: Progression, Regression or Stagnation* is based on a number of reports produced by ESART, including: the *Pilot Studies Report*, the *2011 GPS Draft Trend Report*, the *Final Summary Report 2011* (on the full 39 country cohort), and the individual country profiles (available upon request at aids@unesco.org). Text from these reports was used and adapted as necessary, and new text developed by Scott Pulizzi and Audrey Kettaneh from UNESCO's Section of HIV and Health Education.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent and Reproductive Health
ART	Antiretroviral Treatment
ARV	Antiretroviral
CIDA	Canadian International Development Agency
CS	Civil Society
CSE	Comprehensive Sexuality Education
EFA	Education for All
ESA	Eastern and Southern Africa
EMIS	Education Management Information System
ESART	EduSector AIDS Response Trust
FBO	Faith-Based Organization
FPE	Free Primary Education
GPS	IATT Global Progress Survey (2011-2012)
GRS	IATT Global Readiness Survey (2004)
HAKT	HIV and AIDS Knowledge Test (SACMEQ)
HAMU	HIV and AIDS Management Unit
HEARD	Health Economics & AIDS Research Division (University of KwaZulu-Natal)
HIV	Human Immunodeficiency Virus
HR	Human Resources
IATT	Inter-Agency Task Team on Education (UNAIDS)
IIEP	International Institute for Educational Planning (UNESCO)
ILO	International Labour Organization
LAC	Latin America and the Caribbean
LSE	Life Skills Education
MENA	Middle East and North Africa
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MTT	Mobile Task Team on the Impact of HIV and AIDS on Education
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PLHIV	Persons Living with HIV
SACMEQ	Southern and Eastern African Consortium for Monitoring the Quality of Education
SE	Sexuality Education
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group (IATT)
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive Summary

Education is the foundation for the success of all HIV programming. Individuals need the requisite knowledge, attitudes and skills to adopt healthy behaviours and to act against discrimination. Personal efficacy skills and health literacy are essential for making informed choices and accessing and using prevention and treatment methods and services across one's lifespan. Comprehensive HIV education should therefore be part of a broad skills-based curriculum that addresses HIV in the learner's context and in an age-appropriate way over critical years of development. In addition, general education that fosters literacy, numeracy, and critical thinking skills, among many others, supports the AIDS response by building self-esteem, assertiveness and economic independence, thus reducing vulnerability, especially for girls. Better educated learners have the skills to be healthy, and teachers who have the skills and support to live healthy will have the opportunity to teach better.

The education sector therefore has a key role to play within a national AIDS response, and has a number of advantages that position it to fulfil this role effectively including its high degree of geographic coverage, access to a large proportion of the youth of a country, and a large skilled workforce. These represent opportunities for the national response to be translated into actions. Given the importance of the education sector in a national response, the UNAIDS Inter-Agency Task Team on Education (IATT) commissioned the 2011-2012 HIV and AIDS Global Progress Survey (GPS). The Survey aimed to measure progress and trends in education sector responses to AIDS since the 2004 Global Readiness Survey (GRS) in different epidemiological settings, and to provide a comparative analysis between 2004 and 2011-2012.

The 2011-2012 Global Progress Survey (GPS) used a more focused and intensive sampling strategy than the 2004 survey with fewer countries but a greater depth of data collected. Independent facilitators oversaw and managed the country data-collection processes, and engaged civil society representation in the data-collection meetings. As both the 2004 and the 2011-2012 surveys depended largely on the subjective inputs of MoE officials, the utility of this information at the country level is inevitably limited by the extent to which country respondents are able to accurately report implementation, particularly in decentralized, under-monitored and under-reported education systems.

This report highlights key findings from the 2011-2012 survey as well as other recent research, to provide a picture of how countries' education sectors are responding to the challenges of HIV and AIDS, what progress has been made since 2004, as well as to point out the main policy implications of the current situation. The findings have been grouped in this report into four main categories: enabling environment and mainstreaming; human resource issues; teaching and learning; and orphans and vulnerable children.

The data show mixed results with progress in some fields, stagnation in others, but many of the necessary conditions trending in the positive direction since 2004, and almost all countries have an education sector AIDS policy; there is increasing space within the curriculum to teach about HIV and more teachers have been trained to teach HIV; there are more EMIS units in place and there are increased protective policies and services for learners and teachers. But many challenges still remain.

The report highlights some of the critical action points that need to be addressed to improve the effectiveness of the education sector's response:

- Establish and maintain a high-level political will for a comprehensive AIDS response in education, including school-based activities and teacher education.
- Develop an effective and country-appropriate management system to coordinate and implement existing policy and plans.

Better educated learners have the skills to be healthy, and teachers who have the skills and support to live healthy will have the opportunity to teach better.

- Strengthen existing EMIS units to track HIV-sensitive indicators to ensure that the effects of HIV and AIDS on the education sector is understood and can adequately be planned for and addressed. If no HIV indicators specific to education exist, countries should consider using the UNESCO/IATT on Education's Global M&E Framework for Comprehensive Education Responses to HIV and AIDS.
- Establish clear mechanisms and guidance for private providers of education service.
- Support sector-wide teacher training on HIV education for pre- and in-service inclusive of HIV content and skills-based pedagogical approaches.
- Ensure that curricula and teaching materials are age-appropriate, scientifically accurate, gender-sensitive and life skills-based and are available in every school and taught to all learners.
- Ensure effective school-level implementation by clearly delineating the roles and responsibilities: teachers mandated and tasked with teaching comprehensive sexuality and HIV education; recognition of teachers' role by school administrators and the community; oversight role of principals including identifying obstacles, challenges and shortfalls.
- Engage parents and the community members in implementation.
- Establish clear mechanisms for health sector collaboration in both the provision of services to learners and staff and in technical support to update educational content in line with developments in the medical field.
- Scale up workplace policies so that all education staff are protected and supported to do their jobs effectively.

While the wider system functionality of the education sector is beyond the scope of this report, the success of the sector's response to AIDS is largely dependent on its functionality. If the internal capacity and efficiency of the education system is compromised in any way, this will inevitably limit the potential for an effective AIDS response. As such, a number of systemic challenges will continue to put pressure on the education sector and affect its ability to respond. Increasing demand, limited internal resources, declining external funding, inadequate infrastructure, limited human resources and retention of these, and the pace of socio-economic change are a potent mix, requiring determined and sustained reform efforts beyond the AIDS response.

1. Introduction

1.1 Background

Progression, Regression or Stagnation? We ask this question because education is the foundation for the success of all HIV programming and it is thus critical to monitor the continued role of the education sector in the AIDS response. Every year there are new learners coming of age who need the information and skills to protect themselves, and the education sector has the responsibility to deliver. Comprehensive sexuality education, which includes HIV, sexual and reproductive health, decision-making and critical thinking skills, enables young people to learn about HIV risk in their context and develop the skills to protect themselves now and across their lifespan. Comprehensive sexuality education, considered in the context of critical enablers in the UNDP/UNAIDS *Understanding and acting on critical enablers and development synergies for strategic investments*,¹ is central to each of the UNAIDS goals: zero new infections, zero AIDS-related deaths and zero discrimination. Individuals need the requisite knowledge, attitudes and skills to adopt healthy behaviours and act against discrimination. Personal efficacy skills and health literacy are essential for making informed choices and accessing and using prevention and treatment methods and services across one's lifespan. In addition, a meta-analysis² suggests that those who receive comprehensive sexuality education may be less likely to become sexually active at an early age and more likely to protect themselves when they do start having sex.

“Ending AIDS is possible – and education is the key to success.”

Michel Sidibé,
Executive Director of
UNAIDS, Remarks on the
occasion of the
Global Education
First Initiative launch,
27 September 2012.

WHAT IS HIV EDUCATION?

This report examines HIV education. Effective HIV education, including AIDS is part of comprehensive sexuality education. Evidence shows that comprehensive sexuality education that is age-appropriate, gender-sensitive and life skills-based can provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality and lifestyle. In many education sectors, comprehensive sexuality education is taught in the subject areas of family life/health education and in biology/natural science. HIV education can also occur in subject areas such as social studies and civic education, for example when aspects of stigma and discrimination are taught and when teaching about HIV transmission other than through sex. Teaching HIV across several subject areas requires coordination to ensure consistent and effective approaches across the interconnected individual and social dimensions of the topic. This report refers to all aspects of HIV education and explicitly states comprehensive sexuality education where appropriate.

HIV education should be part of a broad skills-based curriculum that addresses HIV in the learner's context and in an age-appropriate way, over critical years of development. While a behaviour change campaign through mass media or social marketing raises awareness among populations, it does not constitute comprehensive HIV education. Education is a process of human development, not merely information delivery. Comprehensive HIV education is one critical aspect of the AIDS response because it supports all basic programme activities, but it is not sufficient in itself. It must therefore be placed within a mainstreamed multisectoral national programme. In addition, general education that fosters literacy, numeracy and critical thinking skills, among many others, supports the AIDS response by building self-esteem, assertiveness and economic independence, thus reducing vulnerability, especially for girls. Better educated learners have the skills to be healthy. Therefore, teachers that have the skills and support to live healthy will have the opportunity to teach better.

1 UNDP, UNAIDS. 2012. *Understanding and acting on critical enablers and development synergies for strategic investments*. New York, UNDP.

2 UNESCO. 2009. *International Technical Guidance on Sexuality Education – An evidence informed approach for schools, teachers and health educators*. Paris, UNESCO.

Gender inequality and harmful gender norms remain key drivers of the HIV epidemic in many regions, and schools have a key role to play in promoting both gender equality and positive gender norms. Schools can thus have a further impact on HIV by demonstrating gender equality in staffing and in practices, as well as providing a safe environment that promotes positive gender norms and by delivering education in which the content also promotes understanding of gender and equality.

Thus the education sector has a key role to play within a national AIDS response, and has a number of advantages that position it to fulfil this role effectively. These include its high degree of geographic coverage, access to a large proportion of the youth of a country, and a large skilled workforce which represent opportunities for the national response to be translated into actions.

Given the importance of the education sector in a national response, the UNAIDS Inter-Agency Task Team on Education (IATT) commissioned the 2011-2012 HIV and AIDS Global Progress Survey (GPS). The Survey aimed to measure progress and trends in education sector responses to HIV and AIDS since the 2004 Global Readiness Survey (GRS), and was funded by UNESCO and the Canadian International Development Agency (CIDA). The main objective of the 2011-2012 GPS was to assess the role and progress of education sector engagement in national responses to AIDS within different epidemiological settings, and to provide a comparative analysis between 2004 and 2011-2012.

The 2011-2012 survey reviewed progress on a number of different topics which have been grouped in this report into four main categories: enabling environment and mainstreaming; human resource issues; curriculum and teaching; and orphans and vulnerable children. This report highlights key findings from the 2011-2012 survey as well as other recent research to provide a picture of how countries' education sectors are responding to AIDS, what progress has been made since 2004, as well as to point out the main policy implications of the current situation.

1.2 Findings from the 2004 Global Readiness Survey (GRS)

The first global survey to measure the readiness of the education sector to respond to AIDS took place in 2004 and covered 71 high-, medium-, and low-prevalence countries. On balance, the review found that ministries of education (MoE) and civil society (CS) were making considerable steps toward institutionalizing effective responses.

The review specifically noted that:

- Most MoEs reported having HIV and AIDS management structures in place with diverse and encompassing representation;
- Senior officials had publicly discussed HIV and included it on the agenda of senior management meetings, particularly in high-prevalence countries;
- Progress had been reported on mainstreaming, through the development of education sector AIDS strategic plans;
- Information addressing HIV and AIDS had in many places been integrated into school curricula at the primary and secondary levels;
- Partnerships were developing in response to AIDS between MoEs, other government agencies and ministries, private sector, non-governmental organizations (NGOs), and faith-based organizations (FBOs) and religious groups.

The findings also suggested that there was scope for improvement, and an important need for:

- Education sector AIDS policy development;
- Sector-wide strategic plans to implement, monitor and enforce policy;
- Improvement in access to, and use of, high-quality data to inform policies and plans in the sector;
- More holistic and comprehensive responses to management and mitigation;
- Secure and sustained funding arrangements;

- Improved collaboration and partnerships between MoE, civil society, teacher unions and development partners;
- Capacity-building (e.g., planning and budgeting, management, data use for planning) at all levels of the MoE, and retention and experiential growth to ensure HIV and AIDS management structures provide the necessary dedicated coordination and management functions.
- Increased support for educational systems to provide prevention programmes for staff and learners; teacher training in HIV education and life skills development; orientation programmes addressing treatment, care and support; and the establishment of guidelines for teachers to deal with HIV and AIDS in school settings – including the establishment of universal precautions. Further efforts to integrate HIV and AIDS into school curricula;
- Holistic responses addressing the educational, psychosocial and material needs of learners infected and affected by HIV and AIDS.

These and other findings from the 2004 GRS are the baseline for comparison with data from the new 2011-2012 survey. For access to the 2004 GRS report, go to <http://unesdoc.unesco.org/images/0014/001446/144625e.pdf>.

The GPS aimed to measure progress and trends in education sector responses to HIV and AIDS since the 2004 Global Readiness Survey (GRS), and was funded by UNESCO and the Canadian International Development Agency (CIDA). The main objective of the 2011-2012 GPS was to assess the role and progress of education sector engagement in national responses to HIV and AIDS within different epidemiological settings, and to provide a comparative analysis between 2004 and 2011-2012.

2. The 2011-2012 Global Progress Survey (GPS)

2.1 Countries Surveyed

The 2011-2012 Global Progress Survey (GPS) used a more focused and intensive sampling strategy than the 2004 survey with fewer countries but a greater depth of data. Data were collected from 39 countries³ in three categories of HIV epidemic: generalized; concentrated and low-level. Of these, 30 (77%) had participated in the 2004 GRS baseline, and so provide the opportunity to measure change over eight years. Seventeen out of the 39 countries sampled have a generalized epidemic, all of which were included in the 2004 GRS. Sixteen countries have a concentrated epidemic, of which 12 (71%) were included in the 2004 GRS, and six countries have a low-level epidemic, of which five (83%) were included in the 2004 GRS.

The survey aimed to include countries with a broad geographic coverage and a range of income levels. Of the 39 countries that participated in the 2011-2012 GPS, 22 were located in Africa, six in Asia Pacific, four in Latin America and the Caribbean (LAC), two in the Middle East/North Africa (MENA), and five in East and Central Europe and Central Asia. Similarly the countries come from a range of economic classifications. The 2011-2012 sample include 16 low income countries, eight lower-middle income countries, 14 upper-middle income countries, and only one high income country (please see Annexes 1 and 2 for further details on the countries surveyed and their selection process).

Two sets of data analysis were conducted. The first analysed the full 39 country sample, while the second, the trend analysis, compared data from the 2004 GRS to the 2011-2012 GPS and covered the 30 countries that participated in both surveys. This report uses both sets of findings to review policy implications.

2.2 Data Collection Instrument

The 2011-2012 GPS follows on from the baseline 2004 GRS. It was undertaken by the EduSector AIDS Response Trust (ESART) which was selected through a competitive bidding process, and was also the team originally responsible (as Mobile Task Team on the Impact of HIV and AIDS on Education) for the 2004 GRS. The survey methodology is outlined in greater detail in Annex 1. The methodology used in the 2011-2012 GPS addressed most of the perceived shortcomings of the 2004 GRS instrument. It targeted a smaller country sample but was designed to capture considerably more detail than the 2004 GRS baseline. The 2011-2012 data collection instrument was expanded from 137 to 351 questions in 11 focus areas to provide greater insight into the practical problems confronting the implementation of policy and planning. It was also restructured to review better the capacity of MoEs to manage, monitor and report their programmed response to HIV and AIDS. This approach was intended to help quantify the education sector's contribution to the national AIDS response and identify sectoral trends, lessons and replicable practices since 2004.

Another major difference in the 2011-2012 GPS data collection instrument was the use of independent facilitators to oversee and manage country data collection processes, and engage civil society representation

The 2011-2012 data collection instrument was expanded from 137 to 351 questions in 11 focus areas to provide greater insight into the practical problems confronting the implementation of policy and planning.

³ For a description of how the countries were selected, please see Annex 1.

in these meetings. Civil society in this instance generally refers to non-governmental entities conducting programmes in the education sector. The country facilitators were responsible for guiding the participants through the data collection process and recording the findings of each meeting. It was hoped that the inclusion of civil society in data-gathering meetings would stimulate more objective interrogation of the issues and that this would be assisted by the greater breadth and depth of the 2011-2012 instrument.

Once the data were input and cleaned, individual country reports were generated. These were then sent to the respective countries for verification, to ensure that they accurately reflected the situation on the ground and the discussions that took place during the data-gathering process.

Although the 2011-2012 GPS was independently facilitated and included external civil society partners, both this survey and the baseline 2004 GRS depended largely on the subjective inputs of MoE officials. The utility of this information, at the country level, is inevitably limited by the extent to which country respondents are able to accurately report implementation, particularly in decentralized, under-monitored and under-reported education systems. It should be noted that while the 2011-2012 GPS has been effective in capturing key indicators of national education sector AIDS responses, it has been less effective in capturing data on provincial and/or district level planning and implementation in highly decentralized countries, such as South Africa and Nigeria.

The emphasis at the national level has had the effect of expanding the focus of the survey beyond narrow AIDS response boundaries and raises the wider contextual issue of education system functionality, monitoring and reporting. In short, it reminds us that the effectiveness of the education sector's AIDS response will be limited by the effectiveness of the education system which manages it. If this wider system is not fully functional at every level, it is unlikely that the AIDS response can be comprehensively implemented or properly mainstreamed into the routine business of this sector. It follows therefore that effective education system management emerges as the key to any regeneration of education sector AIDS responses.

The success of the sector's response is largely dependent on the functionality of the education system itself.

2.3 Education Sector Systemic Challenges

In preparation for the 2011-2012 GPS, the research team conducted a multi-country case study, which found⁴ that there are four main systemic challenges that can impact a comprehensive education sector response to AIDS and which have not yet been successfully addressed in most of the countries surveyed. The success of the sector's response is largely dependent on the functionality of the education system itself. If the internal capacity and efficiency of the education system is compromised in any way, this will inevitably limit the potential of the HIV and AIDS management unit or focal point to coordinate and direct the expected response. If the budget is under pressure and subject to competitive stresses, this too will limit the flow of funds to the sectoral AIDS response and exacerbate the contextual problem of wider system functionality.

The second challenge is the variability of education management information system (EMIS) operations. If an education system has no reliable and up-to-date management information, it cannot analyse and monitor performance and efficiency, particularly in respect of demand, supply, outputs and quality. In the absence of such data, the impacts of HIV and AIDS cannot be benchmarked and tracked, or their response mainstreamed as a routine function of system operation. Without this underpinning, it is also clear that monitoring, evaluation and reporting will be difficult to initiate and sustain.

The third challenge is the high and increasing percentage of private schools in some countries. Apart from the governance issues, which are not always clear in terms of policy and regulation, many of these schools are run by churches or other faith-based organizations (FBOs). Anecdotal evidence suggests this has varying but profound implications for life skills, adolescent reproductive health, HIV and STI education and messaging, and has the potential to complicate any national or education sector approach.

The last main challenge revealed in the study is the growth in primary enrolment due to free primary education (FPE), which should be commended. It appears that in many countries little planning or

⁴ EduSector AIDS Response Trust (ESART). 2011. *Progress Report on Education sector (EDSEC) Engagement in National HIV&AIDS Responses, Phase 1 Summary Report*. Unpublished project report.

preparation is in hand for the wave of enrolment that will hit the secondary level in the coming years. Kenya, for example, is confronted with rising pupil/classroom ratios and growing demand for new classrooms, yet has frozen teacher posts. There is little evidence of gearing-up training or other human resource (HR) issues, and this will have implications for AIDS responses, since budgets will be stretched to deal with increased teacher recruitment and training, infrastructural development and materials production, for example. This points to the potential of reduced education system functionality, thereby reducing AIDS response capacity.

These systemic challenges of increasing demand, limited internal resources, declining external funding, inadequate infrastructure, limited human resources and retention of these, and the pace of socio-economic change are a potent mix, requiring determined and sustained reform efforts beyond the AIDS response.

3. Key Findings and Policy Implications

The 2011-2012 Global Progress Survey (GPS) consisted of 351 questions in 11 focus areas. This section aims to distil key findings from the different areas into four sections to make the data manageable and bring focus to the analysis. These sections are:

3.1 Enabling Environment and Mainstreaming

3.2 Human Resource Issues

3.3 Teaching and Learning

3.4 Orphans and Vulnerable Children

The full data set and country reports are available upon request from aids@unesco.org.

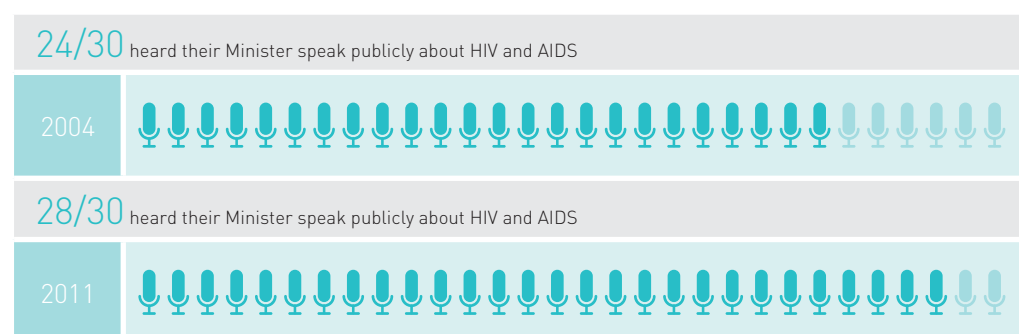
3.1 Enabling Environment and Mainstreaming

3.1.1 Enabling Environment

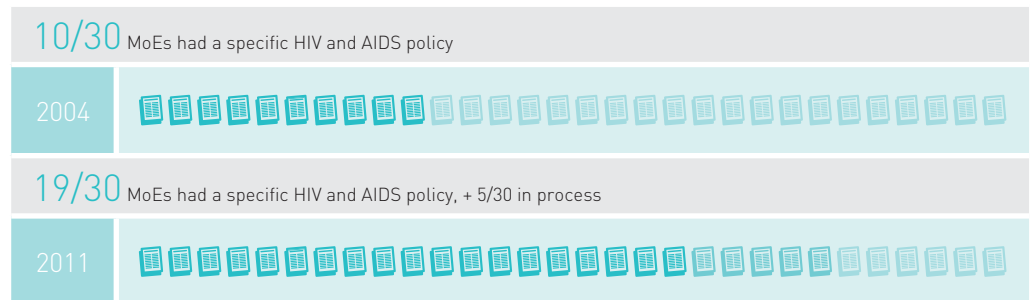
An enabling environment may be a political, legal, social, bureaucratic or systemic climate conducive to the achievement of identified goals or objectives, characterized by advocacy and perhaps involving the removal of barriers or constraints inhibiting such development. In the context of HIV and AIDS, the goal of increasing comprehensive knowledge of HIV among young people requires an environment that allows implementation of comprehensive sexuality education in schools and linkage to other relevant services. An enabling environment may be *political* (enjoys the support and/or advocacy of sectoral or political leaders); *legal* (in which laws and policies against discrimination on the basis of HIV-status, risk behaviour, occupation and/or gender are in place, and are monitored and enforced); *social* (in which social norms accommodate HIV-prevention messaging and support healthy behaviour choices); or *bureaucratic/systemic* (in which sectoral structures, regulations and procedures facilitate the implementation of AIDS policies and strategies). Some of these, for example a national AIDS policy, are outside of the control and remit of the education sector. However, as a whole they affect the ability of the sector to effectively respond to AIDS. The following findings do not cover all the aspects of an enabling environment but rather highlight key findings of the survey.

Political advocacy – Representatives of almost all MoEs, 28/30 countries (93%), reported in 2011-2012 that they had heard their education minister speak publicly about the impacts of HIV and AIDS on education, a significant increase on the 2004 level of 80% (24/30). However, this does not infer sustained advocacy, as only 30% of these had heard their Minister speak “often”. Sixty per cent had only heard the Minister “occasionally”, while one had heard the Minister speak “only within the MoE”.

An enabling environment may be a political, legal, social, bureaucratic or systemic climate conducive to the achievement of identified goals or objectives.



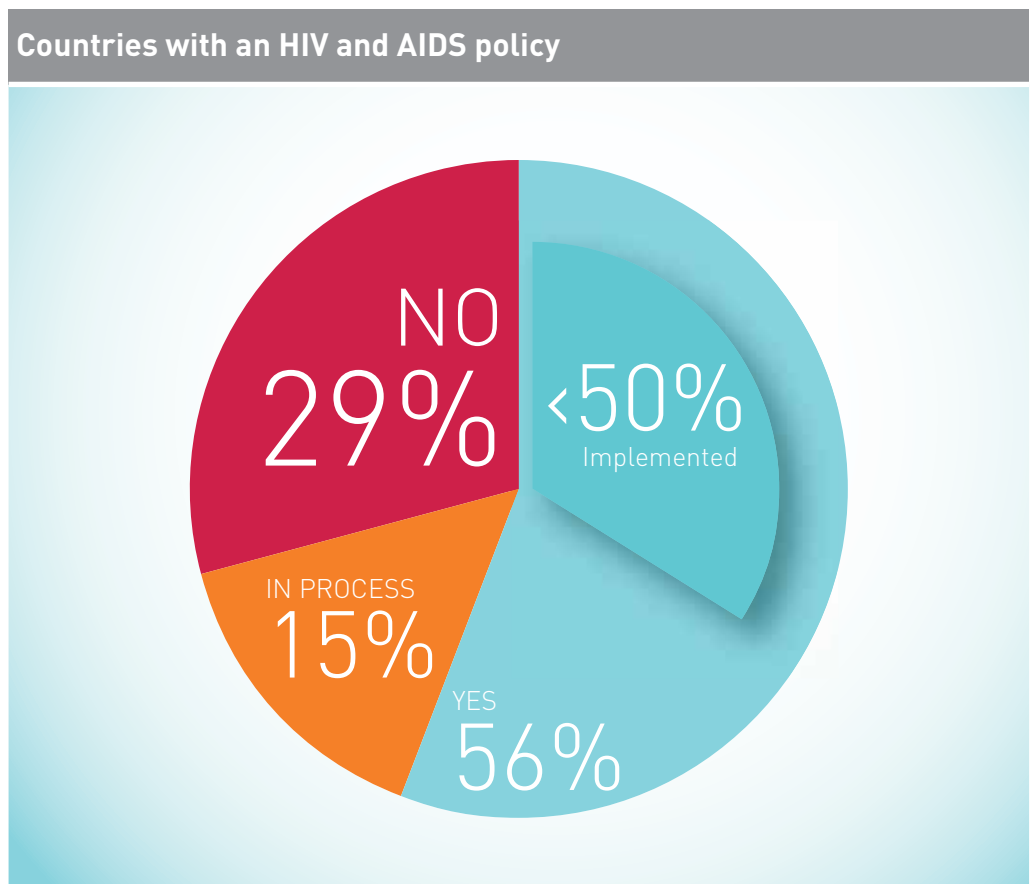
Policy development and implementation – The positive change in the number of countries with a specific education sector HIV and AIDS policy in place, ranks as one of the highlights of the 2011-2012 GPS. In 2004, 10/30 countries (33%) had a policy, rising to 19/30 (63%) in 2011-2012, with 5/30 (17%) in progress. This very significant increase in the number of countries with a specific education sector HIV and AIDS policy suggests the commitment of countries to develop appropriate tools to support and guide the response.



Only 7/16 countries with a concentrated epidemic had a policy, with two in process of development.

The full 39 country cohort reported that 56% (22) of countries had a policy with another 15% in the process of developing one. The data, broken down by epidemic context, show that only 2/17 countries with a generalized epidemic do not have an education sector HIV and AIDS policy and three are in the process of developing one. This confirms a surge in policy development in generalized epidemic contexts, with many countries adapting regional policies to speed the process. However, only 7/16 countries with a concentrated epidemic had a policy, with two in process. Of those that did not have or were not developing a policy, two countries with a generalized epidemic and three countries with a concentrated epidemic had actually mainstreamed HIV and AIDS in the National Education Sector Policy.

While policy development has seen a marked increase, the responses to the question of how well the Education Sector HIV and AIDS policy has been implemented shows that action and implementation remain a big challenge. More than half of the 22 countries with a policy in place reported an implementation rate below 50%.

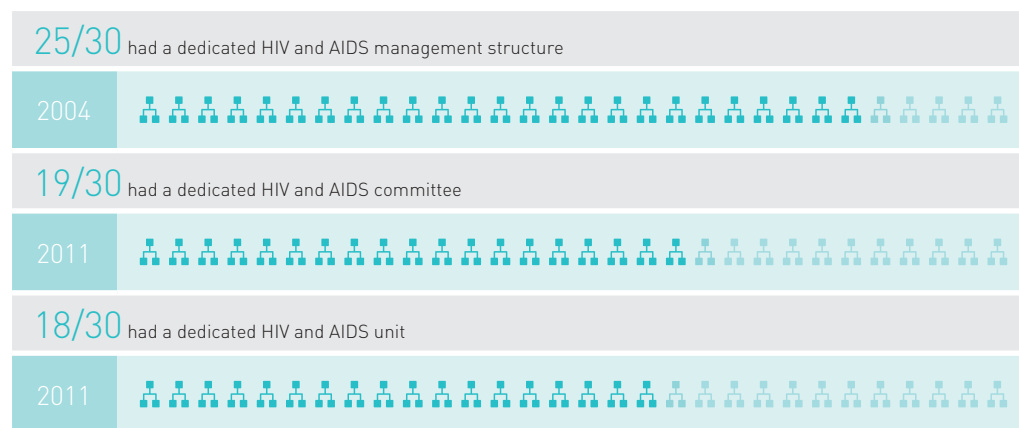


Education Management Information System (EMIS) – The growth in the number of education management information system units over the eight years is a very positive systemic development. In 2004, 19/30 countries had an EMIS, by 2011-2012, 29/30 countries (96%) had one in place.

When asked if their EMIS system had been reviewed or amended to include HIV and AIDS-sensitive indicators, only 10 (53%) of 19 countries that had an EMIS in 2004 could confirm this. By 2011-2012, the situation had deteriorated further with only 13 of 29 countries (45%) with an EMIS able to confirm such a review or amendment process had taken place. This indicates a significant proportional decline. This apparent lack of engagement from EMIS reflects other observations and experience, and suggests a lack of management interest or direction, a lack of understanding of the topic, and perhaps a sense that this is not really education business.



Dedicated National Education Sector HIV and AIDS Management Structures – In the past, this has ranked as one of the most important markers of commitment to an education sector AIDS response as, by definition, these structures should be responsible for coordinating, implementing, monitoring and reporting on the Education Sector AIDS response – and now moving to ensure its mainstreaming. As noted above, the policy environment has strengthened significantly, yet the MoE units and structures responsible for action have declined in number. The number of countries with dedicated response structures (including committees and/or units) actually *declined* from 25/30 (83%) in 2004 to 19 (63%) and 18 (60%) respectively over eight critical years of policy development. Twenty-one or 54% of the 39 country 2011 cohort reported having a dedicated unit. This decline suggests a number of possibilities.



- First, it could signal declining levels of education sector commitment or interest (“AIDS fatigue”) because administrators do not want to dedicate resources. Yet evidence of increasing policy development over the same period contradicts this – unless this policy development has been driven by development partner pressure and funding. It should also be noted that policy development tends to be a lengthy and bureaucratic process, suggesting that the surge in the number of policies reported could have been commissioned years before, and does not accurately reflect current levels of interest or attention. Whichever the case, it reconfirms the fact that the existence of policy does not guarantee implementation, or the means to achieve this. (See sidebar p. 19, The Rise and Fall of HAMUs).
- Second, linked to the problem of sustaining what was initially characterized as “crisis response” in the education sector, there is the challenge of skilled/experienced staff retention in what remains a stigmatized area of management and one struggling more than ever for resources in an increasingly

GLOBAL M&E FRAMEWORK FOR COMPREHENSIVE EDUCATION RESPONSES TO HIV AND AIDS

Building on the work of the UNAIDS IATT on Education, through extensive consultations at national, regional and global levels and field tests in Africa, Asia and the Caribbean, UNESCO has developed a global monitoring and evaluation framework for comprehensive education responses to HIV and AIDS. In total, 15 indicators are recommended for inclusion in the Global M&E Framework to measure process (such as policy development, implementation status, and national education programme) and outcomes (knowledge and behaviour) of the education sector responses. It is recommended that 10 of these indicators be integrated into the Education Management Information System.

These can be accessed at www.unesco.org/new/en/hiv-and-aids/about-us/unaid-iat-on-education/

competitive internal environment. This is underlined by the fact that only two countries out of 30 still had any HIV and AIDS management unit (HAMU) staff members left from 2004. The fact is that in a number of countries, described as “model” HAMUs in 2004, there is now little evidence of a managed response, committed staff or prioritized planning (see sidebar, The Rise and Fall of HAMUs).

- Third, the decline in these structures could imply an accelerating move to mainstreaming, in which the AIDS response is integrated in the routine business of relevant MoE divisions and then monitored and reported nationally, rather than managed in the traditional sense. However, in spite of some positive trends in this regard, there is insufficient evidence of serious mainstreaming implementation to support this theory as yet.
- On balance, and in light of the decline in HIV prevalence reported in a number of countries with generalized and concentrated HIV epidemics, it could be that AIDS has slipped from the education sector radar. As an MoE function it may have been “institutionalized” in the corridors of bureaucracy and lost both its sense of urgency and the oversight of top management. Alternately, as mentioned previously it could be a sign of improved harmonization and alignment. The degree to which learners acquire knowledge and develop skills will be the deciding metrics.

The migration of the response towards a mainstreamed approach raises questions about the potential need for a new management model and may in fact render some aspects of the HAMU model obsolete.

While there has been a decline in management structures, data from the 2011-2012 GPS show high levels of preparedness in countries with a generalized epidemic with somewhat limited capacity in countries with concentrated epidemics, and lack of such management capacity in low-level epidemic countries which is understandable. In the full cohort analysis of 39 countries, 14/17 generalized epidemic countries confirmed they had a HAMU, with one more “In Process”, versus 6/16 countries with concentrated epidemics and only one low-level epidemic country (with another “In Process”). The migration of the response towards a mainstreamed approach raises questions about the potential need for a new management model and may in fact render some aspects of the HAMU model obsolete.

Eighty-one per cent of countries that reported having a HAMU said it included senior staff at the level of Deputy-Director or above. This is important as HAMUs led by mid-level or junior staff would have little chance of making their views known at senior management meetings. There was, however, a wide variety in the size of staff complements, ranging from two to 35, with the majority having less than 10 permanent staff members. In addition, the reported expertise present within these HAMUs show important gaps. In nearly 50% of HAMUs there is no expertise represented or available in financial management, human resource management and EMIS/statistics and research. These areas of expertise are key to the AIDS response, and if the unit is not drawing on this from other parts of the ministry instead of having it “in house”, the response will suffer.

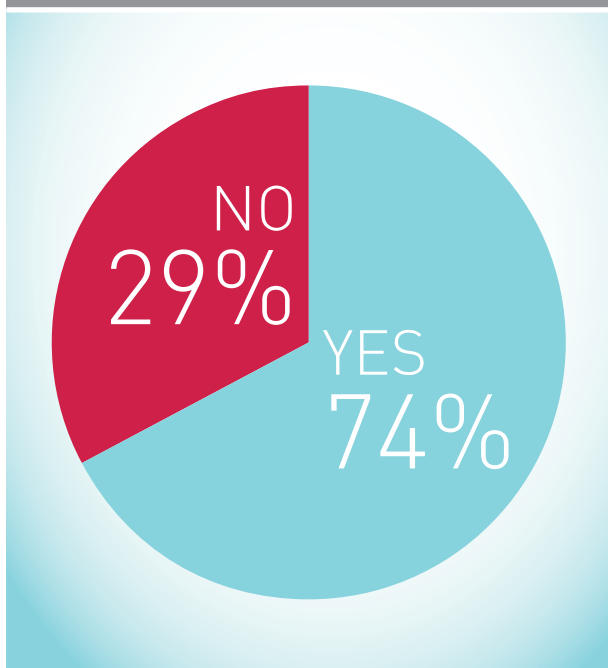
3.1.2 Mainstreaming

There are many definitions of mainstreaming and little agreement on what it constitutes. Here, mainstreaming is defined as the systematic integration and infusion of the topics of HIV and AIDS into key aspects of education sector business. Thus, it should be incorporated into core functions of the sector such as legislation and policy, planning and budgeting, human resource management and development, curricula and syllabi, programmes, research and information management, quality assurance and standards, monitoring and evaluation, infrastructure development and maintenance, and devolution and decentralization, among others.

74% or 29 countries out of the 2011-2012 full cohort, reported that the AIDS response is mainstreamed in education management and planning processes at the national level.

The results of the 2011-2012 GPS provide a consistent picture of MoEs in transition towards a more sustainable, systemic response, not only to AIDS, but to other important issues as well. The move towards a more systemic response endorses the undeniable fact that there are a multitude of developmental challenges that interrelate with one another and that dealing with one in isolation from the others is counter-productive and wastes resources. In particular, this is an acknowledgement that issues – like HIV, gender inequality, poverty, adolescent reproductive health and rights, employee rights, and so on, if unaddressed or inappropriately attended to, have the potential to severely impact on the MoE’s core mandate of teaching and learning.

HIV response mainstreamed in education management and planning processes at the national level



While there is agreement that mainstreaming is the best approach to adopt to manage an issues like HIV and AIDS, there is little consensus on what mainstreaming is and how to implement it. In this context, the GPS findings as well as other recent research,⁵ suggest the need for guidance for MoEs on mainstreaming and its potential benefits, as well as the identification of possible models for managing the AIDS response that could be applied dependent on country-specific contexts.

Furthermore, a third fundamental motive for moving to mainstreaming is the potential for the system-wide changes that are made to enhance many of the traditional functions of a sector and to remove some of the bottlenecks, creating a win-win situation.

The Rise and Fall of HAMUs?

The concept of HIV and AIDS management units (HAMUs) had its origins in the early 2000s and was promoted by the Mobile Task Team on the Impact of HIV and AIDS on Education (MTT), based at the University of KwaZulu Natal/HEARD.

The MTT trained HAMU personnel from 19 MoEs across Africa at its first three-week Winter School in 2004, followed by further mentoring to support policy/strategy development and implementation. HAMUs from Kenya, Namibia, Uganda and Zambia in particular stood out as models of good practice and developed an interactive network to support one another.

This formula of policy/strategy development and implementation planning, coordinated by trained, well-resourced personnel, commended itself as a model for replication. However, attrition and promotion (ironically, as a result of training) thinned the ranks of these units and replacement personnel were not adequately orientated or trained. More importantly, it became clear that these “parallel” units, policies, strategies and plans were increasingly marginalized in the wider MoE environment – and were not seen as an integral part of the education system architecture. Complicating this further, the ILO recommended that these units be moved to HR divisional management, as they saw HIV and AIDS as HR issues.

The net effect of these challenges was a steady decline in HAMU profiles and importance, and an apparently diminishing role for them within the education sector.

By 2011, models of good HAMU practice were difficult to identify, with growing confusion around the future role of these units in the context of mainstreaming. The 2011–2012 GPS brought these structural shortcomings into sharp focus: a scheduled two-month data collection process was extended to eight months by the apparent inability of some HAMUs to coordinate the process.

This research experience is in sharp contrast to the 2004 GRS process, in which most country focal points and HAMUs managed to coordinate the process within two months – without the aid of the facilitators who were made available in 2011. The conclusion may be that HAMUs were an appropriate management mechanism at a critical point in the development of the education sector response to HIV and AIDS, but have now been overtaken by the changing dynamics of the response.

The question is whether HAMUs should continue to have a role in the coordination, monitoring and reporting of a mainstreamed education sector response, or whether an entirely new management model for the education sector should be conceived and developed, including systems for coordination with national management structures such as National AIDS Commissions, and systems such as a national monitoring and evaluation system.

⁵ E.g. EduSector AIDS Response Trust. 2011. *HIV&AIDS AND EDUCATION: Bold Targets; Bold Responses. A Review of HIV&AIDS Policy Response and Implementation in the SADC Region.* (unpublished)

MANAGEMENT OPTIONS FOR AN EDUCATION SECTOR HIV AND AIDS RESPONSE

Education sector AIDS responses are mostly managed, either through a management function such as a HAMU or through a mainstreamed approach (please see description above). Each has its advantages and disadvantages and there is no one size fits all. The epidemic, country and ministry specific contexts are the most important factors in deciding how to manage the response.

A management function can be appropriate for countries with a generalized epidemic, as dedicated staff have the responsibility to plan, implement and monitor the response. The existence of the function can demonstrate that the MoE considers AIDS an important issue, and dedicated staff takes responsibility and are assessed on the work. However, if the staff do not include senior staff, or do not report to a very senior staff or if the management function is side-lined by its positioning within the MoE, it will not be able to effectively fulfil its mandate. This increases the marginalization of the work. In such a situation, staff end up doing piecemeal work where they are unable to influence, and the response is weakened. In many countries this has been the case.

The positioning of the HIV and AIDS management function within a MoE is currently being debated by education stakeholders with a growing movement to integrate the function within a school health/life skills function/unit. HIV prevention and education are already a part of life skills in most countries and health education is critical to the development of learners. The

positioning of HIV within a greater health education agenda is a management choice based in part on the fact that cognitive, psycho-social, emotional coping and self-management skills which are key to HIV and sexuality education work, can also be used to address a number of other health topics such as violence prevention, substance use prevention, malaria and even hygiene promotion. The ultimate objective is to help young people acquire the requisite knowledge and develop the attitude and skills to be healthy. This in turn facilitates the achievement of educational targets, as healthy learners learn better and better educated learners have the skills to be healthy.

The current disarray in some HAMUs indicates that there are sustainability issues. As mentioned above, only two members of staff from 30 countries in 2004 were still present in 2011-2012, indicating a high attrition rate, and in some countries decreasing donor interest and funding has reduced staffing levels. Given competing priorities within MoEs, many might not be willing or able to prioritize a dedicated and appropriately staffed HAMU. This suggests the need for some countries, especially those with a generalized epidemic, to review and adapt existing management systems to improve the effectiveness of their response. One possible management option to consider is mainstreaming of HIV and AIDS throughout the ministry, with responsibility allocated to individuals or section chiefs to ensure implementation, while maintaining a management function/technical central point to which other staff members can turn for information and assistance. This would therefore entail the mainstreaming of HIV and AIDS across sections such as EMIS, curriculum development, HR, etc., as well as the

appointment of individuals, possibly positioned within a school health unit, who would act as experts and drive the response. One argument put forward in favour of maintaining some HIV specific positions in the short and medium-term is that mainstreaming, for example in the case of gender, has not proven successful in most settings thereby suggesting the need for a driving force within the ministry. Should the decision be to maintain a management/technical function, its positioning will be dependent on the particular ministry. It could be positioned within a unit that has authority and a mandate to work cross-sectorally, e.g. school health where synergies would be greatest, or if such a unit does not exist or is weak, it could be its own independent unit properly positioned within the hierarchy and reporting to a position of authority.

While countries with a generalized epidemic may opt for a mainstreamed model with dedicated staff, this may not be sustainable either organizationally or financially for countries with a concentrated epidemic, and in low-level epidemic countries, a management function is unrealistic and unnecessary. In such cases, countries could adopt a mainstreamed approach, with responsibility placed within each section of the ministry.

Regardless of epidemic level, there is a need to sustain progress and ensure that HIV is given strong prominence in an otherwise crowded agenda. While HIV and AIDS need to be normalized to de-stigmatize, it must be kept exceptional to ensure the issues stay on the radar and stigma is overcome. As a result, and unlike other diseases such as malaria, HIV functions and responsibilities therefore should be highlighted in individual job descriptions/terms of reference throughout the ministry.

Policy Implications

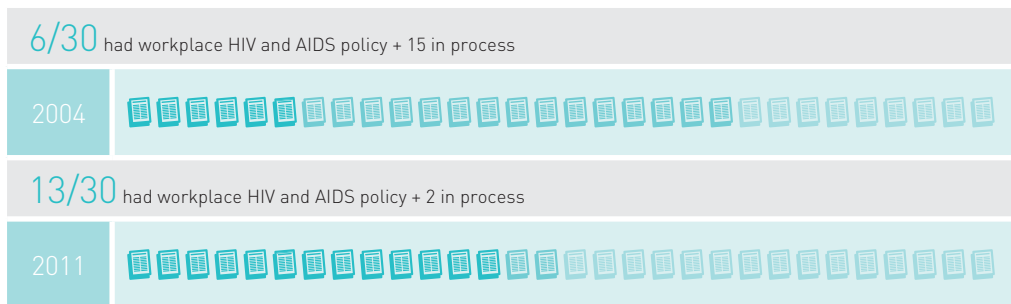
- The existing weakness of many EMIS units should be addressed for systemic reasons, and to strengthen the AIDS response. The coordination and management of the AIDS response should be closely linked to EMIS to provide a shared monitoring and reporting function.
- The high levels of policy development should now be followed up with strong and coordinated implementation and monitoring. To that end, an effective and country-appropriate management system should be implemented to improve efficacy and efficiency.
- Mainstreaming, the systematic integration and infusion of HIV and AIDS into key aspects of education sector business, is occurring, but quality control, accountability and sustainability need to be ensured.
- For programmatic and resource reasons, the education sector's AIDS response should be mainstreamed into core functions of the ministry and at all levels – national, district and institutional – regardless of whether a management/technical function is in place, and the responsibility should be integrated into relevant job descriptions throughout the ministry.
- The lack of a clear understanding or agreement on what mainstreaming is and how it should be implemented indicates the need for further exploration of this issue. More information on how to mainstream and possible models should therefore be made available to interested countries.
- The decision of what type of management system to use is dependent on the epidemic, country and ministry context.

3.2 Human Resource Issues

Teacher and human resource (HR) issues are central to the business of education and encompass demand for, training, supply and well-being of the system's most expensive resource, and so are informed by the system's key statistical indicators. This section is therefore intended to provide information relating to the adaptation of HR procedures and functions in response to the impact of HIV and AIDS. It is linked to the Enabling Environment section as these issues require a framework conducive to the effective implementation of a response. Teacher and HR Issues are also linked to education sector workplace HIV and AIDS programmes, which are intended to provide a structured and inclusive response to prevent and reduce the impact of the disease, at all levels and in all institutions in the system. The issue of teacher training and orientation and the adaptation of the tertiary curriculum to support this is covered in the following section "Teaching and Learning".

3.2.1 Workplace Policies

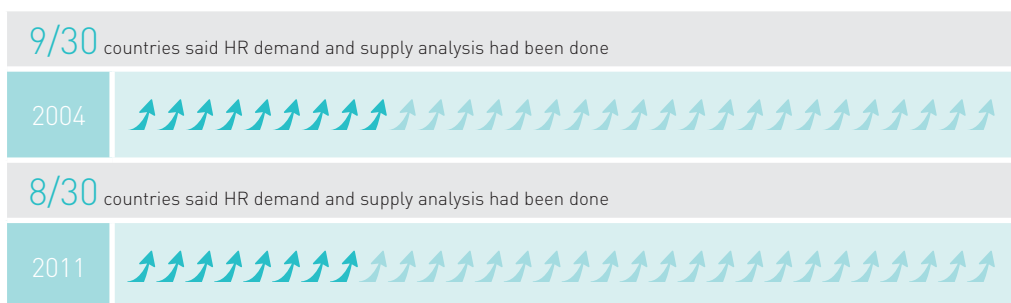
The number of MoEs with **education sector workplace policies** in place more than doubled over eight years, and suggests a global commitment to improving the education sector's AIDS policy environment. However, this increase was off a low base. Only 20% of countries in 2004 had a workplace policy in place, with another 50% in the process of developing one. While the number with workplace policies in place climbed to 43%, with another 7% in process by 2011-2012, two countries claiming to have policies "in process" in 2004 still had not completed these, some eight years later. This may suggest unexpected levels of difficulty, but it is more likely that changes in education sector leadership, staffing and priorities, as well as perennial resource constraints, may be responsible.



The full 39 country sample does however show that countries that need it most, those with a generalized epidemic, are more likely to have a workplace policy in place, 11/17 (plus one in development). This contrasts with 3/16 (with one in development) for concentrated epidemic countries, and 1/6 in process of development in low-level epidemic countries.

3.2.2 Teacher Supply and Demand Analysis

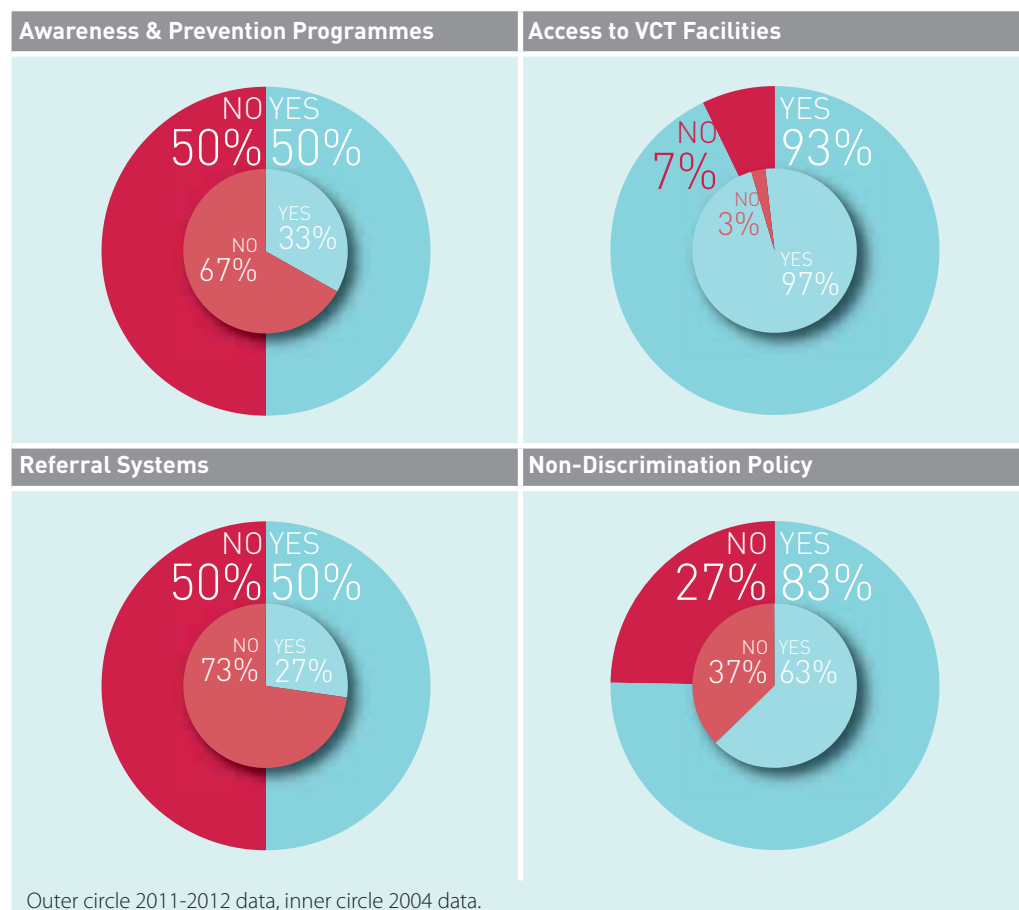
MoEs were asked in both 2004 and 2011-2012 if an **analysis of the impact of HIV and AIDS on the demand and supply of human resources** in the education sector had been conducted. Only nine countries (30%) in 2004 stated that such an analysis had been done, indicating that 70% of the sample had not undertaken this fundamental measurement of their systems. In addition, the 2011-2012 GPS confirmed that four of nine countries which claimed to have done such an analysis in 2004, had not in fact done so. By 2011-2012 only 8/30 countries (26%) reported having conducted such an analysis.



3.2.3 Referral Systems and Workplace Programmes

MoEs were asked about access to voluntary counselling and testing (VCT) and treatment referral systems. Given the emerging prominence of ART as a prevention strategy, the importance of providing both of these services is growing. Twenty-nine out of 30 countries (97%) in 2004 reported that MoE teachers and staff had **access to VCT facilities**. While the figures for VCT access remained high in 2011-2012, **referral systems** for access to HIV and AIDS treatment for MoE teachers and staff were less positive, with only 15/30 countries (50%) reporting that such referral systems were in place. Given the importance of access to ART, these findings suggest the need to prioritize this issue, in collaboration with NGO and ministry of health (MoH) partners.

16 of 17 generalized epidemic countries had an HIV awareness programme in place, or were in the process (3 countries) of developing one at national level. In contrast only 7/16 concentrated epidemic countries (with one in process), and 2/6 low-level epidemic countries (with one more in process) had programmes at the national level.



While only 56% of the 2011-2012 39 country cohort reported having **HIV awareness programmes** for employees, 16/17 generalized epidemic countries had one in place, or were in the process (three countries) of developing one at national level. In contrast only 7/16 concentrated epidemic countries (with one in process), and 2/6 low-level epidemic countries (with one more in process) had programmes at the national level. Implementation appears to be taking place beyond the national level, with similar figures being reported for both district and educational institution levels.

Other key HR issues that have seen some progress in the last eight years include non-discrimination, which should be entrenched in policies at every level, from the National Constitution and Bill of Rights down, and confidentiality as a right, which should be entrenched in workplace policy and regulations, and protected by relevant and legally binding regulations and procedures.

The trend analysis of 30 countries shows that while only 19 countries (63%) in 2004 had a **policy of non-discrimination** for the recruitment, advancement, continued employment and benefits of HIV and AIDS-affected personnel, this rose to 25/30 countries (83%) in 2011-2012, reconfirming that the wider policy environment has enjoyed some attention over the last eight years. The increase in non-discrimination policy suggests a maturing of response management but does rely on the integrity of application and confidentiality of information. Twenty-one countries (70%) in 2004 claimed to enforce **confidentiality of information** about HIV and AIDS-affected employees, rising to 27/30 (90%) in 2011-2012; however,

several respondents admitted that while this policy was unquestioned, human nature and dynamics at an institutional level sometimes led to “accidental” disclosure. **Access to condoms** within or in the vicinity of all education institutions was limited to 16/30 countries (53%) in 2004 and apparently remained so, dropping slightly to 15/30 countries (50%) by 2011-2012; this remains a controversial issue and these comparatively low levels of access suggest that there is not yet a critical mass of support within MoEs.

Policy Implications

- Countries without HIV and AIDS workplace policies, and in particular those with a generalized or concentrated epidemic, should ensure that one is developed. The policy should be congruent with all national and education sector workplace policies. The policy does not necessarily need to be sectoral as long as it addresses the particular HR, prevention and treatment needs of education sector staff.
- The education sector in each country should have a clear understanding of the effect of HIV to respond effectively. Teacher demand and supply models that include HIV impact modelling should be used especially in countries with a generalized or concentrated epidemic, and regular analysis should feed into sector planning.
- To that end, EMIS units should be strengthened and HIV indicators mainstreamed to ensure that their effects on the education sector are adequately planned for and addressed (see the previous section for a discussion on mainstreaming).
- Increased coordination with MoH and other health partners at national, district and local level is required to ensure greater access to services, referrals and to ensure continuity of service.
- HIV awareness programmes are essential to maintain levels of awareness and to promote prevention in primary and secondary education. The already high levels of awareness programmes in countries with a generalized epidemic should therefore be boosted to 100% and countries with smaller epidemics should prioritize this aspect not only for the well-being of staff but to facilitate knowledge transfer to learners.

3.3 Teaching and Learning

Data from a number of different sources (SACMEQ, UNAIDS, etc.) indicate that knowledge levels are still not at desired levels. This section deals with issues that directly affect the teaching and learning of HIV primarily in the classroom, beginning with the curriculum. The curriculum provides a framework within which teaching and learning take place. The challenge is for system and curriculum planners to create space, in an already crowded agenda, for the contextual issues of life skills and its health components, such as sexuality education, adolescent and reproductive health, and sexually transmitted infections, including HIV, to be taken and taught seriously. The absence of these subjects from the curriculum means there is little or no possibility that they will be taught at all. However, their inclusion is no guarantee they will be taught, as the responsibility for the transmission of subject-related knowledge still lies with teachers, who may be more or less equipped or willing to share what many of them still regard as ‘sensitive’ material, and beyond their scope of responsibility. Inclusion in the curriculum does however provide a measurable means of ensuring that teachers are required to teach the subject area. Curriculum planners are critical to ensure that life skills includes certain non-negotiable components that together will ensure a minimum if not desirable level of HIV knowledge, within the context of comprehensive sexuality education and relationships. This section therefore tracks the inclusion of key subject-area components in the curriculum, the related development of support materials for use in the classroom and the orientation of parents and advocacy of HIV-messaging among traditional, community and religious leaders.

KNOWLEDGE LEVELS

Age-appropriate sexuality education may increase knowledge and contribute to more responsible sexual behaviour. However, there are significant gaps in even basic knowledge about HIV and its transmission. In 26 of 31 countries with generalized epidemics in which nationally representative surveys were carried out recently, **less than 50% of young women have comprehensive and correct knowledge about HIV**. Notably, young women are lacking in knowledge concerning the effectiveness of condoms in preventing HIV transmission. In 21 of 25 countries with nationally representative surveys, young men had less than 50% comprehensive and correct knowledge about HIV.⁶

6 UNAIDS. 2012. *Report on the Global AIDS Epidemic*. Geneva, UNAIDS.

3.3.1 Generic Life Skills Programmes

LIFE SKILLS

“There is no common definition of ‘life skills’ and although the World Health Organization and others have given definitions, the concept is elastic and includes a range of skills and knowledge. Important in its conception are the personal, interpersonal and cognitive psychosocial skills that enable people to interact appropriately, manage their own emotional states and make decisions and choices for an active, safe and productive life.”⁷

The GPS reviewed the issue of life skills as findings from 2004 revealed that it was a plausible vehicle for HIV education. While the GPS was not able to explore life skills in depth, UNICEF conducted a global evaluation in 2012. The evaluation found strong evidence of life skills education (LSE) developing relevant knowledge, skills and attitudes among learners, both in thematic risk areas and general psychosocial skills. While life skills education is having an impact, there is little systematic monitoring and evaluation beyond knowledge outcomes⁸. The question of whether LSE impacts on educational outcomes remains unanswered, as intended psychosocial skill outcomes are not currently measured. There is, however, anecdotal evidence that some parents and teachers attribute a positive impact on educational outcomes to life skills education.

Other major findings include the fact that LSE programmes are closely aligned with national and sectoral policies, and that coverage is growing as LSE becomes integrated into national education systems and curricula. However, implementation remains variable, with a significant gap at the pre-primary level, and a considerable gap between quality standards in design and the realities of implementation.

The UNICEF evaluation also pointed out that evidence from schools suggests that life skills education has a tendency to be squeezed out in the context of teacher shortages, overcrowded curricula, limited teaching material, and the focus on traditional examinations, of which life skills education is rarely a part. Life skills education suffers from the systemic resource constraints of many education systems in terms of human resources, teaching and learning materials, curriculum time, school capacities, etc.

GPS findings on increased coverage were similar to UNICEF’s. In 2011-2012, 31 of the 39 countries surveyed (79%) indicated that they provided **generic life skills** at lower primary level and 31 countries (79%) indicated provision at upper primary level – this represents a slight increase at both levels over 2004. These numbers increase to 35 (90%) in lower secondary and 32 (82%) in upper secondary. Half of the lower primary life skills programmes include HIV, while it is included in the life skills programmes at all the other levels. It is important to understand classroom dynamics and the reality of how much attention each of the component parts of generic life skills got, in comparative terms. Some respondents commented, for example, that more “sensitive” subject areas, such as HIV and sexuality education, might get very little of the total time allocated to generic life skills, in favour of less delicate issues such as inter-personal relationships or careers. In addition, teachers need the mandate, support and skills to teach HIV and other “sensitive” subjects successfully. Most countries, but not all, reported that there were support materials for life skills and HIV education.

The increase in life skills from the 2004 baseline suggests that this trend can be built upon. Formalized life skills give the education sector an opportunity to address HIV in a structured and contextual way. However, without a clear mandate, there can be little assurance that it will be taught consistently to all learners.

Policy Implications

- All countries should mandate a life skills curriculum that addresses age-appropriate health issues to promote the health and well-being of their learners.
- The life skills curriculum should explicitly state that HIV be addressed along with minimum standards for doing so. These standards should reflect epidemiological conditions relevant to learners and their vulnerability, rural and urban settings for example, while all curricula should include anti-stigma and discrimination objectives.
- Teachers should be supported to implement the mandated curriculum to ensure that the learning objectives are met. Consideration should be made for supporting teaching staff to adopt an interactive approach, if it is different from their normal style of teaching.
- All countries should scale up comprehensive sexuality education which includes HIV education as part of or complementary to life skills, aiming to reach all learners.

7 UNICEF Evaluation Office. 2012. *Global Evaluation of Life Skills Education Programmes. Executive Summary*. New York, UNICEF.

8 UNICEF Evaluation Office. 2012. *Global Evaluation of Life Skills Education Programmes*. New York, UNICEF.

In 2011–2012, 31 of the 39 countries surveyed (79%) indicated that they provided generic life skills at lower primary level and 31 countries (79%) indicated provision at upper primary level

3.3.2 Teacher Training and Orientation

In 2004, 16/30 countries (53%) confirmed that their teachers had life skills and HIV orientation programmes. In 2011-2012, however, the question was revised to confirm how many countries provided professional preparation of teachers by level and by subject area. The question was asked for both pre-service training and in-service training. In the 2011-2012 cohort of 39 countries the number reporting **pre-service teacher training** at the primary level for generic life skills and HIV was 29/39 (74%) and 24/39 (62%) respectively. At secondary level, the numbers were 31/39 (79%) for generic life skills and 28/39 (72%) for HIV education. For **in-service training**, these numbers increased to 32/39 (82%) and 31/39 (79%) at primary level, and 34/39 (87%) and 33/39 (85%) for secondary level.

2011-2012	Primary		Secondary	
	Life Skills	HIV and AIDS	Life Skills	HIV and AIDS
Pre-Service Training	29/39 74%	24/39 62%	31/39 79%	28/39 72%
In-Service Training	32/39 82%	31/39 79%	34/39 87%	33/39 85%

Despite these apparently high scores for teacher training, the evidence relating to the quality and scale of HIV and life skills delivery in the classroom would suggest that there are still significant gaps between training and delivery: there is continuing concern that effective and comprehensive HIV education within the context of life skills is not receiving adequate attention or delivery in the classroom. The UNESCO/IIEP Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) provided concrete evidence to support this contention through its 2007 HIV and AIDS Knowledge Test (HAKT) of teachers and learners in Grade 6, in East and Southern Africa (ESA).

SACMEQ III HIV AND AIDS KNOWLEDGE TEST

The Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) is a network of 15 Ministries of Education, 11 of which were sampled in the 2011-2012 GPS Trend Report (Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe). With technical support from UNESCO's IIEP, SACMEQ has undertaken three large-scale cross-national studies of the quality of education in the ESA region since 1995. The most recent of these, SACMEQ III (2007-2011) included a **detailed assessment of learner and teacher knowledge about HIV**.

This SACMEQ HIV and AIDS Knowledge Test (HAKT) was designed to provide a valid assessment of learner and teacher knowledge about HIV and AIDS, linked to official school curriculum frameworks, textbooks and teaching materials used by these SACMEQ countries. The HAKT was administered in late 2007 to 61,396 Grade 6 learners and 8,026 teachers in 2,779 schools across the 15 SACMEQ countries.

The SACMEQ results showed that during 2007 **two-thirds of grade 6 learners did not have the minimal level of knowledge about HIV and AIDS required to preserve and promote their health**. Percentages of learners with minimal knowledge ranged from 17% in Mauritius to 70% in Tanzania, with an average across these countries of 36%, far below the expected level of 100%. The percentage of learners with minimal knowledge in the 11 countries included in the 2011 GPS Trend Report ranged from 19% in Lesotho to 70% in Tanzania – an average of 39% across this sub-sample.

By contrast, the percentage of teachers in SACMEQ countries (and in the sub-sample of 11 countries involved in the 2011 GPS Trend Report) who reached equivalent minimal knowledge levels was 99%. **The huge gap between the high knowledge levels of teachers and the low knowledge levels of their grade 6 learners came as a surprise**, as it might be assumed that teachers with high levels of knowledge about HIV and AIDS should be able to transmit this important information to their learners.

Grade 6 learners (with an average age of 13.5 years) are entering a stage of mental and physical development where they may become sexually active, and/or may choose to become involved in high-risk behaviours. It is therefore essential that they are provided with the knowledge and skills to protect themselves. The SACMEQ III report concludes that MoEs should take immediate action to address these research findings and facilitate the development and implementation of more effective HIV prevention programmes, focusing on the upper primary level. It is notable that there were also significant differences in learner knowledge about HIV by socioeconomic status, location, gender and age. This finding has implications for issues of orphaning, vulnerability, nutrition, care and support discussed under section 3.4, and suggests that MoEs should expand and intensify the delivery of HIV prevention education to poor and rural communities.

As the SACMEQ study confirms, teachers are either uncomfortable or feel un-mandated to present or share what is considered “sensitive” subject material. This includes HIV and AIDS, and other topics within comprehensive sexuality education. The limited breadth of pre-service training and the ad hoc nature of in-service teacher training seems to have had little effect on developing their skills or confidence to deal with these critical subjects. This finding is supported by the UNICEF LSE evaluation⁹ which indicates that existing training is not adequately addressing important elements for life skills education delivery, such as the psychosocial skills and attitudes of teachers themselves.

Pre-service training should be the focus of concentrated orientation and training in these subject areas, to ensure that a new generation of teachers can enter the classroom equipped and prepared to deal with these life-saving issues. While teacher training and curriculum planners may argue that there is little room to expand pre-service training, there is a strong case for doing so as it is logistically easier to manage and deliver, has significantly wider reach and thus is more cost effective. In addition, as pointed out in the UNICEF evaluation¹⁰, LSE interventions usually include a teaching methodology characterized by interaction, learner autonomy and collaborations. These characteristics are difficult to introduce and are perceived by some teachers and parents as less likely to lead to success in (traditional) examinations. However, LSE has provided a vehicle for these methodologies and, in some countries, is seen as a driver for changing teaching methodology. While in-service training can offer some advantages, namely flexibility to respond to changing needs and updating of skills for existing teachers, there are ongoing challenges, particularly in relation to the multiplicity of different providers and the lack of coherence between providers in content or pedagogical approaches. In all cases, it is critical that teacher education is directly linked to the latest in-school curricula, and that training is consistently updated given the high rates of teacher attrition and reassignment to different schools or subjects.

Policy Implications

- The content and methods for teaching skills-based comprehensive sexuality education, needs to be routinely taught as part of pre-service training so that incoming teachers are systematically and routinely prepared.
- The content of the teacher training should include health issues of urgent relevance to young people, such as adolescent and reproductive health, sexuality education, gender equality and empowerment, sexually transmitted infections, HIV, family life and interpersonal relationships. Training should focus on teacher well-being first and then on training to effectively deliver a curriculum.
- The teaching methods should be interactive and learner-centred, so that learners can acquire knowledge and develop attitudes and skills to enable them to adopt healthy behaviours.
- Improved planning and coordination of teacher training would reduce the impact of teacher attrition or re-assignment. Greater coordination of all teacher training providers by MoE (with a focus on in-service providers) would increase quality and coherence.

3.3.3 Orientation for Parents and Community Members

An important component of effective HIV education is that parents understand, are comfortable with, and along with community members, reinforce what is learnt in the classroom. Parental and community member orientation sessions are a way to achieve this. Orientation sessions also are an opportunity for parents and community members, who may have little formal understanding of the issue themselves, to gain knowledge and understanding. Efforts to reach them can therefore contribute to wider prevention, treatment and care efforts across whole communities.

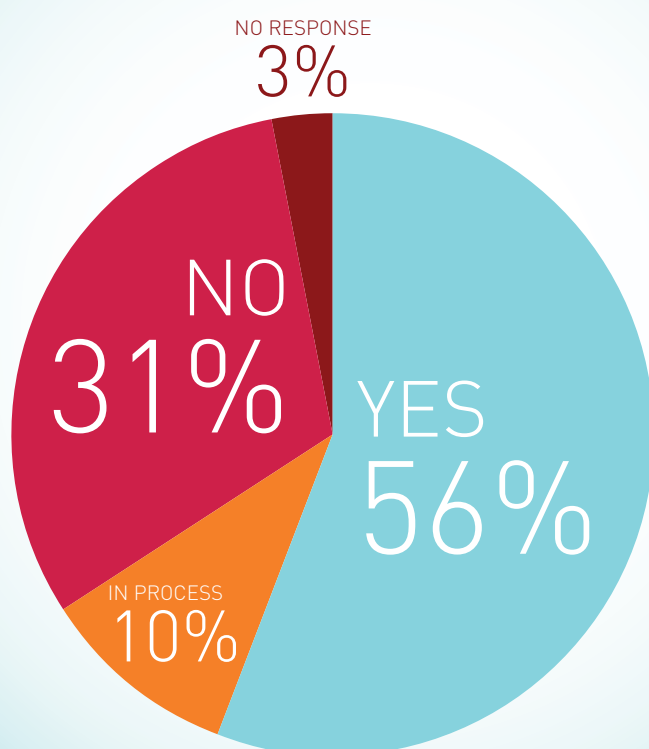
In 2011-2012, 22 of the 39 countries¹¹ (56%) reported having an **orientation process for parents** on life skills, including HIV. The trend analysis shows a significant increase from 8/30 countries (27%) in 2004 to 18/30 (60%) in 2011-2012. Twenty-eight of the full 39 country survey in 2011-2012 (72%) had made efforts to ensure that **religious, community and/or traditional leaders** support the HIV-prevention approach adopted by the education sector, including its curriculum, messaging and materials.

9 UNICEF Evaluation Office. August 2012. *Global Evaluation of Life Skills Education Programmes*. New York, UNICEF.

10 *ibid.*

11 Among the 39 countries surveyed, 38 responded.

Orientation for Parents and Community Members



The attention to this important contextual dimension (parent and community members orientation) of the AIDS response has the possibility to strengthen school-based programmes with the additional benefit of increasing awareness and knowledge for parents and community members to promote their own well-being.

Given the conservatism of teachers in regard to “sensitive” subjects, probably largely grounded in their community-based and traditional value systems, advocacy in this arena may have strategic effect. There is no indication of the extent of coverage across countries or whether or not these processes are managed by teachers or counsellors. The attention to this important contextual dimension of the AIDS response has the possibility to strengthen school-based programmes with the additional benefit of increasing awareness and knowledge for parents and community members to promote their own well-being.

Policy Implications

- Efforts should be made to routinely consult with parents and community members about the vulnerabilities of young people and discuss ways to address these through education so that they understand, support, and reinforce school-based HIV education.
- Orientation programmes should serve the additional purpose of imparting knowledge and skills for the health of parents and community members.
- The education sector should make efforts to systematize the orientation for high quality and wide coverage.

3.3.4 Tertiary Level

In 2011-2012, estimates of the percentage of students who have access to HIV information and prevention materials in the tertiary sector ranged from 10% to 100%. The majority of learners get this information in countries with generalized epidemics, but the figure is much lower in other countries, confirming greater attention to tertiary needs in more affected countries.

In 2004, 9/30 countries (30%) reported having reviewed and **adapted their tertiary curriculum**. In 2011-2012, the question was broken down to provide some insight into which subject areas of the tertiary curriculum had been adapted. This increased level of detail provides focal points for attention and confirms that many countries (between three and five) are still in the process of adaptation. Of those who had completed the adaptation, 18/30 (60%) had adapted the areas of generic life skills, gender equality

and empowerment, HIV and other STIs, and family life and other interpersonal skills. Seventeen out of 30 (57%) had adapted adolescent and reproductive health and sexuality education, while 16/30 (53%) had adapted stigma, discrimination and homophobia. (It is noted that a number of respondents remarked that in the latter category, homophobia may not be addressed to quite the same degree, if at all, as stigma and discrimination – and that its bracketing with these two subjects may convey a misleading impression).

Tertiary Curriculum Review & Adaptation							
	Generic life skills	Adolescent reproductive health	Sexuality education	Gender equality & empowerment	HIV and AIDS other STIs	Stigma, discrimination & homophobia	Family life & interpersonal relationships
2011	18/30 60%	17/30 57%	17/30 57%	18/30 60%	18/30 60%	16/30 53%	18/30 60%
2011 in process of adaptation	5/30 16%	4/30 13%	5/30 16%	3/30 10%	4/30 13%	3/30 10%	3/30 10%
Total 2011	23/30 76%	21/30 70%	22/30 73%	21/30 70%	22/30 73%	19/30 63%	21/30 70%

Note: in 2004 9/30 countries reviewed and adapted their tertiary curriculum. No broken-down data are available for that year.

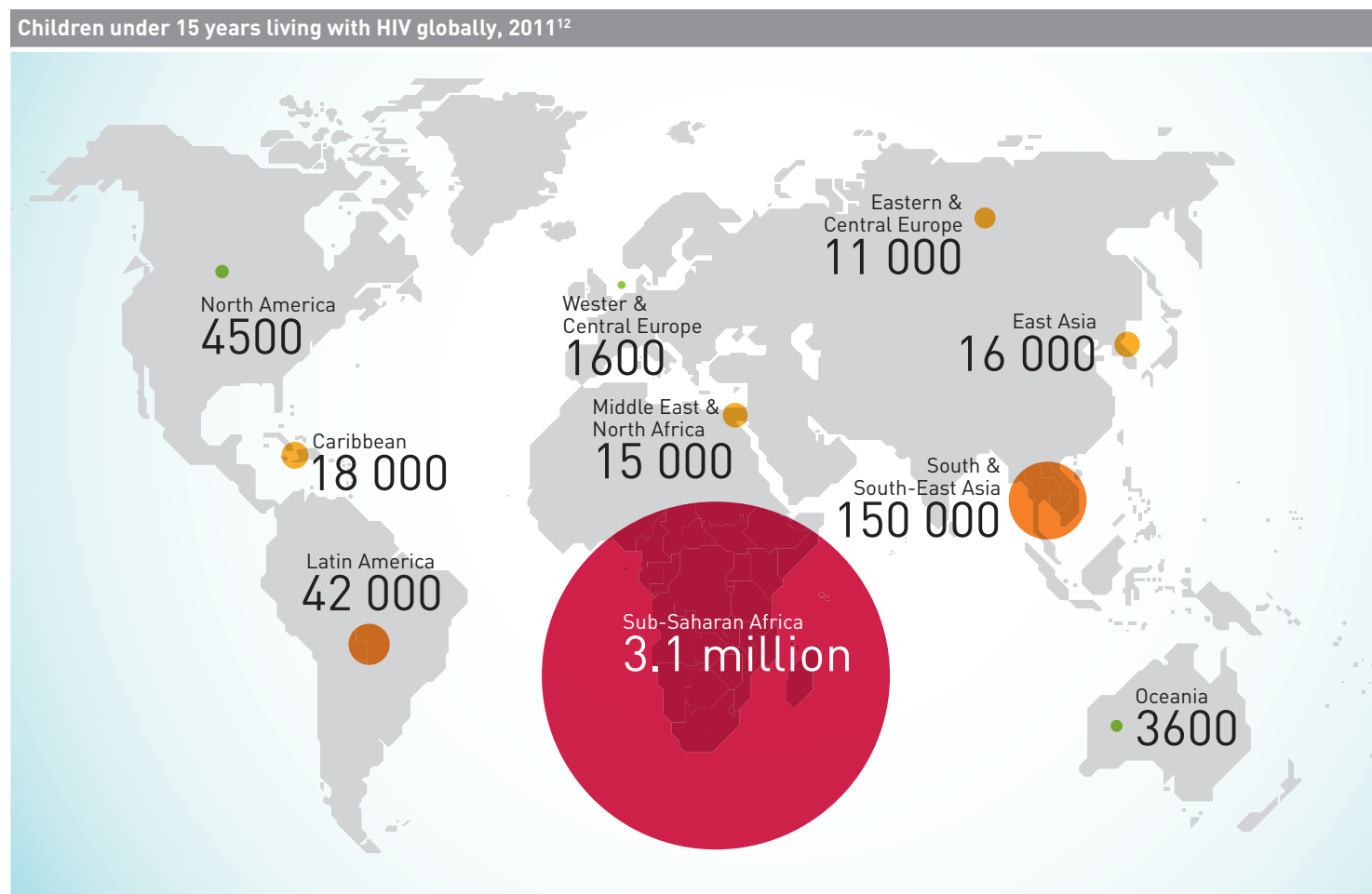
Given the complexities and slowness of curriculum change, a doubling of countries reporting adaptation in order to include these HIV related subjects, over an eight-year period, is notable. However, many countries reported that the adaptation of these subjects and their inclusion in the curriculum does **not** automatically mean they will enjoy adequate coverage or time allocation in the lecture room, given earlier and repeated comments about teacher/lecturer reluctance to teach subjects they find uncomfortable or embarrassing.

Many learners in this age group are sexually active and are living in a more independent environment than in secondary school and some may be away from their home and spending more time on their own than previously. The importance of reaching young people in tertiary institutions with life skills is critical as they are vulnerable in this transition period to adulthood and need knowledge and skills to make this transition healthier.

Policy Implications

- The increase in life skills at tertiary level institutions indicates a growing recognition among education staff that learners should receive a high-quality life skills education regardless of the their academic discipline of study so that they are in better position to adapt healthy behaviours.
- Life skills for this age group should reflect the contextual needs of learners in tertiary schools. The life skills curriculum should address adolescent and reproductive health, sexuality education, gender equality and empowerment, HIV, sexually transmitted infections, stigma and discrimination (including homophobia), and family life and inter-personal relationships.

3.4 Orphans and Vulnerable Children



Source: UNAIDS, *Report on the Global AIDS Epidemic*, 2012.

In 2011 there were an estimated 3.3 million children below the age of 15 living with HIV and approximately 17.3 million children under the age of 18 had lost one or both parents to AIDS.¹³ The global concerted effort to roll out prevention of vertical transmission programmes has significantly decreased the number of new infections. Half of all reductions in new HIV infections in the last two years have been among newborn children.¹⁴ In 2011, there were an estimated 330,000 children newly infected with HIV. New infections in children were 43% lower than in 2003, and 24% lower than 2009.

This section covers support systems for learners, students and orphan and vulnerable children (OVC), the extent to which they have been scaled-up over the last eight years,¹⁵ and the capacity of the education sector to care for them, inside and outside the system.

The 2004 GRS pointed out the scope for improvement and important need for “Holistic responses addressing the educational, psychosocial and material needs of learners infected and affected by HIV and AIDS”. The increasing availability of antiretrovirals (ARVs) also requires MoEs and governments to fulfil their obligations to Education for All and ensure the opportunity of a quality education for all learners. As mentioned in the 2004 GRS report, the enrolment and retention of OVC in schools can be seen as an important opportunity to provide social protection and monitoring, along with access to nutrition, the cognitive skills required for informed decision-making, and

12 UNICEF 2012, Based on UNAIDS and UNICEF reports. http://www.childinfo.org/hiv_aids.html (Accessed 30 November 2011.)

13 UNICEF 2012, Based on UNAIDS and UNICEF reports. http://www.childinfo.org/hiv_aids.html (Accessed 30 November 2011.)

14 UNAIDS. 2012. Global Fact Sheet. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf (Accessed 30 November 2012.)

15 Issues relating to learners, students and OVC are also addressed directly and indirectly in other sections of this report (for example, under Curriculum).

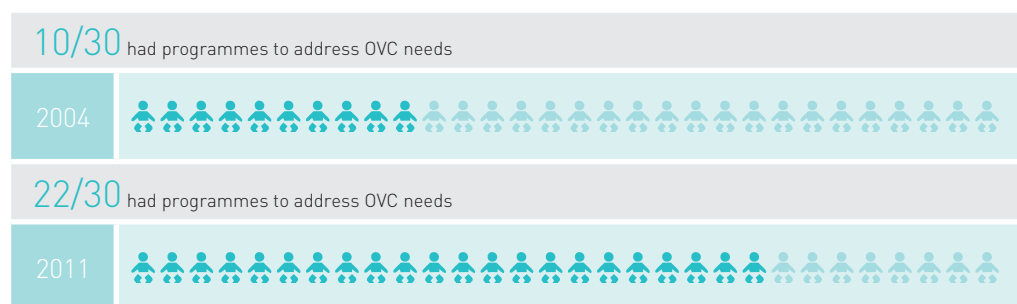
sufficient education for employment or entrepreneurial activity. It is the MoEs responsibility to ensure that OVC are enrolled and complete at least a basic education.

In 2004, while MoE AIDS strategic plans often stated the rights of HIV-positive children to education, few if any had moved beyond strategy development to programme implementation. In addition, there was little evidence of widespread multisectoral collaboration to provide an integrated and holistic response to the OVC crisis. In 2004, community programmes were in evidence in most of the surveyed countries, most providing material support to OVC in the form of school bursaries and occasionally food aid to ensure retention of OVC in school. While this form of ad-hoc social protection helps in the short-term, it is limited in scope, as it can never reach all those in need and cannot assure learners' right to an education.

In 2011-2012 on balance, progress on this issue can be reported, with the caution that, while these issues are reported in the context of the AIDS response (and its progress) several of them have wider significance for the education sector. For example, demand for feeding schemes is driven in the first instance by widespread poverty, and the vulnerability borne of the accelerating rates of orphaning – largely driven by AIDS-related mortality – have added extraordinary dimension to this problem, but the fact is that education systems have to prioritize response to nutrition and school health with or without HIV. The fact that all existing problems are made worse by HIV and AIDS is a key message that has relevance for all education sector AIDS response planning.

3.4.1 OVC Programme Coverage and Teacher Training

In 2004, 10/30 countries (33%) reported having **programmes to address the needs of orphaned and vulnerable children** in the education system, by 2011-2012, 22 countries (73%) of the 30 countries in the trend analysis had programmes.



By 2011-2012, 16 out of the 17 (94%) of generalized epidemic countries had them in place. This impressive increase in programmes suggests that there is serious attention to this issue in most highly affected countries. However, the number of countries with systems to identify and categorize OVC was lower (13/17 generalized, 7/16 concentrated and 4/6 low-level epidemic countries). This suggests that countries with no systems to identify OVC for targeted care and support nevertheless had support programmes in place, which provide ad hoc support where possible.

In 2004, only 3/30 countries (10%) reported that their **teachers received training in caring for HIV-infected learners**. By 2011-2012 this number had risen to 16/30 (53%). This percentage decreases to 46% when considering the full 39 country sample (11/17 generalized, 6/16 concentrated and 1/6 low-level epidemic countries).

The trend analysis of 30 countries shows a five-fold increase in teachers receiving training in caring for HIV-infected learners but comes off a very low base, and is still far from universal coverage. In addition there is a lack of information on what training might imply, whether this was in-service (ad hoc workshops, for example) or pre-service (an integral part of the professional preparation of teachers), and how many teachers were trained and for which level, primary or secondary. It is likely that this issue is perceived by some countries or in some parts of the education system as a "grey" area, overlapping the primary responsibility of the health sector. For example, teachers might regard this as a health or counselling role rather than something they should be doing in the classroom, especially given that in some circumstances teachers feel overstretched and stressed by their existing under-resourced workloads. This implies the need for a clear delineation of roles and responsibilities between the education and health sectors, increased coordination and comprehensive multisectoral planning. Whatever the case, the fact is that teachers must have the knowledge and professional skills to deal with what now amounts to a routine and recurrent feature of classroom life, and be trained to manage this. Relative to other related challenges

in the system, this may be comparatively easy to resolve (through additional modular training in-service and, optimally, pre-service) in the medium term.

Policy implications

- The extent and depth of OVC programmes require some further research in regard to scale, continuity and resource availability to ensure continual and equitable access. Given decreasing funding levels, MoEs will also need to identify priorities and sustainable funding.
- The need for multisectoral collaboration in the development, implementation and evaluation of OVC programmes require a clear delineation of roles and responsibilities among the education and health sectors, other government sectors such as social welfare, as well as civil society for increased efficacy and efficiency.
- To successfully plan and implement multisectoral OVC programmes requires coordination at the national, district and local levels. While this may not be best led by the education sector, the sector remains a key player which should be proactive in its engagement.
- In-service and pre-service training modules and materials should be standardized and included in teacher training curriculum in countries with a generalized epidemic for a teaching workforce better prepared to meet learner needs in the school.

3.4.2 School Feeding

In 2004, 20/30 countries (67%) said there was currently a **school feeding scheme** in place, with one more country in the process of developing one. This rose to 23/30 countries (77%) in 2011-2012.

The 39 country analysis shows that the largest focus of response to OVC needs was in nutrition, with 77% of all countries indicating they had school feeding schemes in place (12/17 generalized, 15/16 concentrated and 3/6 low-level epidemic countries). While there is more emphasis on the primary level, feeding schemes are spread across all levels of education: in generalized epidemic countries, there is equal coverage across primary with limited but fairly equal spread across secondary. In concentrated and low-level epidemic countries, there is more emphasis on lower than upper primary and slightly more on lower than upper secondary. Five out of 12 countries with a generalized epidemic said that their feeding schemes were growing in scale, three were stable and three were “shrinking”, with 1 other non-response. Of 15/16 concentrated epidemic countries with programmes, seven said they were growing, four were stable and one was “shrinking” while three others did not respond. One of the three low-level epidemic countries reported their programme was growing, the other two were stable. On the face of it, this suggests some positive growth, but it should be remembered that there is no evidence that the programmes in question cover all OVC or are country- or education-level wide.

While 77% of countries reported having a feeding programme in place, coverage is uneven as they are only available in some districts, or at certain levels of the system and/or are only available for limited (or uncertain) periods, often depending on funding. The percentage of children reached is unknown and could vary widely. It should also be noted that responses to this question could be considered speculative rather than quantitative, as this is an example of the inability of national respondents to quantify what can really only be answered with surety at provincial, district or institutional levels. Moreover, school feeding schemes are also vulnerable to fluctuations in resource availability, suggesting that such schemes may vary in scale and depth even on a month-to-month basis. School feeding often relies on NGO or community implementation and on the ability of the MoE, or its donor partners, to provide sustained funding to these “agents”. Many respondents noted that such funding was often irregular and/or unreliable, resulting in staggered or sporadic patterns of provision in some countries.

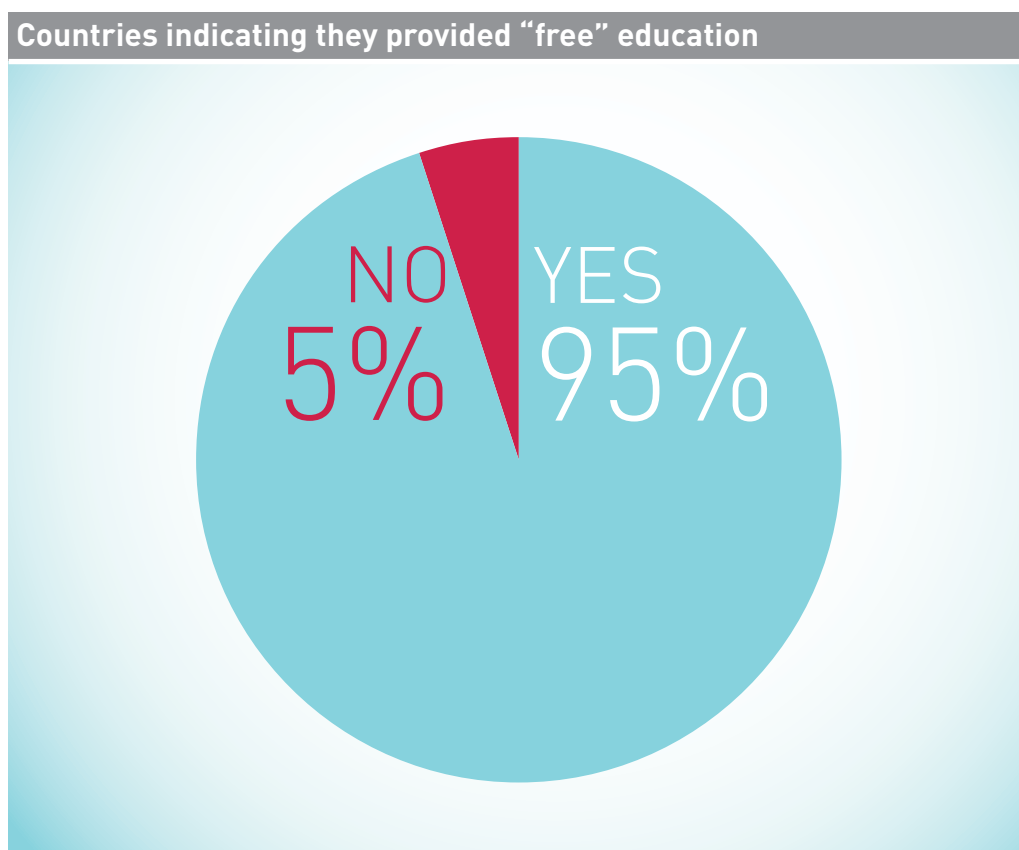
Policy Implications

- As in the previous section, the extent and depth of OVC feeding programmes may require further research in regard to need, scale and continuity. Given dwindling global resources for HIV and AIDS, MoEs will need information to prioritize interventions.
- As recommended in the 2004 GRS report, countries should systematize the use of country-adaptable guidelines to help quantify and geographically locate the need for school feeding programmes, according to simple and practical criteria. Such guidelines can support informed decision-making on the prioritized provision and extension of programmes and enable monitoring of this support and its related impact on enrolment, retention, school health and vulnerability. In addition, data collected should be channelled to the national level to ensure appropriate prioritization.

While 77% of countries reported having a feeding programme in place, coverage is uneven as they are only available in some districts, or at certain levels of the system and/or are only available for limited (or uncertain) periods, often depending on funding.

3.4.3 Free Education, School-Fee Waivers and Exemptions

Poverty is one of the main factors contributing to school drop-out as school fees and associated costs exacerbate the problem not only for AIDS orphans but for millions of children from vulnerable families. The 2004 GRS report showed that nearly two-thirds (62%) of all MoEs had regulations that provided for exemption from school fees for children from poor or vulnerable families. The figure was highest in low-prevalence countries, possibly reflecting the comparative strength of their economies and social support systems. Ninety-five per cent (of the 39 country sample) indicated they provided “free” education.



Of the 30 countries in the trend analysis, 15 (50%) in 2004 reported the granting of **school-fee waivers or exemptions** to an undefined percentage of poor, orphaned, vulnerable or HIV and AIDS-affected learners, rising to 21/30 countries (70%) in 2011.

While progress towards universal “free” education is occurring, it does not necessarily suggest that education is in fact “free” in most countries. It does however suggest a growing commitment to Education for All (EFA) and other international and regional conventions. Ninety-five per cent of countries (16/17 countries with a generalized epidemic; 15/16 with a concentrated and 6/6 with a low-level epidemic) indicated they provided “free” education, however it should be noted that this is *highly* definitional. There is frequently some disconnection between national policy intent and implementation. Respondents in a number of countries noted that there is little control over “voluntary”, supplementary or other fees levied at the school level, and that these may be the difference between institutional survival and/or closure in some cases. In addition, in many countries parents and carers must also cover other costs such as uniforms, books, supplies and meals. It is therefore rare if there is no cost whatever to the family, although this may be in conflict with stated national education policies. Disaggregation of response by level confirms that while 95% claim that lower primary education is free, this drops incrementally by level to 81% for upper primary, 68% for lower secondary and 57% for upper secondary. Only 41% reported that tertiary education was “free” and even pre-primary was only reported to be free by 57% of countries. Given the disproportionate share of enrolment in primary, these disaggregated data suggest that the initial estimate of 95% was high.

Similarly, the reported increase in school-fee waivers or exemptions to an undefined percentage of affected learners does not imply that these waivers and exemptions have been taken to scale, as the survey question

simply sought to establish whether or not such policies exist. Thus it can only be said that in principle such assistance is available and it falls to individual countries and their education sector partners to quantify its scale.

Policy Implications

- Although a policy of “free education” is in place in an increasing number of countries, there are often hidden costs to the family. The real situation on the ground is therefore unknown and requires research and benchmarking. These data are crucial for policy development, implementation planning and financing.
- Abolishing school fees, especially for the first six years of schooling could dramatically expand school enrolments, particularly among girls and OVC. This in turn could have an impact on HIV transmission, as school is often a protective factor. However, if education budgets are not increased proportionally and in line with the greater levels of attendance, schools will be forced to achieve more with less, thereby resulting in decreases in quality.

3.4.4 Out-of-School Youth

Twenty one out of thirty countries (70%) in 2004 said “efforts had been made” to include **out-of-school youth** in HIV awareness programmes, rising slightly to 24 (80%) in 2011-2012.

In the 39 country sample, 15/17 with a generalized epidemic claim to have made efforts to include out-of-school youth in HIV awareness efforts versus 9/16 with concentrated and 4/6 with low-level epidemics.

While the increase in effort to reach out-of-school youth is encouraging, the question sought to establish whether “efforts” had been made, and respondents were not asked to indicate what these efforts might involve. As such what is being done and the numbers reached as well as the quality of the interventions is unknown. Nevertheless, this increase confirms that the problem of awareness amongst out-of-school youth is on the agenda and receiving some, if unquantified, attention.

However, it is a cause for concern that only 56% of countries with a concentrated epidemic have made efforts, as at-risk groups in concentrated epidemics often include out-of-school youth. While this group can be reached through mass media and other means of communication, they are not being reached by the requisite, sequenced life skills needed to protect themselves in an environment characterized by poverty, isolation and the need to survive.

As mentioned in the 2004 GRS report, most education systems have failed to substantively address the social and educational needs of out-of-school youth, often on the basis that action lies outside their mandate. This underscores the difficulty of engaging the more specific life skills and HIV awareness needs of out-of-school youth. Since 2004, this situation has unfortunately not significantly improved, and as mentioned in the UNICEF LSE evaluation,¹⁶ the lack of structures or systems to ensure the coordination and complementarity of non-formal LSE interventions is affecting implementation.

Policy Implications

- There is currently a lack of data and research on the content and depth of programming for out-of-school youth. This lack of data will need to be addressed to enable effective programming. In some settings, youth-serving organizations have effectively reached young people with methods such as peer outreach, though the coverage is limited, documenting the good practices could be helpful.
- The provision of sequenced life skills that build key knowledge and skills for survival and protection should constitute a major strategic focus for the education sector, and should include efforts to get many of the young people who wish to back into school.
- Vocational training and other non-formal education should integrate life skills based comprehensive sexuality education which includes sexual and reproductive health, HIV, decision-making and critical thinking skills.

Only 56% of countries with a concentrated epidemic have made efforts to include out-of-school youth, a major at-risk group in some concentrated epidemics.

16 UNICEF Evaluation Office. August 2012. *Global Evaluation of Life Skills Education Programmes*. New York, UNICEF.

4. Conclusions

This report asks if there has been progression, regression or stagnation in the education sector AIDS response. As the findings show, all three are true. These mixed findings reveal an opportunity to build on strengths to address current weaknesses in the education sector response. We can see from the 2011-2012 GPS data that many of the necessary conditions for an effective education sector response to AIDS are trending in the positive direction since 2004. Almost all countries have an education sector HIV policy; there is increasing space within the curriculum to teach about HIV and more teachers have been trained to teach HIV; there are more EMIS units in place; and, there are increased protective policies and services for learners and teachers. But many challenges still remain. While there is a policy in place in nearly all countries, implementation is low. While there are life skills in the curriculum and teachers trained, the extent to which HIV is addressed is still low, the quality of the teaching questionable, and the level of implementation unknown although anecdotally reported to be very low. While there are more EMIS units, the collection of HIV-related indicators is low.

These findings engender several questions: what management models can sustain the progress and increase coverage? How can HIV be successfully mainstreamed so that the existing management structures ensure it is implemented effectively? How can EMIS be improved to inform decision-making on HIV issues in the education sector? Can services for vulnerable learners keep pace with increasing enrolment? Can in-service teacher training continue at its current rate? How will HIV become a routine part of pre-service teacher training? How can teacher training be improved to ensure that teachers are skilled in addressing the issues and using the methods for effective HIV instruction? And, what are the best ways to deliver HIV education in low and concentrated epidemics?

The primary education objective is that all learners, regardless of wealth, health status or sex can access good quality education in a safe environment, and that they receive an age-appropriate, scientifically accurate, and contextually adapted HIV education that helps them acquire the knowledge and develop skills to adopt healthy behaviours. The education should be rights-based, gender-sensitive and life skills-based. It should be delivered by a well-trained teacher who is competent in interactive methods and participatory pedagogy and is comfortable talking about HIV and connected topics such as sexuality in a constructive way with learners. This teacher should have the knowledge, skills and access to services to live healthy themselves. This teacher, along with all education staff should be protected to do their job, regardless of their HIV status. The teacher should be equipped with a curriculum and support materials. The teacher should have the support of administration and the protection of a policy. Finally, parents and the community should be involved to support and reinforce this learning. Collectively, these are the necessary and sufficient conditions needed for an education sector response to HIV that promotes lifelong healthy development and global citizenship. The school setting should be supportive to learners and staff, offering services, referral, and non-discriminatory policies and practices so that they can learn and work. The broader education sector needs to support schools by providing a policy framework and implementation with effective management and oversight.

The GPS findings reveal a mixed picture and an uneven education sector response. The steps needed to build systemic capacity have not changed significantly since the 2004 administration. The advantage now is that the education sector has elements of progress to draw on to address weakness and scale up successes. These are the critical action points:

- Establish and maintain a high-level political will for a comprehensive AIDS response in education, including school-based activities and teacher education;

- Develop an effective and country-appropriate management system to implement the existing policy and plans;
- Strengthen existing EMIS units to track HIV-sensitive indicators to ensure that the effects of HIV and AIDS on the education sector is understood and can adequately be planned for and addressed. If no HIV indicators specific to education exist, countries should consider using the UNESCO/IATT on Education's Global M&E Framework for Comprehensive Education Responses to HIV and AIDS;
- Establish clear mechanisms and guidance for private providers of education service;
- Support sector-wide teacher training on HIV education for pre- and in-service inclusive of content and skills-based pedagogic approaches;
- Ensure that curricula and teaching materials are age-appropriate, scientifically accurate, gender-sensitive and life skills-based and are available in every school and taught to all learners;
- Ensure effective school-level implementation by clearly delineating the roles and responsibilities: teachers mandated and tasked with teaching comprehensive sexuality and HIV education; recognition of teachers' role by school administrators and the community; oversight role of principal including identifying obstacles, challenges and shortfalls;
- Engage parents and the community members in implementation;
- Establish clear mechanisms for health sector collaboration in both the provision of services to learners and staff and in technical support to update educational content in line with developments in the medical field;
- Scale up workplace policies so that all education staff are protected and supported to do their jobs effectively.

These conclusions feed into a larger context of an effective way forward. The context of HIV education has undergone considerable change in the intervening years of the two surveys. Thankfully the scenarios of an education sector collapse have not transpired, in part because of effective prevention, treatment, care and support. Advances in treatment have improved the lives of parents and learners as well as the education staff although high levels of stigma and discrimination persist. More people will be living with the virus for a longer time than previously. However, there is anecdotal evidence of HIV fatigue and that progress against the epidemic has led to a degree of complacency, including in the education sector. The education sector must look for ways of ensuring that all learners receive HIV education and sustain this education in a holistic way alongside other subjects. Otherwise the hard-earned gains of recent years may risk sliding backwards, and at every development stage, learners will require new and different education about HIV and life skills to respond to their evolving capacities and needs.

The list of critical action points is long and the resources and change needed to achieve them are limited. Additionally, the wider systemic challenges concerning sector capacity, budgeting, and increasing private influences revealed in the case studies still prevail. It is incumbent upon the education sector to plan strategically and look for emerging opportunities. The increase of life skills education and its associated health topics offers the sector an opportunity to secure the longer term viability of HIV education by integrating it into a broader health context. Learning technologies may improve to increase access to education, improve skills-based learning, and offer new rubrics for assessment. Burgeoning themes such as environmental education and entrepreneurship education are coming at a time when there is more pressure to reform education than ever before. The increase in private sector influences on and provision of education are yet other factors that may significantly alter the current paradigm of education. Considering these potential changes, what will HIV education be like in the future?

One thing is certain: HIV will continue to be an important issue for the education sector because of the sector's critical role in addressing stigma and discrimination, in building skills and developing citizens with critical thinking abilities, and helping new generations of young people stay healthy. There will always be a new cohort of young people who have the right to education, and who deserve the opportunity to build skills that will help them adopt healthy behaviours. While HIV is important for the education sector, education is central to its response. Education helps reduce stigma and discrimination thereby strengthening the global response to AIDS. Furthermore, education is a critical enabler that promotes the knowledge, attitudes, and skills that make biomedical, behavioural and structural interventions effective and sustainable. The objectives of Getting to Zero: zero new HIV infections, zero discrimination and zero AIDS-related deaths are possible and it starts with education.

One thing is certain: HIV will continue to be an important issue for the education sector because of the sector's critical role in addressing stigma and discrimination, in building skills and developing citizens with critical thinking abilities, and helping new generations of young people stay healthy.

5. Annexes

Annex 1

Phased 2011-2012 GPS Development and Methodology

The 2011-2012 Global Progress Survey (GPS) follows on from the baseline 2004 Global Readiness Survey (GRS). It was undertaken by the EduSector AIDS Response Trust (ESART), the team originally responsible (as Mobile Task Team on the Impact of HIV and AIDS on Education) for the GRS. The development of the methodology was phased.

1. Pilot Study and Process Revision

The initial phase was a desk review of existing documentation, together with targeted national Education Sector/MoE enquiries in association with UNAIDS/UNESCO country officers. This included review of:

- The 2004 GRS Report and linked 2005 Policy Implications for Education and Development report, focusing on the identification of baseline issues that could be tracked and reported in 2010/11 in order to inform a progress analysis and highlighting key lessons learnt in the 2004 GRS process;
- The IATT Strategic Approach (UNAIDS IATT on Education, 2009), to help distinguish between different types of education responses in varying epidemic scenarios and focus on gender equity issues;
- The UNESCO report, *Strengthening HIV and AIDS Education Sector Response in Southern Africa: A Review of Current Evidence and Proposed Action to Reinvigorate Response (2010)*, as well as related tools, methodologies and policy implementation indicators and reporting;
- All Education Sector HIV and AIDS policies, strategies, plans and reports to inform analysis of change/trends in countries between the 2004 GRS and the 2011-2012 GPS.

The pilot phase of the 2011-2012 GPS started in September 2010 with a pilot study in four countries (Swaziland, Kenya, Viet Nam and The Bahamas) representative of different socio-economic categories and epidemiological settings, three of which were involved in the 2004 GRS. All four had active and organized civil society structures available to participate in the data-gathering process. These country studies were completed in January 2010 and subsequent reports informed the revision of the 2011-2012 GPS data-gathering instrument and associated processes – including the drafting of the 2011 *Field and Facilitator's Guides*. These draft documents were reviewed by the IATT's Technical Advisory Group (TAG) and field tested in Zambia, leading to further revision and improvement.

2. Country Sampling Strategy

The country sampling strategy was designed to ensure the participation of a representative target selection of 40 countries in 2011-2012 (39 actually participated), based on an adaptation of the UNAIDS classification of low- and middle-income countries by income level, epidemic level and geographical region.¹⁷ This strategy took cognizance of the following issues:

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- *HIV Epidemic Categories:* In 2004, the 71 countries involved¹⁸ were subdivided into high (+6%), medium (2%-6%) and low (0.05%-2.0%) HIV-prevalence categories on the basis of available UNAIDS data¹⁹ for 2001. The 2011-2012 GPS sought to ensure a basis for comparative analysis with 2004 data and therefore adopted three epidemic categories that coincided with the segmentation of 2004 and adhered to standard UNAIDS' classification. These were Countries with Generalized HIV Epidemics; Countries with Concentrated HIV Epidemics; and Countries with Low-Level HIV Epidemics;
- *Classification of Country Economies by Income:* Based on data provided by the World Bank, the main criterion is gross national income (GNI) per capita and every economy is therefore classified as low income, middle income (subdivided into lower middle and upper middle), or high income, according to GNI per capita in 2011, using the World Bank Atlas method. Thus the HIV epidemic category is linked with country income classification, providing a further dimension to the trend and review analysis;
- *Classification by Geographical Region:* For the purpose of analysis, geographical regions are defined as:
 - East, South and South-East Asia;
 - Eastern Europe and Central Asia;
 - Latin America and the Caribbean;
 - Middle East and North Africa;
 - North America;
 - Oceania;
 - Sub-Saharan Africa; and
 - Western Europe;
- *Classification by 2004 GRS Participation:* 70 countries were initially targeted for selection, which, based on the 2004 experience of a 61% response rate, was expected to provide a final sample of about 42 countries. Of these, *at least 50%* were required to have participated in the 2004 GRS to ensure the basis for comparative analysis. In the event, exactly 43 countries initially agreed to participate, but four dropped out along the way. The final sample for the 2011-2012 GPS was therefore 39 countries. Of these, 30 (77%) participated in the 2004 GRS baseline study, well ahead of the 50% target.

On this basis, the second phase of the 2011-2012 GPS was initiated in July 2011, with invitations from UNESCO's Assistant Director-General for Education – on behalf of the IATT – to 70 countries to participate in this follow-up global progress survey.

3. Survey Design and Data Collection Instrument Validation

The 2011-2012 GPS survey design built on the experience and lessons of the 2004 GRS and was required to provide sufficient correlation to facilitate comparative analysis. Key points of the survey design included:

- Validation of the list of key topics identified in the 2004 GRS instrument and the identification of additional issues of topical concern, through research, review, pilot country studies and field testing;
- Development and validation of a comprehensive survey instrument to be sent to selected sample countries electronically for data collection and return;
- Use of a single data collection instrument in all three epidemiological settings, on the basis of the 2004 GRS experience (with appropriate adaptation of questions), and on the understanding that countries could leave questions for which they had no data or which fell outside their epidemiological experience;
- Development of methodological guidelines in five language options, including a *2011 GPS Field Guide* and a *2011 GPS Facilitator's Guide*, designed to clarify roles, responsibilities and logistics for the data collection process at country level;
- Requirement that each country group of respondents should include specified senior representatives of the MoE (approximately five) as well as civil society representatives (approximately three) involved in the education sector AIDS response;

¹⁸ 117 countries were invited to participate in the 2004 GRS, of which 71 (61%) accepted and participated.

¹⁹ Country selection was based on UNAIDS-reported adult (15-49) HIV-prevalence rates for 2001.

- Distribution of all GPS documentation, in the interest of transparency and understanding, including the data collection instruments and *2011 GPS Field Guide*, to all country respondents – if possible ahead of the data-gathering meeting and in their chosen language option.

Based on feedback from the 2004 GRS, analysis of these data and extensive reporting of these, the four-country GPS pilot study and inputs from the IATT TAG, the 2004 data collection instrument was completely revised. This revision was driven by the need to better understand barriers to the implementation of education sector policy and to capture additional layers of detail across the 11 categories used in 2004. The data collection instrument was consequently expanded from 137 questions to 351, an extremely ambitious increase given the distance methodology employed. On completion of this revision, the data collection instrument was field-tested in Zambia, and lessons learnt from this process informed several more structural and grammatical changes.

In terms of process, following acceptance of the invitation to participate, each country nominated a contact person/coordinator, who then received a full set of GPS documentation by email for distribution and dissemination. These included the 2011-2012 GPS data collection instrument; the *2011 GPS Field Guide*; and a copy of the *2011 GPS Facilitator's Guide*. This documentation clearly articulated process steps to the convening of an inclusive meeting of stakeholders, inside and outside the MoE, guidelines for the completion of the data collection instrument and deadlines for completion of the data collection process. This was followed by a sustained (email) follow-up process from ESART's administrative hub. This addressed the identification and selection of facilitators in each case, guided by the MoEs and UNESCO country offices involved. This interactive communication process was undertaken in all five of the languages involved and responded almost instantly to any queries or concerns that arose. From the point at which country facilitators were identified, this communication was channelled through these "agents", copied to the MoE contact persons concerned. This email communication was supported by the 2011-2012 GPS website (www.iatt-gps2011.org) and resulted in almost weekly exchanges, initially with the list of 70 invited countries, and later with the final 39 country sample.

It was assumed that the involvement of an independent facilitator, in-country and on-site, would ease the problem of responding to this demanding list of issues. In addition, it was hoped that the inclusion of civil society in data-gathering meetings would stimulate more objective interrogation of the issues and that this would be assisted by the greater breadth and depth of the 2011-2012 instrument. In the event however, and in spite of the involvement of independent facilitators, many of the MoEs involved took considerably longer to respond than planned.

4. Language and Translation

As was the case in 2004, with the assistance of UNESCO, the English language data collection instrument, the *2011 GPS Field Guide* and the *2011 GPS Facilitator's Guide* were translated into French, Portuguese, Russian and Spanish. Since the instrument was designed to be completed electronically, all five versions were integrated into one Excel document, which was emailed to selected country UNESCO offices, MoE contact persons and 2011-2012 GPS facilitators. Each of the languages was linked to facilitate the viewing of the responses in any language, irrespective of which language it had been completed in. Minimal typing and Excel skills were required to enter responses, since the majority of questions had "radio" buttons which had only to be clicked (e.g. YES or NO).

Every country also received an English-language data capture instrument, support documents and set of translations. This helped ensure country facilitators could carry out their facilitation and oversight role, regardless of their fluency in the local language, thus enhancing the transparency of the process.

5. Data Gathering Logistics and Timing

Based on 2004 GRS experience, the expanded 2011-2012 data collection instrument and field testing, it was estimated that the data collection meeting/process would take approximately four hours, assuming effective facilitation and adequate preparation by participants. This proved to be an accurate assumption in most cases, even allowing for the expanded size of the groups to include civil society representation. Data-gathering meetings were almost all convened in the country's MoE offices, where the facilitator introduced the process, posed the instrument's questions and captured the group consensus response on a laptop computer.

The facilitator was tasked with stimulating debate where appropriate and allowing discussion to flow within reasonable boundaries, given the time constraints. The intention was to create the space for discussion

and the development of a working consensus. However, the facilitator was required to record any minority or dissenting views against the question concerned. This approach worked well and the ensuing debates should be considered an important learning experience for all the parties concerned. Relevant comments and dissenting views were captured by the facilitator in an attached *Comments* section of the instrument; these were then collated and included in the Country Reports returned to every country.

6. Data Collection

Participation in the 2011-2012 GPS was initiated by an exchange of letters between UNESCO's Assistant Director-General for Education and country MoE Permanent Secretaries or Ministers. In terms of this formal exchange, the data-collection phase was scheduled for completion by the end of October 2011. However, country response was extremely mixed, notwithstanding the agreement of these countries to participate, and led to repeated extensions of the deadline for completion. This was finally stretched to 29 February 2012, at which point three countries were still outstanding. Data from two of these three countries were only collected in early March 2012, with the third responding in April 2012.

As a result, preliminary cleaning and analysis of data only began in February 2012, with late returns still outstanding. Notwithstanding these delays, data for 35 of 39 countries were checked, analysed and processed to provide a draft report by May 2012. Initial outputs included a preliminary presentation of findings to the IATT in May 2012 and development of a set of 39 GPS Country Reports in June 2012, which mirrored country responses. To ensure transparency and double-check returns, these reports were returned electronically to all 39 countries in late June 2012 for verification, with any missing data fields or apparent anomalies highlighted for attention. In the event, only one country added additional data within the stated deadline.

7. Contextual Issues and Process Caveats

- The 2011-2012 GPS (and the 2004 GRS) were designed to obtain information on progress in the *national* education sector response to HIV and AIDS and do not deal adequately with highly decentralized systems (such as South Africa's provincial and Nigeria's federal structures) where planning and response implementation are delegated to sub-national levels. To address this shortcoming, a modified 2011-2012 GPS questionnaire can be used by countries themselves to (regularly) monitor and report key indicators of AIDS response progress within their own systems. In addition, it will be recommended to other participating countries and indeed all countries with Generalized and Concentrated HIV epidemics that they utilize this modified instrument as the basis of their regular monitoring and reporting activities, given its comprehensive spread of related themes. These efforts should complement the Global M&E Framework for Comprehensive Education Responses to AIDS.
- Although the 2011-2012 GPS was independently facilitated and included external civil society partners, both this survey and the baseline 2004 GRS depended largely on the subjective inputs of MoE officials. The utility of this information, at the country level, is inevitably limited by the extent to which country respondents are able to accurately report implementation, particularly in decentralized, under-monitored and under-reported education systems.
- Extensive delays (up to six months) in the 2011-2012 GPS data collection process in some countries delayed the analysis of the data, and could suggest problems in these MoE AIDS response structures, as these delays were in sharp contrast to the rapid response to the 2004 GRS.
- There was a widespread failure of MoE EMIS units to provide complete statistical data on their basic education systems. EMIS units had been given an additional two-weeks lead time (before the data-gathering meeting) to pull together the statistical data concerned – management information that it could be assumed would be to hand and readily available. However several EMIS units were not able to produce many of these very basic statistics, and management representatives at the subsequent data-gathering meetings were also largely unable to provide statistics pertinent to their own divisions. This confirms long-term observations of the repeated fall and rise of EMIS units and their capacity, at least in sub-Saharan Africa. This therefore has implications for the education sector response to AIDS and for the wider education systems. It implies a sustained lack of demand for management information and the inability of many systems to adequately monitor and report their activity and expenditure. For these reasons, UNESCO Institute of Statistics' (UIS) data were finally used as a default set for the 2011-2012 GPS.

Annex 2

2011-2012 IATT GPS Country Sample

Europe & Central Asia	◆ AZERBAIJAN 0.1% NO	◆ RUSSIAN FEDERATION 1.0% YES		■ UKRAINE 1.1% YES
	◆ LITHUANIA 0.1% NO			
	● TAJIKISTAN 0.2% NO			
East, South & South-East Asia	● BANGLADESH 0.2% NO	● CAMBODIA 0.5% YES	◆ MALAYSIA 0.5% NO	● MYANMAR 0.6% YES
	◆ THAILAND 1.3% YES			■ VIET NAM 0.4% YES
Latin America & Caribbean	◆ BRAZIL 0.5% YES	◆ COLOMBIA 0.5% YES	◆ JAMAICA 1.7% YES	◆ PERU 0.4% YES
Middle East & North Africa	★ ISRAEL 0.2% YES	◆ TUNISIA 0.1% NO		

Notes to the Country Sample Table:

1. 39 countries have been included, in THREE categories of HIV epidemic: Generalized; Concentrated and Low-Level.
2. Percentages represent adult (15 to 49) HIV-prevalence (UNAIDS 2009). The prevalence rate for Ethiopia is from 2012.
3. Of the 39 countries sampled, 30 (77%) were sampled in the 2004 GRS and can be linked for purposes of trend analysis.
4. 17 countries are in the Countries with Generalized Epidemic category, all of which (100%) were included in the 2004 GRS.
5. 16 countries are in the Countries with Concentrated Epidemic category, of which 12 (71%) were included in the 2004 GRS.
6. 6 countries are in the Countries with Low-Level Epidemic category, of which 5 (83%) were included in the 2004 GRS.

Sub-Saharan Africa	● GAMBIA 2.0% NO	● MALI 1.0% YES	◆ MAURITIUS 1.0% NO	● NIGER 0.8% YES	■ SENEGAL 0.9% NO
	● CENTRAL AFRICAN REPUBLIC 4.7% YES			● DEMOCRATIC REPUBLIC OF THE CONGO 1.4% YES	
	● ETHIOPIA 1.5% YES			◆ GABON 5.2% YES	
	■ GHANA 1.8% YES			● KENYA 6.3% YES	
	■ LESOTHO 23.6% YES			● MALAWI 11.0% YES	
	● MOZAMBIQUE 11.5% YES			◆ NAMIBIA 13.1% YES	
	■ NIGERIA 3.6% YES			◆ SOUTH AFRICA 17.8% YES	
	■ SWAZILAND 25.9% YES			● TANZANIA (UNITED REPUBLIC OF) 5.6% YES	
	● UGANDA 6.5% YES			■ ZAMBIA 13.5% YES	
	● ZIMBABWE 14.3% YES				

LEVEL OF HIV EPIDEMIC

	Low level
	Concentrated
	Generalized

ECONOMIC CLASSIFICATION

●	Low Income
■	Lower Middle Income
◆	Upper Middle Income
★	High Income

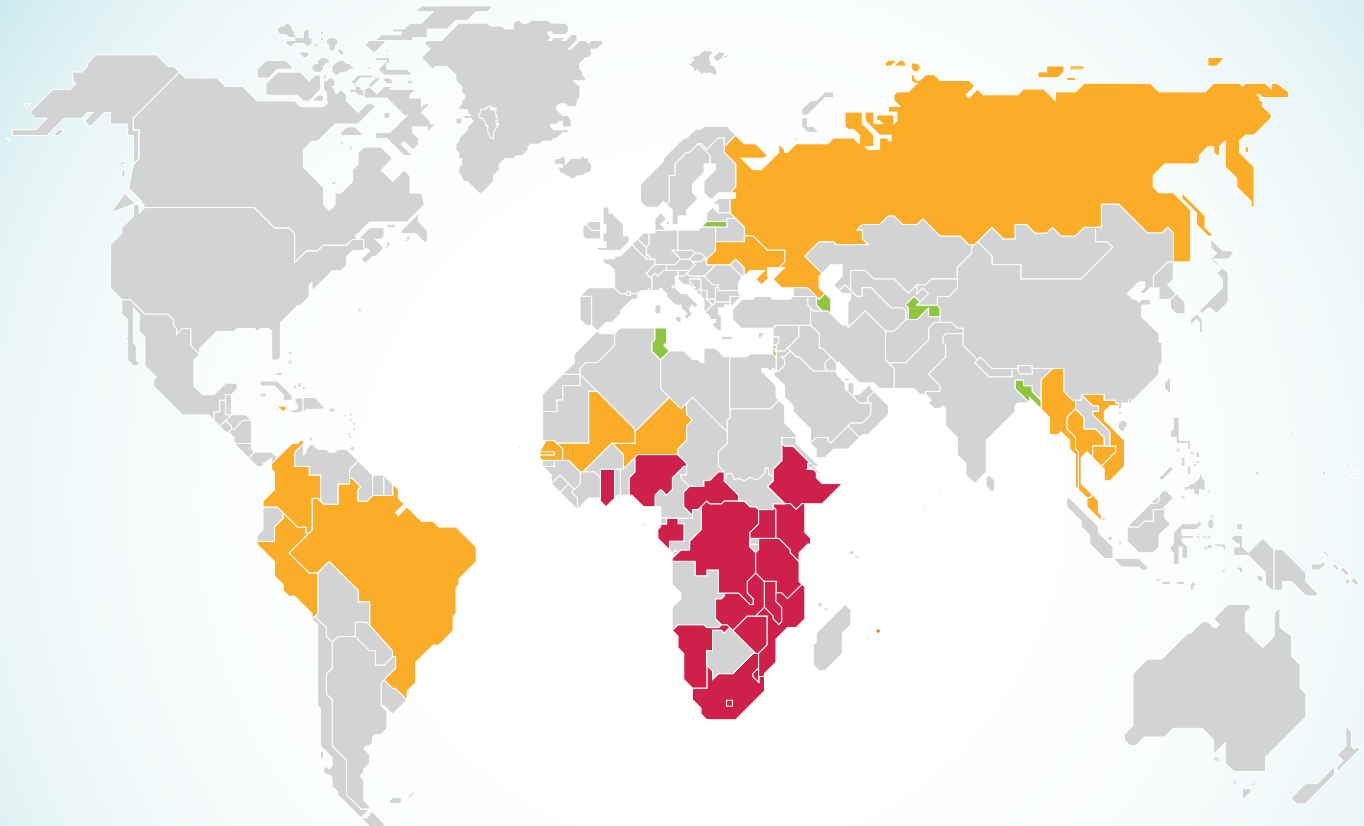
INCLUDED IN 2004 GRS

YES
NO

Annex 3

Map of 39 Countries Surveyed

Map of 39 Countries Surveyed



Level of HIV epidemic
■ low level
■ concentrated
■ generalized

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2011-2012 Education Sector HIV and AIDS Global Progress Survey

Progression, Regression or Stagnation?

The 2011-2012 Global Progress Survey (GPS) is a 39 country survey of HIV and AIDS policy and programmes in the education sector. This report highlights key findings from the GPS to provide a picture of how countries' education sectors are responding to HIV and AIDS, what progress has been made since the 2004 Global Readiness Survey, as well as pointing out the main policy implications of the current situation.

It is designed to act as a catalyst to revitalise the education sector's response by providing insight and initiating discussion among stakeholders on the in-country situation and how the response can be improved.

To request individual country profiles and the full data set, please contact aids@unesco.org

The UNAIDS Inter-Agency Task Team on Education

The UNAIDS Inter-Agency Task Team (IATT) on Education was created in 2002 to support accelerated and improved education sector responses to HIV and AIDS. It is convened by UNESCO and includes UNAIDS cosponsoring agencies, bilateral agencies and donors, and civil society.

For further information on the UNAIDS IATT on Education and to access IATT technical products, please visit <http://www.unesco.org/new/en/hiv-and-aids/about-us/unaid-iatt-on-education/>



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