Cross-cutting program for HIV & AIDS Education

Assessment of Curriculum Response in 35 countries for the EFA Monitoring Report 2005 "The Quality Imperative"

May 2004

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Assessment of curriculum response in 35 countries for the EFA monitoring report 2005 *"The Quality Imperative"*

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May 2004

Content

IBE/2005/RP/HV/03

ACRONYMS

CBO Community Based Organization
EFA Education for All
IBE International Bureau of Education
NGO Non Governmental Organization
OVCs Orphans and Vulnerable Children
RH Reproductive Health
STD Sexually transmitted diseases
STI Sexually transmitted infections
UNAIDS Joint United Nations Program on HIV/AIDS
UNESCO United Nations Educational, Scientific and Cultural Organization
VCT Voluntary Counselling and Testing

Introduction

Since the late 1980s, interest has grown in the development of health education in schools. This interest has been spurred on by the AIDS pandemic. There has been an increasing quantity and variety of material intended for the education of students at the primary and secondary levels. It is acknowledged that the search for affordable vaccines may take years. Treatment therapies are still not easily available in most developing countries and their availability does not call for abandoning or relaxing HIV/AIDS education, on the contrary. In the meantime, health education, which focuses on trying to influence values, attitudes and eventually behaviours, has been seen as a key strategy for holding back the spread of HIV. Education must reach those who are at highest risk[1]. Evidence suggests that a primary group for such education is teenagers and young adults and that HIV/AIDS education should definitely be part and parcel of the school curricula in order to contribute meaningfully to the fight against HIV/AIDS, especially among the school-aged children:

> *"In many developing countries more than half the population is below the age of 25 years. In many countries over two thirds of adolescents aged 15-19 years, male and female, have had sexual intercourse. Adolescents and young adults (20-24 years of age) account for a disproportionate share of the increase in reported cases of syphilis and gonorrhoea world-wide... In addition, at least one fifth of all people with AIDS are in their twenties, and most are likely to become infected with HIV as adolescents."*[2]

> *"Without education, AIDS will continue its rampant spread - with AIDS out of control, education will be out of reach"* [3]

> *"Often times, our policy makers have referred to education as the `Vaccine` against HIV/AIDS. Education as a critical means of changing behaviour at the formal level is not in doubt, and especially so in the case of HIV/AIDS which has deadly consequence. A well structured curriculum-based approach to preventive education on HIV/AIDS is therefore the sine qua non option in protecting the Nigerian youths and adults alike"*[4]

To what extent, however, has attention been paid to health education (including HIV/AIDS prevention education) in relation to the curriculum of schools in Sub-Sahara Africa, East Asia/Pacific and Latin America/Caribbean regions? The need to document, analyse and disseminate information on curricular in the battle against HIV/AIDS in the school context is clearly justified.

Purpose of the study

The study intends to provide information on how Ministries of Education and schools address HIV/AIDS education through the curriculum, by:

- Reviewing and synthesizing existing information on the existence of policies and inclusion of HIV/AIDS education in school curricula.
- Reviewing, analysing and comparing available information on HIV/AIDS education curricula in three regions under study.

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1 Barnet, E., K. de Koning, and V. Francis, (1995).

2 WHO AIDS series (1992).

3 Peter Piot, Executive Director UNAIDS

4 Olusola Adara, Curriculum specialist, Director Special Programme Centre (SPC) in Abuja (Nigeria, IBE expert seminar on HIV/AIDS curriculum development, Geneva, June 2003.

Scope, methods and sources

This study does not address the level of implementation of HIV/AIDS education, but the framework and conditions set in policies and curricula for curriculum implementation. This analysis will however lead to an evaluation of the likely quality of implementation that may be expected, regarding criteria established through existing research and evaluation. From the analysis of the curriculum, which states goals, intention and, what can be expected to be actually implemented as HIV/AIDS education in schools and class rooms. It therefore looks at the following aspects:

- What is the status of HIV/AIDS educational policy?
- Has there been a comprehensive HIV/AIDS educational policy in relation to goals, placement, content, approach, training of teachers and resources?
- How comprehensive is HIV/AIDS curriculum in relation to approach, goals, content, practical skills and magnitude of the problem?
- How coherent are the curricula when compared to policy framework?

The analysis reviews first a few crucial data on HIV/AIDS prevalence, youth sexual behaviours and basic features of the education systems *(Table 1)* and explores the policy and institutional framework surrounding HIV/AIDS education *(Tables 2.1 and 2.2),* for the set of countries under scrutiny.

We then look at *intended official school curricula* for primary and secondary levels, to identify whether HIV/AIDS education is formally included, what the goals are for HIV/AIDS education, what the approach is, how many hours are dedicated to it and what status it has such as mandatory or examinable status (*Tables 3.1, 3.2, 3.3. and 3.4*).

We also look at the location of HIV/AIDS in the curriculum, *(Table 4).* The thematic areas and more specific contents these goals are translated into (Table 5). Teacher training and partnerships with NGOs and CBOs are addressed in the last section, about ways to move forward and improve HIV/AIDS education in school settings, based mainly on secondary sources, work done by the IBE and others in Sub-Saharan Africa.

Geographic focus

The geographic focus is on Sub-Saharan Africa (18 countries), with examples from countries of two other regions, namely East Asia/Pacific (11 countries) and Latin America/Caribbean (7 countries). The selection of these regions was based on adequacy of information available on each region and country, and the magnitude of HIV/AIDS in different regions and countries (see appendix A for a list of countries included in the study).

Methodology

The study uses mainly qualitative methods. Numerous documents were collected and analysed (mainly countries' policy and official framework documents, schools' curricula and syllabi, country reports and local studies). Data are analysed and presented by region and country, by level of education (basic/primary and secondary), and for the following aspects:

1. Inclusion of HIV/AIDS in education policy
2. Inclusion of HIV/AIDS in the official curriculum and analysis of how HIV/AIDS is included in the curriculum.

Some quantitative data are also examined, mostly for the analysis of relevant dimensions of the background of HIV/AIDS education (school gross enrolments for primary and secondary education, HIV/AIDS prevalence, risk behaviours and level of knowledge related to HIV/AIDS of young people).

Data sources

The study primarily draws on data included in the IBE HIV/AIDS Curriculum Global Databank[5], the IBE bibliographic catalogue[6] and the Bank of World Data on Education.[7] However, it has been difficult for some countries to collect complete data (policy, curriculum, syllabi). We therefore limited our analysis to the most recent official documents, reports and studies that were available to us at the moment of the study. In addition, HIV/AIDS education is sometimes not yet formalized at policy and curriculum level. To somehow compensate the lack of official documents, secondary sources, such as country reports and regional review, have been used, in order to have a set of countries as large as possible. The type of sources used is mentioned throughout the analysis whenever relevant.

Limitations of the study

The study does not claim to be comprehensive and exhaustive. The sample was not large enough for generalisation and fair representation of sampled countries, and time allocated to the study was insufficient to collect more data in a systematic way. The necessity to use secondary sources, as mentioned above, clearly represents a limitation of this study. However, data are sufficient to identify trends and "types" of responses, and to make it possible, based on existing research and evaluation on the effectiveness of curricular approaches, to discuss likely consequences of HIV/AIDS curriculum on implemented programs in school and classrooms.

1. What makes a "good" HIV/AIDS curriculum?

Although quality education is a shared goal, quality as a concept in the context of education has always been difficult to define as it is complex and multidimensional[8,9]. Most public debates on the quality of education include concerns about a student's level of achievement and the relevance of learning to the world of employment[10], but also in regard of new challenges brought by a changing world, HIV/AIDS being one of those challenges that education has to address.

[See in the appendices Table 1: HIV/AIDS prevalence, HIV/AIDS knowledge and sexual behaviour of youth, school enrolment - most recent available data]

Some aspects of the background are also crucial to develop HIV/AIDS curricula that respond to the needs and some key-characteristics of the broader context of education. Regarding the context, the level of HIV prevalence is a first indicator of the urgency and scope of the problem. HIV prevalence data for young people are hardly available, and even for the general population these data are only evaluations. However, in all African countries of our sample, Senegal, Ghana and Benin are the only three countries with HIV prevalence under 5% (see table 1). All other African countries are above and have reached the level of a generalized epidemic. HIV prevalence among the general population tends to be overall much lower in the two other regions, but more detailed epidemiological data show that prevalence is very high in some groups that are in contact with the general population (in particular commercial sex workers and drug users) and that the epidemic could very easily spread rapidly among other groups of the population, as it has in other context, in particular when poverty is high and lack of health services widespread. These relatively low prevalence rates do not justify in any case lack of action from the education sector.

[5] www.ibe.unesco.org/hivaids
[6] http://databases.unesco.org/IBE/IBEDOCS/
[7] http://www.ibe.unesco.org/International/Databanks/Wde/wde.htm
[8] Grisay & Mahlck, 1991
[9] Hawes & Stephens, 1990
[10] The quality of learning and teaching in developing countries

When looking at the few available statistics for younger population, the main finding is that HIV prevalence is very low among children aged 10-14 and start to increase at this moment (data not shown on the table), which corresponds to the starting age for sexual debut in many countries (as shown in Table 1). These two sets of data are worth taking into account seriously, as they support an early intervention for HIV/AIDS education, before the onset of sexual activity and among a group that is not yet infected by HIV. It is crucial not to miss this "window of opportunity". [11]

For the education system it has the implication, particularly in countries where children sometimes start school when they are older, repeat classes or do not attend school regularly, and do not have a linear schooling. Enrolment is also dramatically dropping at the end of the primary level in many countries of our sample.

These data underline the importance for HIV/AIDS education to already start at primary level and to comprehensively address issues directly related to HIV/AIDS already at the 3rd or 4th year of school. In addition numerous studies on behaviors show that it is easier to promote safer sexual behavior before the onset of sexual activity. This is the reason why this study also considers how HIV/AIDS education is included or not, and how, at primary school, so that data are made available for children who are in the "window of opportunity", not being infected yet. We will also look at regional differences and trends, as HIV prevalence, level of knowledge about HIV/AIDS and age at sexual debut vary quite a lot across regions.

Against this background, the question is: what makes a good school HIV/AIDS curriculum? Quite an important stock of research on health education exists and some of it has examined the criteria to evaluate the effectiveness of sexual and reproductive health education programmes, including HIV/AIDS education, in changing behaviours. It is true that most of this research work has been carried out in developed countries. Adjustments for cultural and institutional differences in developing countries should certainly be considered before applying directly its results in developing countries. However, and overall, it seems that many results of scientifically sound research carried out in developed countries can still be applied to develop and evaluate education policy and programmes in developing countries.

A summary review of literature shows that health (including HIV/AIDS prevention) curriculum and school-based programs are more effective when:

1. The learning has been well planned in an explicit, written instructional programme, (comprised of required learning outcomes (curriculum), a recommended set of teaching methods, selected teaching/learning materials and a programme of teacher in-service) that is approved by the school board, known by the school principal and followed by the teacher (King et al, 1990; Allensworth, 1997).
2. Required or mandatory learning outcomes are described clearly in the curriculum by the education authorities (King et al, 1990; Otis, 1996).
3. The instructional time required to learn about HIV/AIDS, STD and sexuality is stipulated and adequate to achieve the required learning outcomes (Connell et al, 1985; King et al, 1990; Butler, 1993).
4. Non-didactic teaching methods are recommended and promoted; exemplars are included in the supporting curriculum documents (Saskatchewan Education, 1996; Shannon & McCall Consulting, 1990).
5. The required learning outcomes for HIV/AIDS, STD and sexuality are part of a comprehensive health or personal/social development curricula (Kerr, 1989; Neutens *et al*, 1991).

[11] World Bank, 2002

6. Students are offered additional opportunities to learn about HIV/AIDS, STD and sexuality in related curricula such as family studies, physical education and science (Institute of Medicine, 1997; Centres for Disease Control, 1997).
7. Other opportunities for learning about HIV/AIDS, STD and sexuality are encouraged integrated with suggested interdisciplinary learning activities and curricula (Health Canada, 1994).
8. Youth or student leadership through empowering opportunities related to sexual health promotion is supported, implemented and monitored (Shannon & McCall, 1997; Warren & King, 1994; Carr, 1996).
9. The requirements of teacher pre-service training relevant to HIV/AIDS, STD and sexuality are made available to faculties of education for inclusion within teacher pre-service programmes (Saskatchewan Education, 1996; Birch, 1994).
10. In-service teacher training is provided systematically to all involved teachers, also crucial when new areas (such as HIV/AIDS prevention) and new teaching methods (such as life skills education) are integrated in the curriculum (IBE 2004).
11. Positive teacher attitudes, beliefs as well as appropriate levels of comfort and confidence are supported, implemented and monitored (Hamiliton & Levenson-Gingiss, 1989; Health Canada, 1994).
12. There is a diffusion or implementation plan (Jubb, 1989;) that includes provision to create supportive networks of school district and community contacts as well as ongoing exchanges among teachers (Beazley et al, 1996; Fullan, 1991).
13. Parental involvement in education and instruction is actively encouraged, implemented and monitored (Kelsey et al, 1998; Brock & Beazley, 1995).
14. The involvement of community-based organizations, the local media and community leaders is encouraged, implemented and monitored (Scollay et al, 1992).

Effective programmes are those that have had a positive influence on behaviour as regards to sexuality, drug use and non-discrimination, and not those that simply increased knowledge and changed the attitudes of students. From the review of literature, the following is a summary of the characteristics of effective curricula and programmes for HIV/AIDS prevention education[12]:

- Base the intervention/programme on sound theoretical approach.
- Focus on life skills with the aim of reducing risk-tasking behaviours, particularly by delaying first sexual intercourse and encouraging protected intercourse.
- Concentrate on personalising risk through active participation of learners, by using appropriate role-playing and interactive discussions.
- Provide clear messages on sexual activity and discuss straightforwardly the possible results of unprotected sex, and in equally clear terms provide comprehensive information on the ways to avoid such an outcome.
- Explain where to turn for help, support and services (such as peers, school staff and facilities, and outside facilities).
- Provide occasions to model, practice communication and refusal skills useful for self-protection and to build self-confidence.
- Address pressure from peers and society. Reinforce values, norms and peer group support for resisting pressure, both at school and in the community.

[12] Kirby (2001) provides an excellent summary of main characteristics of successful programs, based on a systematic and in-depth review of US based programs; the review by UNAIDS (1997) also provides such review, that includes developing countries.

- Provide sufficient time for classroom work and interactive teaching methods such as role-play and group discussions.
- Select teachers and peers who believe the programme and train them.
- Start at the earliest possible age with adapted messages and teaching methods, and certainly before the onset of sexual activity.

Against this background, the question arises, how should the education system respond to HIV/AIDS?

2. Policy framework for HIV/AIDS education sector response

Several policy levels are taken into consideration: at the country level, the existence of a national multi-sectorial HIV/AIDS policy, and accompanying strategic plans that mentions clearly goals and ways to prevent the spread of HIV and to reduce its impact in the country (level 1). Roles and responsibilities of the education sector may be mentioned in some national policies and they have been reviewed in this analysis. However, general HIV/AIDS national policies and strategic plans have not been analysed in detail. (Table 2.1).

The policy framework specific to the education sector comprises of the policy level (level 2) and the strategic plan (level 3), two levels that are considered crucial for an effective and national implementation of HIV/AIDS education in school settings.

2.1 HIV/AIDS Education sector policies and strategic plans

National policy frameworks for the education sector define with varying level of detail the specific goals, tasks and resources for developing and implementing a national response by the education system to the challenges posed by HIV/AIDS. Some countries do not yet have a formal policy framework as such, but have developed guidelines and adopted directives for their education systems. The level of comprehensiveness of the policy framework in the education sector (table 2.2), as well as its scope, or areas covered, (Table 2.3) are reviewed and analysed in detail whenever official documents were available.

[See in the appendices Table 2.1: HIV/AIDS Education sector policies and strategic plans]

All countries under review have a HIV/AIDS national policy and/or strategic plan at national level, except for Brunei and Malaysia,[13] for which we could not find such written document. These policies and framework are often multisectoral and many of them include some general provisions regarding the education sector. In some countries, such provisions are contained in a national multi sectorial policy document usually under the leadership of the National AIDS Council.[14]

In contrast, not all countries have adopted a specific HIV/AIDS policy framework. The Sub-Saharan Africa region is clearly ahead of the two other regions in terms of the number of countries having developed a specific HIV/ADS policy framework for the education sector and in terms of comprehensiveness of such framework (almost two third of half Sub-Saharan African countries have a national multisectoral HIV/AIDS policy and a policy and plan for the education sector).

[13] We could not find any data on such policy for Brunei. In Malaysia, some policy documents exist, but it seems that they do not constitute yet a policy as such.
[14] This aspect has not been reviewed in detail here.

A few countries seem to have developed a strategic plan for the education sector before having developed a policy for the education sector: Ghana, Mozambique, Senegal, Uganda, Cambodia, Thailand and Haiti.

Overall, one third of the countries of our sample have adopted a complete HIV/AIDS policy framework (3 levels). Two additional countries have made good progress in developing such a framework

- In Sub-Saharan Africa, out of 18 countries, 9 have adopted a HIV/AIDS policy for the education sector and 2 are currently developing such policy. Thirteen countries have a HIV/AIDS strategic plan for the education sector. Two countries (Cameroon and Tanzania) that do not have an education sector HIV/AIDS policy or strategic plan have national multisectoral policies that clearly mention the role of the education sector in responding to HIV/AIDS.[15] We could not find data for 3 countries (Angola, Benin, and Swaziland). All countries that have a HIV/AIDS education sector policy have a comprehensive approach that includes a national multisectoral HIV/AIDS policy, and a policy and strategic plan specific to the education sector.

- In the Asia/Pacific region, only a minority of countries have an education sector HIV/AIDS policy or strategic plan in place. Indonesia seems to be the only country with a comprehensive framework, whereas Cambodia is developing a complete policy framework for the education sector. China, Vietnam and Thailand have either an HIV/AIDS policy or a plan specific to the education sector. Three countries more: (India, Mongolia and Philippines) have no HIV/AIDS policy or framework in place for the education sector but have national multisectoral policies that clearly mention the role of the education sector in responding to HIV/AIDS.

- In the Latin America/Caribbean region, only one country of our sample, Brazil, has a HIV/AIDS policy specific to the education sector. It is also the only country that has a complete HIV/AIDS policy framework. The Bahamas has a national multisectoral policy that includes clear provisions for the education sector, whereas as Columbia and Chile have included HIV/AIDS in their national policy on sexual and reproductive health (such policy being promulgated by the Ministry of Health in Columbia and the Ministry of education in Chile). Chile and Haiti are the 2 other countries that have started to develop a HIV/AIDS policy framework specific to the education sector.

A comprehensive HIV/AIDS policy framework that has certainly been identified is one important condition for an effective HIV/AIDS response by the education sector. However, the quality of the content and orientation of this framework is also important.

[15] Other National multisectoral policies may mention the education sector, but we decided not to mention it for countries that have a specific education sector HIV/AIDS policy framework

2.2 Comprehensiveness and scope of HIV/AIDS education policies and strategic plans

We reviewed areas of concerns that are *explicitly* addressed in the policy framework.[16] Seven different areas of application emerged from the documents that were available to us. All of the education specific policies or strategic plans address at least one of the following seven main areas:

1) Provision for reviewing/monitoring process of the policy/plan implementation.
2) Provision to address the impact of HIV/AIDS on the education system.
3) Prevention as a general purpose for HIV/AIDS education.
4) Recommendations/provision to include HIV/AIDS in the curriculum.
5) Support for teachers and schools staff, including teachers training.
6) Inclusion of community resources in school settings.
7) Fight against stigma and discrimination.

A few other issues are explicitly addressed by policies and plans in a few countries in relation with HIVAIDS prevention, in particular gender issues and peer education.

We considered that policy frameworks covering 6, 7 or 8 areas were comprehensive, those covering 4 and 5 areas were fairly comprehensive and those covering less than 4 areas were not comprehensive. To get a more complete idea of the kind of contents that were addressed by policies regarding the role and responsibilities of the education sector, we also included countries that did not have a specific education policy framework (levels 2 and 3) but that did mention explicitly the education sector's roles and responsibilities in their national HIV/AIDS policy (level 1).

[See in the appendices Table 2.2 : Level of comprehensiveness of education sector HIV/AIDS policies and plans]

Out of 28 countries that explicitly mentions roles and responsibilities of the education sector, half (14 countries) have a comprehensive approach, one third have a fairly comprehensive approach (9 countries), whereas the remaining 5 countries have an approach that is not comprehensive. All countries from the Sub-Saharan region have very comprehensive or fairly comprehensive approaches, except for Cameroon (for which only secondary source was available). From the documents that were available to us, countries from the Asia/Pacific region seem to have a less comprehensive approach, whereas Latin America and the Caribbean countries seem to have fallen behind planning comprehensive policies (although we also had less primary sources available for these countries). Their policy framework in the education sector is also less developed, which may also be part of the explanation for these results.

2.3 Scope of education sector HIV/AIDS policies and plans

The area that is more often explicitly addressed by policies and strategic plans in the education sector refers to the role of education to provide HIV/AIDS prevention in schools (Dimension 3), mostly with students as the main and primary target group: all the countries that have an education specific policy or strategic plan consider education to HIV/AIDS as being a general goal and a fundamental aspect of education policy (Table 2.3). Provisions to include HIV/AIDS education in the curriculum (Dimension 4) and to support teachers and school staff (Dimension 5) come next. On the other hand, the three aspects less commonly addressed are the inclusion of community resources to support education in addressing

[16] Some data may be missing for the countries for which we had only secondary sources available (in italics in our tables) of for which data were altogether missing.

HIV/AIDS (Dimension 6), provisions to address the impact of HIV/AIDS on the education system (Dimension 2) and provisions to address stigma and discrimination (Dimension 7).

Frequency of the main seven aspects addressed explicitly by HIV/AIDS policy frameworks for the education sector (by region: Sub-Saharan Africa / Asia/Pacific / Latin America/Caribbean) (n=28):

1. Prevention as a general purpose for HIV/AIDS education (Dim 3): 27 countries (14/8/5)
2. Include HIV/AIDS in the curriculum (Dim 4): 24 countries (14/8/5)
3. Support for teachers and schools staff, including teachers training (Dim. 5): 23 countries (13/8/2)
4. Provision for monitoring process of the policy/plan implementation (Dim.1): 17 countries (12/4/1)
5. Inclusion of community resources in school settings (Dim. 6): 15 countries (11/3/1)
6. Provision to address impact of HIV/AIDS on the education system (Dim. 2): 13 countries (9/2/1)
7. Fight against stigma and discrimination (Dim. 7): 12 countries (8/4/0)

When comparing the countries whose education policies and strategic plans have a comprehensive scope (6-8 dimensions, table 2.2) with the ones that have a complete set of policies and strategic plans (all 3 levels, table 2.1), eight African countries[17], one Asian country (Cambodia) and one Latin-American country (Brazil) are highlighted.

[See in the appendices Table 2.3 Scope of education sector HIV/AIDS policies and plans]

The other countries that also have a comprehensive scope (6-8 dimensions, table 2.2) are Ghana, Mongolia, *Philippines* and *Thailand*. These countries, however, do not have a complete set of policies. This is characteristic of countries whose policies are very complete and therefore is not needed to be completed by other policies or strategic plan.

Dimension 1: Provision for a reviewing or monitoring process of the policy implementation.
This provision comes in fourth position in respect with its frequency in policy frameworks specific to the education sector (17 countries out of 28). The reviewing or monitoring process may be more or less comprehensive. Only a few countries seem to have a comprehensive system to review all the aspects of the implementation of their HIV/AIDS education policy, South Africa being the best example. Most other countries review only some elements of their response, and limit it to process evaluation (and not to impact analysis or efficiency analysis). It is however encouraging to see that almost three quarters of the countries have some kind of provision for reviewing their policy framework or to monitor its implementation. Capacity-building in this area certainly needs to be strengthened, so that policies will be actually better implemented than they are currently. A better integration of policy level and programming/implementation level seems necessary, A good policy being also a policy that is efficiently implemented.

Dimension 2: Provision to address the impact of the HIV/AIDS on the education system.
Addressing the impact of HIV/AIDS come in sixth position, less than half of the countries having included it (13 countries out of 28). It concerns all aspects related to the management and planning of the education system, to allow it to fulfil its roles and still deliver quality education; despite the burden of the epidemic (for instance one important aspect in regard with the HIV epidemic is to make sure that enough teachers are trained to staff all schools). Almost half of the countries for which we had data have this provision. It appears more frequently in the African countries (9) than in the Asian/Pacific (2) or Latin-American/Caribbean countries (1). Except for two countries for which we could not find such

[17] Botswana, Mozambique, Namibia, Nigeria, South Africa, Uganda, Zambia, Zimbabwe.

provision (Botswana and Tanzania), all the sub-Saharan countries have this provision explicitly integrated in their education policy or strategic plan. This is encouraging because it demonstrates that the governments acknowledge the importance of addressing the impact on the education sector. Concerns may however exist on the capacity and resources available in many affected countries to collect data that are needed to address the impact of HIV/AIDS and plan an effective response. Resources are available at the international level to support affected countries in this endeavour.

Dimension 3: Prevention as a general purpose of HIV/AIDS education
Not surprisingly this is the most common dimension mentioned as an explicit and overall goal and responsibility of the education sector in most policy frameworks (27 out of 28 countries). School children are the main target of school-based prevention, although teachers and school staff are also sometimes mentioned (in these cases, we considered that this represents a form of support to teachers (Dimension 5)). Malaysia is the only country for which we could not find this dimension, but we could consult only secondary sources.

Dimension 4: Recommendations or provision to formally include HIV/AIDS in the curriculum at national level.
This dimension comes second and this is also encouraging (24 out of 28 countries). As we will see below, curriculum status goals and contents may however differ in an important way across the countries under study. Four countries that do not mention this provision in their policy framework either have a weak or still underdeveloped policy framework (India, Malaysia, Colombia, and Haiti). The fifth country (Brazil), on the opposite, has a strong and well developed framework, but a federal political structure that may explain this absence.

Dimension 5: Provide support to teachers and schools staff or teachers training.
Teacher training comes third in term of frequency (23 out of 28 countries). Training teachers well is certainly key to successful implementation of HIV/AIDS education in schools. Other kinds of support are however also crucial for teachers and other school staff, in particular the provision of relevant preventive information and skills, counselling and care services, so that they can protect themselves from getting infected and continue their work when infected. The protection of their rights and fight against discrimination are also important aspects of this support. A stronger institutional legitimacy to teach HIV/AIDS education in particular through HIV/AIDS curriculum development will also help them in their difficult task of providing HIV/AIDS education to their students.

Dimension 6: Inclusion of community resources in school settings.
This dimension comes in the fifth position (15 out of 28 countries). Inputs from the non-formal sector and NGOs may be important resources, in particular at school level, in settings where the education sector is further stretched to (or beyond) its limits to deliver basic education. These inputs often allow innovative approaches to be developed and implemented at local level into the classrooms and the schools as a whole. They can provide a contribution and support to teachers that have to adapt to a new and difficult topic and to new teaching approaches without the necessary training and support. All but three African countries, four Asian countries and one Latin-American country (Brazil) mention community resources in their policy.

Dimension 7: Address stigma or discrimination.
This is the least frequently mentioned dimension to be explicitly included in policy frameworks (12 out of 28 countries). It is however an important dimension, as stigma and discrimination, within a community or at country level, leads to silence and denial. Stigma and discrimination may also hinder the development and implementation of good HIV/AIDS policies and programmes.

Other dimensions: integration of gender in education policy framework
Seven countries, six from the Asia/Pacific region and one from Sub-Saharan Africa, integrate explicitly gender in their education policy framework. These are Cambodia, China, Mongolia, Philippines, Thailand, Vietnam and Mozambique. This result is also a reason for concerns, as gender inequality fuels the epidemic, by putting girls and women at higher risk of getting infected.

3. HIV/AIDS education in the curriculum

This section examines the results and analysis in relation to curricula of primary and secondary schools for selected countries in Sub-Saharan Africa, East Asia/Pacific and Latin America/the Caribbean. Official curriculum documents were not available for all countries and some secondary sources have been used (countries in Italics in Table 3.1). At this stage we did not take into consideration existing teaching and learning material. The findings are reported under the following sub-headings:

- Inclusion of HIV/AIDS in official curriculum
- Approaches employed
- Status of HIV/AIDS in curriculum and time allocation
- Subjects where HIV/AIDS is located
- HIV/AIDS Goals as mentioned in curriculum documents
- Thematic areas of HIV/AIDS in curriculum

It is necessary to note first that curriculum structures and syllabi may differ quite importantly across regions. Some of these documents are more detailed than others, some include all subject areas in one document whereas others provide one document with general goals and a set of documents presenting each a subject area in a separate subject curriculum. In some cases, we did not find the syllabus that should have accompanied the curriculum. Subject areas are labelled differently across countries. Subject areas may be combined under a more general label such as social science, or health education, thus comprising various specific topics to be taught, without always providing all detailed information on those topics. Time allocation in particular is often missing from the documents under review. The relative importance of subjects, particularly in new subjects in the curriculum, a typical example is HIV/AIDS education), is not always accordingly reflected in the curriculum. Finally, the status and other features of a curriculum are often difficult to grasp.

3. 1 Inclusion in the curriculum

Most countries are certainly concerned about the impact of HIV/AIDS and mention HIV/AIDS prevention as being part of the curriculum and a subject that should be taught. HIV/AIDS education is surprisingly mentioned almost as often in the primary curriculum as it is in the secondary curriculum (table 3.1). However, it appears that it is included only during the last years of primary education, when most children are already in their teenage years (not shown in table 3.1). Moreover, HIV/AIDS education is often mentioned in a very general way and it is not always easy to understand from official curricula or secondary sources, how exactly HIV/AIDS education is integrated.

[See in the appendices Table 3. 1 Inclusion of HIV/AIDS in official curriculum]

- Except for six countries (Angola, Lesotho, Mozambique, Nigeria, Tanzania and Zambia), most documents show that the inclusion was done already in the 1990s (data not shown in table 3.1)

- In Sub-Saharan Africa, most countries have included HIV/AIDS in official curriculum at both primary and secondary levels, except for two countries, Angola and Mozambique, which are in the process of reviewing their school curricula and will integrate HIV/AIDS in the course of the review process.

- Two countries have not yet integrated HIV/AIDS in their curriculum in the Asia/Pacific region (Brunei and Myanmar) whereas three other countries are in the process of integrating it (Mongolia, China and Malaysia).

- In the Latin America/Caribbean region, two countries do not have HIV/AIDS education at primary level (Chile and Peru), and one does not have it at both levels (El Salvador).

In large federal states, school curricula are under the responsibility of state or province governments. Therefore, the inclusion of HIV/AIDS education may not be uniform. For instance, in India and China, such education is still missing from the curriculum in many states or provinces. In contrast, in Brazil and Nigeria, national provisions have been made to include HIV/AIDS education in schools of all states. Its actual implementation may however still vary quite importantly over the national territory.

In countries where prevalence is still relatively low compared to Sub-Saharan Africa, and where Islamic and Catholic religions play a strong role in shaping strict society norms in general and in particular school curricula, the integration of HIV/AIDS in the curriculum seem to be slower. These countries appear indeed to be more reluctant to integrate HIV/AIDS education. The content and scope of HIV/AIDS education, once introduced, may as well be influenced negatively by these religious factors.

The inclusion of HIV/AIDS in the curriculum certainly indicates the intention of governments to address HIV/AIDS prevention through the school system. However, HIV/AIDS education is often mentioned in a very general way. Its goals are also very broadly defined and often quite ambitious. Moreover, most of the time, no precise provision is included in the curriculum regarding its implementation. Such situation is worrisome in a context of policy with very ambitious goals, of curriculum that are already overcrowded and teachers already overextending their capacity to teach the existing program. Such situation often results in a poorly implemented curriculum, if implemented at all.

However, countries that did not yet formally include HIV/AIDS in their curricula, may be implementing HIV/AIDS education programs at school level. In other words, lack of inclusion of HIV/AIDS in the curriculum does not necessarily mean total absence of such education.

A last feature observed is that of a specific HIV/AIDS curriculum indicating how to integrate HIV/AIDS education in the existing curriculum, but generally without providing specific time allocation, not revising the actual school curriculum to fully acknowledge the integration of the new subject.

3.2 Goals of HIV/AIDS education as stated in the curriculum for primary and secondary schools

Most countries integrate written HIV/AIDS goals and objectives for HIV/AIDS education in their curricula for both primary and secondary schools (see Table 3.2). The comprehensiveness and relevance of the goals is yet another aspect to be closely looked into.

Both in primary and secondary schools, where we were able to get hold of either the official curricula or syllabi, there are fairly acceptable goals and objectives written in the documents. However, there are some documents in both primary and secondary whose goals and objectives are not observable and not measurable.

[See in the appendices Table 3.2: HIV/AIDS Goals in primary and secondary schools curricula]

- The most common goal to be found in all documents is the need to transmit knowledge that will help learners to protect themselves against HIV/AIDS. Most curricula explicitly make reference to the risk of becoming infected with HIV, thereby mentioning modes of transmission and spread of HIV/AIDS. Some curricula include topics like casual relationships, having sex with workers, the injection of drugs and the sharing of needles (this is found in some documents in Asia). Modes of prevention are also mentioned.

- Both primary and secondary levels curricula take into consideration to some extent the learning level of students. Based on the available curricula and syllabi, there are few countries that have considered students` several learning domains – knowledge, skills and attitudes. Some of these countries (Botswana, Kenya, Lesotho, South Africa, Malawi, Nigeria, and Zimbabwe) follow a coherent learning domains structure and address knowledge, skill and attitudes levels in their curricula for both primary and secondary levels.

- Other curricula and syllabi reviewed which appear not to have taken students into consideration in terms of the level of the learning domain and address only one or another learning domain.

3.3 General approach used

A wide range of literature identifies four main approaches for inclusion of HIV/AIDS education in the curriculum:

1. HIV/AIDS as a *stand-alone subject*, clearly labelled and including all aspects of HIV/AIDS education,
2. HIV/AIDS as integrated in *one main carrier-subject* that will contain most of the material to be learned;
3. HIV/AIDS as a *cross-curricular issue*, integrated in a few subjects clearly defined as containing some specific aspects of HIV/AIDS education, in a complementary and coordinated approach,
4. HIV/AIDS *infused throughout the curriculum*, with, or without any specific mention of HIV/AIDS in specific subject areas, and in general without defining how to provide a comprehensive and coordinated approach of all topics related to HIV/AIDS.

A fifth possibility may also be observed, but is not considered here as a curriculum approach, as it is based *on extra-curricular activities*, that are in general not carried out by school staff,

are not taking place during the school schedule, although they may make use of the school premises. Such activities exist in many countries to substitute for missing curriculum activities or to complement those. The education systems, at different levels (Ministry, provincial direction and schools) tend to have mixed "feelings" towards such activities: on the one hand they complement, or provide what the education system offers or not able to offer, but on the other hand, it is difficult to coordinate and to control the contents of such activities.

[See in the appendices Table 3.3 Approaches employed by Region – primary and secondary levels]

- Available documents (country reports, policies and framework documents and syllabi) show disparity in how the terms are used for these four approaches, claiming for instance that HIV/AIDS is a stand-alone subject infused throughout the curriculum, or that this approach is cross curricular but then HIV/AIDS hardly appears in the syllabi or in any subject specific curricula. This could be a sign of some conceptual confusion. But it may also be in some countries the result of an incremental process of inclusion of HIV/AIDS in the curriculum over the last few years, integrating some instruction on HIV/AIDS at several places, without keeping a clear and general overview. The introduction of life skills education has also contributed to blur the picture in certain cases. In some countries, it may also mean that several approaches are used concurrently: HIV/AIDS in a carrier subject and also infused throughout the curriculum.

- The two main curricula approaches are to include HIV/AIDS in one main carrier subject or to distribute the contents over a few subjects, theoretically in a coordinated manner, to achieve a comprehensive coverage of the subjects. The main carrier approach tends to be more common in the Asia/Pacific and in the Latin-America/ Caribbean regions.

- The stand alone and infused approaches are clearly the less common approach in Sub-Saharan Africa and has not been adopted anywhere in the two other regions.

- Some countries have designed a HIV/AIDS curriculum that is technically not a curriculum and could be confused for a stand-alone approach. However, more of these documents are .either guidelines as to how to integrate and address HIV/AIDS, or provide examples of activities that altogether achieve quite a comprehensive coverage of the subject. More importantly, these documents do not provide time allocation nor clear placement in the official curriculum and cannot be implemented as such in most cases. They may certainly be very useful documents, once formally integrated into the curriculum.

- *Extra curricular approaches* are generally mentioned as a way to complete and supplement the official curriculum. Involvement in various extra-curricular activities may support and stimulate students towards behaviour change when engaged in debates and other activities, either at their schools or within their communities. In some countries, extra curricular activities may represent almost all HIV/AIDS education that children are going to receive. This was the case in Mozambique before the reform of the curriculum.

The rational for supporting infused or "wide" cross curricular approaches is that HIV/AIDS runs across and affects all aspects of life and should therefore be integrated throughout the curriculum. The risk with such an approach is that, responsibility to teach and provide the necessary information and skills to children is diluted and that none actually provides relevant HIV/AIDS education.

It is also relevant to note at this point that the infused approach is generally evaluated as potentially quite ineffective and expensive. Ineffective, because it usually implies that no time

is allocated specifically to HIV/AIDS, and it is therefore easy to skip altogether, or just to forget about it. Such approach also requires an important amount of coordination when several teachers are involved to achieve a comprehensive and coherent coverage. It is also quite expensive, as all teachers need to be trained to be able to address the subject (that is not an easy one), and to answer questions that may also be quite tricky. This issue may also be relevant for cross-curricular approaches that integrate HIV/AIDS in more than a few subjects. An infused approach may however make sense when only one a few teachers are involved in the delivery of the whole school program, as it is often the case at primary level.

The two other approaches also have their draw backs and difficulties. The cross-curricular approach also involves training an important amount of teachers and coordination between the subjects so that coherent coverage is secured. The main carrier subject approach involves the risk of limiting coverage, for instance to scientific and technical aspects when integrated in science subjects. When integrated in social science, the risk is also to see very little time dedicated to HIV/AIDS, the scope of the subject area being so wide and offering so many possibilities to skip several subjects.

Whatever the selected approach is, HIV/AIDS being a relatively new and sensitive subject, most teachers need appropriate training to be equipped with the necessary skills and knowledge. They may need in addition, support from more experienced and specialized resource persons, such as those having being trained in community HIV/AIDS programs.

3.4 Time allocation and status of HIV/AIDS education

Adequate information on time allocation and status is missing from most reviewed documents. Information on assessment of learning outcomes is also very general.

[See in the appendices Table 3.4 Time allocation and status of HIV/AIDS in curriculum in primary and secondary schools]

Time allocation
Little information is provided on the actual time allocation to HIV/AIDS education in the school programme in most countries. All Asia-Pacific countries have not indicated any time allocation and this makes it difficult to quantify and qualify the effectiveness of the inclusion of the content. No adequate information on time allocation to HIV/AIDS education were available except for a few countries in Sub-Saharan Africa (Malawi, Namibia, South Africa, Swaziland, Zimbabwe).

- Time allocation is stipulated or recommended more often in primary schools than in secondary schools especially in Sub-Saharan Africa countries.

- Overall, the average time indicated for HIV/AIDS education among countries was found to be 46 minutes per week for primary school and 50 minutes for secondary school. However, it should be noted that these countries teach HIV/AIDS education integrated within other existing subjects dedicated to many issues and contents, such as social sciences or life skills education (see Table 5). This means that actual time allocated for HIV/AIDS education may very likely be very minimal.

Lack of data may also be the sign that no specific time is allocated to HIV/AIDS. In other words, it is not scheduled. As HIV/AIDS is often just added to an already crowded curriculum, lack of time allocation or too little time allocated is worrisome. Too little allocated time is also important as HIV/AIDS also requires an interactive approach that can hardly be used if only one period is available.

Status of HIV/AIDS education
Many countries for which data were available indicate that HIV/AIDS education is mandatory, but that only few have made it an examinable subject.

- When it is mandatory and examinable, it is *within* a much larger subject area, which reduces the likelihood of being taught and evaluated, or makes teaching very likely to be limited to very basic factual knowledge. As a consequence HIV/AIDS education teaching may be given a low priority in schools.

- The results also indicate that in secondary schools HIV/AIDS education is more often regarded as mandatory than in the primary school.

- Although many countries indicate that HIV/AIDS education is mandatory in schools, the mode of assessment is not clear.

Most countries indicate that HIV/AIDS component is integrated in the school curriculum in one, or several other subject areas. This means that there will be one question or two in the overall assessment of the subject where HIV/AIDS has been incorporated. Many countries also integrated HIV/AIDS in life skills education that is an approach for which assessment processes have not yet been clearly established. Overall, the status of HIV/AIDS education appears to be quite weak and given relatively low weight in the curriculum, in terms of time allocation, mandatory and examinable status.

4. Subjects where HIV/AIDS is located in primary and secondary schools

For this section and the next one, teaching and learning material were also reviewed in addition to curricula and syllabi, in order to have a more detailed and complete information. Labelling may also differ across countries; in particular we considered a wide range of labels under "social science" (Table 4) and included for instance *Social and Development Studies* or *Environmental Studies*).

[See in the appendices Table 4: Subjects where HIV/AIDS is located, at primary and secondary levels]

- The three most common subject areas where HIV/AIDS education has been included, at both levels, are *Life skills education, Physical and health education*, and *Natural science*. Actually, most countries in the Sub-Sahara Africa and Asia/Pacific regions have included HIV/AIDS education in *life skills education*, whereas such approach is not mentioned once in the Latin/American Region.

- *Guidance and Counselling* is not often mentioned in both primary and secondary schools in all countries in the study, except for Botswana and Lesotho, where it is taught in both primary, and secondary schools. These aspects were however often mentioned at the HIV/AIDS policy level (education sector).

- There are other subjects, in particular art subjects, which are not reflected in Table 4, which integrate HIV/AIDS at both school levels: Dramatic arts in secondary school (Nigeria) and in Namibia, Nutrition and Agriculture (carrier subjects) and Arts are taught in primary schools. HIV/AIDS is also integrated in Music in secondary school in the Philippines.

Countries that have adopted a main carrier subject approach have also integrated some elements of HIV/AIDS education in other subject areas. Main carrier subject may be:

- *Population and family life education/orientation* (4 countries at primary level and 6 at secondary level): the most common option for carrier subject, in particular in the Latin America/Caribbean region. This subject is rarely in the other approaches or as a complement to HIV/AIDS education (Lesotho and Brazil). It has been usually designed to also include all issues related to sexual and reproductive health and often existed before the HIV/AIDS epidemic got much attention from schools.
- *Physical and health education* (5 countries at primary levels and 2 at secondary level): most common in the Asia/Pacific and Latin America/Caribbean regions than in Sub-Saharan Africa. Physical and health education is overall the second "favourite" carrier subject
- *Life skills education* (2 countries at primary level and 3 at secondary level)
- *Natural science* (1 country at primary level and 3 at secondary level)
- *Social science* (1 country at primary level)
- *Religious and civic education* (1 country, at secondary level)

Life skills education is considered to be an effective approach as it allows interactive teaching and participatory learning, which may not be the case in other subject areas. Life skills approach is encouraged since it allows a less formal way of talking about HIV and for practicing and modelling skills. However from other studies and field work, [18] it appears that life skills education is an approach that is not yet always well understood in particular in term of pedagogical implications, in particular regarding interactive teaching methodology, participatory leaning processes and adequate time allocation that such approach requires. Interactive teaching and participatory learning may also happen in the Latin American/Caribbean region, but without being labelled "life skills education". The general inclusion of HIV/AIDS education Life skills education may also be somehow donor driven, as this seems to be the approach favoured by most international agencies and other donors.

Integrating HIV/AIDS education under *Health education* may indicate that HIV/AIDS is still considered mainly a health issue. The advantage may be that a sound life skill approach may be more likely to be adopted, but the disadvantage when HIV/AIDS is integrated in health education, or science subjects for the matter, is that the technical aspects of HIV/AIDS may still be too much emphasized and social and moral sides of HIV/AIDS be ignored.

Population and family life education/orientation has been usually developed and implemented before the HIV/AIDS epidemic got much attention from schools, to address mainly issues of sexual and reproductive health. The advantage of such an approach is that contents related to sexuality may be addressed in a more relevant way than most other subject areas could do, but it may also be addressed within a scope that is too limited and focused on sexuality. It is interesting to notice that such an approach has been chosen in countries with strong religious influences on society (Latin American countries and Nigeria and Malaysia in particular). It may represent a way for the school to exert a tight control on the contents of such teaching.

Guidance and counselling seems to be one area where more attention should be drawn by schools. Both students and teachers have expressed a clear need for a place within schools or easily accessible for students and staff where they may receive advice and counselling for choosing safer life options and accessing needed services, such as HIV/AIDS testing, care support or even treatment as those will become more available. Counsellors are needed in schools where HIV/AIDS orphanhood is rapidly increasing and support and comfort from a

[18] IBE (2004)

mediator is needed to replace parents and guardians' support that is missing altogether. Another important emphasis on guidance and counselling is in connection with the training of counsellors. Issues of counselling, support and comfort are not addressed yet in the majority of curriculum or teaching and learning material for HIV/AIDS education.

5. Specific contents and thematic areas of HIV/AIDS education

When looking at Table 5 below, the multitude of concurrent (or parallel) subject areas in which HIV/AIDS education is integrated is impressive. This concurrence may however runs the risk that such integration in multiple subjects will give students fragmented information and eventually incomplete information.

[Table 5: Thematic areas of HIV/AIDS in curriculum at primary and secondary levels]

Content coverage of HIV/AIDS curricula is in the following themes: [19]

- Basic scientific knowledge (all countries)
- Ways of transmission and prevention (all countries)
- Awareness (11 at primary level and 13 at secondary level)
- Care and treatment, including ante retroviral viral therapies (ARV) (10 at primary level and 7 at secondary level)
- Stigma and discrimination (9 at primary level and 7 at secondary level)
- Information on available services (9 at primary level and 7 at secondary level)
- Gender issues (7 at primary level and 5 at secondary level)

The results show that the two most common thematic areas covered in curricula, at both level of education are *basic scientific knowledge* and information on *ways of transmission and prevention.* Basically all countries for which information was available include predominantly basic scientific knowledge and ways of transmission and prevention of transmission of HIV/AIDS. Awareness (of the risks of getting infected) and information on care and treatment are the two areas mentioned next. The topics of stigma and discrimination, information on available services (to get counselling or be tested for instance) are less often included. Gender is the topic less often cited.

Overall, the scope covered by HIV/AIDS education appears to be more complete at both primary and secondary levels in Sub-Saharan Africa than in the two other regions. There is however room for improvement especially for gender issues, awareness, stigma and information on services. More detailed information needs to be collected for the two other regions in order to better evaluate the quality of the scope of HIV/AIDS education.

Basic factual knowledge on the virus as well as on ways of transmission and prevention is certainly needed, but knowledge and awareness alone do not lead to necessary adoption of safer behaviours. It is essential that such knowledge is completed by skills that students must acquire in order to prevent becoming infected with HIV. Similarly, a lecture about AIDS ("Talk and chalk") will not be sufficient to make sure that students develop the complex understanding and skills they will need to avoid becoming infected. It seems also important that HIV/AIDS education includes also all other aspects as well. Stigma and discrimination lead to fear, silence and isolation, and hamper reaction of solidarity towards those affected by the epidemic. Gender inequality and gender related violence are also considered to be fuelling

[19] For some countries learning and teaching material has also been used to be able to provide more detailed information

the epidemic and putting women and girls particularly at risk. These are challenges that have to be addressed by HIV/AIDS curricula.

6. Teacher training

A review of teacher training schemes put in place to respond to HIV/AIDS could not besystematically performed. However, data from a 3-day seminar with teacher trainers and curriculum developers from nine Southern African countries[20] provide a first insight of the challenges and needs to train teacher to deliver relevant HIV/AIDS education.

In all nine countries, teacher training for HIV/AIDS education appears to be insufficient. In some countries HIV and AIDS prevention has been integrated in pre-service teacher training curricula. However, national strategies to integrate pre-service and in-service training seem to be particularly lacking. Among the nine countries of the region, several have no formal in service and pre-service training that has been put into place to train teachers.

- Although reactions from the teachers to the introduction of HIV and AIDS prevention at school are in general positive, it is perceived as challenging: it represents an additional task in an already crowded curriculum, teachers feel ill-prepared to deliver such a sensitive topic. It seems that teachers themselves do not feel that they have the necessary knowledge and skills nor sufficient legitimacy to teach HIV/AIDS education.
- Teachers are exposed to critics from parents and the community and often lack support from school authorities. There are also opinions in some communities that teachers should not teach subjects related to sexuality.
- Lack of commitment from teachers, since HIV and AIDS is not a mandatory subject in itself, has also been mentioned as an additional barrier to teaching HIV/AIDS education.
- Many of the implemented programmes are still in their infancy, and need to be up-scaled and implemented more systematically.
- Linkages between HIV and AIDS curriculum development and teacher training appeared tenuous.

Strong leadership of ministries of education is essential, as well as the assessment, and provision for adequate funding, in order to develop and rapidly implement effective training programs that will reach all teachers in need of HIV and AIDS training.

7. Towards development and better implementation of HIV/AIDS curriculum

The results regarding the integration of HIV/AIDS education in the curriculum could provide a false feeling of achievement: “after all things are not so bad”. It is true that HIV/AIDS education is often mentioned in the official school curricula, and that those state quite ambitious and relevant goals for it.

7.1 Main weaknesses of inclusion of HIV/AIDS in the curriculum

However, on the one hand curricula “only” represent what is intended to achieve, and on the other hand, in the case of HIV/AIDS education in most of the countries under review, existing curricula often remain very general and do not provide the conditions for a strong and effective implementation, as shown by this review:

[20] Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zimbabwe (see bibliography: IBE 2004).

- HIV/AIDS education has been added in an already crowded curriculum, without making room for it.
- Curricular approaches and their pedagogical implications appear to be somewhat blurred.
- HIV/AIDS education is included in wide subject areas, without being specifically scheduled within these subject areas.
- Subject areas including HIV/AIDS education are often mandatory and examinable subject, but no provision are made to make sure that HIV/AIDS education is taught and that learning outcomes are examined meaningfully.
- Or: HIV/AIDS education is included in one technical subject (natural science) area that does not allow a comprehensive coverage.
- Lack of attention to gender issues is also a concern.
- Teaching methodology is not appropriate.
- Too much emphasis is still given to a cognitive approach.
- In particular, life skills education needs to be better understood to be better implemented.
- No time is specifically allocated to it, or much too little time.
- There is no specific and relevant assessment of learning outcomes, including acquired skills.
- Teachers are not adequately trained and supported.
- Teaching and learning material is often not available.

All these weaknesses mean that too often, HIV/AIDS is not taught in a meaningful and relevant manner. It means in particular that some delicate, but crucial issues, may be easily skipped. HIV/AIDS education as such may also be just not taught at all. Such situation should be of great concern for the education community, at international, national and local levels.

HIV/AIDS education has in most cases been added following an incremental process, often donor driven, and "crisis driven" that may explain some of the "unclarity" regarding approach, status and contents of then HIV/AIDS curricula under review.

Moreover, HIV/AIDS education and related curricula have often also been developed in a context of denial and in situations in which some of the necessary teaching contents enter in conflict with local and traditional values. All this, results in HIV/AIDS education that lacks coherence and comprehensiveness.

7.2 Learning from good practice

There is still too little cross-country exchange and learning. Quality of implementation of existing formal HIV and AIDS curricula and effectiveness of teacher training schemes appear problematic and has hardly undergone any evaluation. However, evaluations of preventive education programmes have been carried out, and although they cover mainly experience in developed countries, most of their findings may also be considered valid for developing countries. These findings should definitely be taken into account in order to develop efficient programmes, in particular all those that enter in the category labelled life skills programmes, taking into account constraints specific to local contexts.

It will be worth to look more in details at some countries that have already developed a complete policy framework and have integrated HIV/AIDS education in their curricula at both primary and secondary levels, and with a comprehensive coverage of topics. Countries that are in the process of doing so may also be of interest to other countries, as they may learn about the process of developing such policy framework and curriculum review. Thorough evaluation of the implementation of HIV/AIDS curricula and of its impact on values, attitudes

and behaviours is however still missing. Criteria mentioned in the first section of this review, on what makes a good HIV/AIDS curriculum, represents a good background to develop and review HIV/AIDS education curricula.

Looking at our data, in Africa, the cases of South Africa, Namibia and Botswana may be good examples to be analysed more in detail, as they are quite comprehensive in their approach, although they have followed a different process to develop and implement HIV/AIDS education in school settings. Nigeria could also be of some comparative interest, also for countries outside Africa, in particular because it has to adjust its response to a federal state and to a strong Islamic religious background, at least in certain states. All countries in Africa seem to be moving towards strengthening the role of the education sector in fighting the epidemic.[21] Curriculum review taking place in some countries (such as Mozambique and Angola) should be the occasion for a systematic and coherent inclusion of HIV/AIDS education that takes stock of existing experiences in other countries.

In the Latin American/Caribbean region, Brazil is certainly a good example of a strong and comprehensive response from the education system and the nation as a whole. It is not sure though that other countries from the region may be able to transfer the Brazilian experience so easily, as their religious and cultural contexts are quite different, in particular due to a much greater influence of catholic religion.

In the Asia/Pacific region, Indonesia and the Philippines seem to have developed, at least based on secondary sources available to us at the moment of the study, a response that is quite comprehensive. These are also two countries for which the religious background is very important and could provide some lessons that may be relevant for other countries in the region or having to deal with similar contexts. Cambodia is in the process of developing what could become a very interesting framework and curricula approach and it may be worth also following its progress.

7.3 Steps forwards to developed and better implement HIV/AIDS curriculum

Curriculum development

The fact is that the existence or not of HIV/AIDS education curricula does not tell the whole story of what is actually being implemented and of initiatives and programmes that are not stemming directly from the curriculum in a top-down process, but rather taking their source and growing from the school level, in a bottom-up movement. A double dynamic needs to be created to allow innovation and experimentation at local level, but at the same time, the top-down dynamic and the insertion of HIV/AIDS education is necessary to scale-up and achieve a national coverage of programmes already implemented in some schools and evaluated as being effective and efficient.[22] Curricula also have to provide stronger and stricter provisions to make sure that HIV/AIDS is actually implemented in schools. In particular, assessment of learning outcomes, in terms of knowledge and skills has to be improved. Some research and assessment tools exist and need to further developed and be used more widely.[23] It is finally also necessary to systematically upgrade the training of all teachers involved in the provision of HIV/AIDS education in schools.

[21] In particular in the framework of the initiative "Accelerating the Education Sector Response to HIV/AIDS in Africa in the Context of EFA. Fore more information, see www.schoolsandhealth.org

[22] Braslavsky 2003

[23] For instance see: UNICEF Quality checklist for selecting teaching and learning materials, IBE appraisal criteria, UNAIDS benchmarks. For more details on tools for appraising HIV/AIDS curriculum, see www.unesco.org/education/ibe/ichae

Teacher training
The training of teachers appears indeed to be critical to an effective delivery of HIV/AIDS curriculum, in particular regarding the implementation of interactive and participatory teaching and learning methods. A seminar recently held in the Southern region of Africa brought out a significant point, that teacher training should have three main goals:[24]

(1) HIV/AIDS programmes for teachers to raise their awareness and help them protect themselves,
(2) HIV/AIDS programmes for teachers to teach prevention to their students, including the delivery of life skills education, and
(3) to help teachers to handle new situations created by HIV and AIDS in their communities and to better respond to specific needs of affected learners.The scope and contents of teacher training is generally much more limited than deemed necessary, is not systematic and sometimes even questionable. Its impact on actual delivery of the curriculum in the classroom has not been evaluated.

The training of pre-service teacher and in-service teachers should be systematic. Selection of voluntary teachers, already convinced by the importance of HIV/AIDS education and committed to it should be taken into consideration. However, all teachers should receive enough information and life skills training themselves so that they are able to adopt safer behaviours and be better examples for their students.

Partnerships for HIV and AIDS education
Inputs from the non-formal sector and NGOs often allow approaches to be developed and implemented at local level into the classrooms and the schools as a whole. They can provide a contribution and support to teachers that have to adapt to a new and difficult topic and to new teaching approaches without the necessary training and support.

Such innovative approaches need to be evaluated and tools and resources for their up-scaling, adaptation and generalization, whenever relevant, made available. Collaboration between NGOs and other community initiatives also needs to be improved to better coordinate partnerships between NGOs and ministries of Education, and to better steer interventions in schools. Dialogue is also necessary in order to better integrate and mainstream external resources from NGOs and other funding agencies into a national legitimate framework that addresses short term and longer term development of HIV and AIDS education.

EFA goals and HIV/AIDS education
Concrete and realistic plans for improvement to be discussed, also in regard with quality of education in general and other actions undertaken in the framework of EFA, as HIV/AIDS may undermine progress made until now and/or future progress towards the goals set in Dakar in 2000.

We will mention here only two points in relation to the EFA goals, the provision of relevant life skills to all children and the achievement of full and equal access of girls to schools, and achievement in basic education of good quality. HIV/AIDS may also be seen as an opportunity, using all resources made available for the development of HIV/AIDS education and all the experience accumulated, to implement at a faster pace relevant and effective life skills education programmes. Those are crucial to protect coming generations of teenagers from HIV, but will also provide them with skills that are useful in other areas of life.

[24] IBE 2004

Gender issues are far from being addressed enough in HIV/AIDS curriculum. This issue is important not only as gender inequality represents additional risks of getting infected for girls, and women in general, but also because the epidemic tends to further accentuate the unequal access of girls to education, as they are more likely to stop attending school in order to take care of sick relatives or because of diminishing family resources due to AIDS. Moreover, recent data show that education in itself has become a protective factor against HIV. Young people who finished basic education or have received some secondary education are less likely to become infected. Girls must also have access to this kind of protection that a higher education level provides.

APPENDICES

QUALITY ANALYSIS OF SET OF CURRICULA AND RELATED MATERIAL ON EDUCATION FOR HIV AND AIDS PREVENTION IN SCHOOL SETTINGS

APPENDICES

Appendix A: Countries included in the review

Africa *(n = 18)*

Angola
Benin
Botswana
Cameroon
Ghana
Kenya
Lesotho
Malawi
Mozambique
Namibia
Nigeria
Senegal
South Africa
Swaziland
Tanzania
Uganda
Zambia
Zimbabwe

East Asia and the Pacific *(n=11)*

Brunei
Cambodia
China
India
Indonesia
Malaysia
Mongolia
Myanmar
Philippines
Thailand
Vietnam

Latin America and the Caribbean *(n=7)*

Bahamas
Brazil
Chile
Colombia
El Salvador
Haiti
Peru

Appendix B: Tables

Table 1 HIV/AIDS prevalence, HIV/AIDS knowledge and sexual behaviour of youth, school enrolment (most recent available data)

		HIV/AIDS and SEXUAL BEHAVIORS						Education system [3]				
		HIV/AIDS Prevalence in % end 2001 [1]	HIV/AIDS knowledge [2] % *Female 15-24 who know 3 main ways of protection*			Sexual behaviors [2]		Structure	Primary Education		Secondary Education	
Region	Countries	country estimates amongst 49 y. old	One faithfull uninfected partner	Consistent use of condom	Abstaining from sex	youth reporting to have had sex before age 15 (Female / Male 20-24)	Median Age at first sex (Female / Male 20-24)	Primary / Secondary (years)	Gross enrolment	Gross enrolement of girls	Gross enrolment	Gross enrolement of girls
Sub-Saharan Africa (n=18)	Angola	5.5	n/a	n/a	n/a	n/a	n/a	4/7	74*	69*	18*	16*
	Benin	3.6	n/a	n/a	n/a	15 / 19	17.2 / 17.6	6/7	95	78	n/a	n/a
	Botswana	38.8	76	79	79	n/a	17.4y / na	7/5	108	108	79*	82*
	Cameroon	11.8	51	46	42	26 / 16	16.3 / 17.0	6/7	108***	100***	n/a	n/a
	Ghana	3	74	70	73	10 / 8	17.5 / 19.5	6/6	80	76	36	32
	Kenya	15	75	52	67	17 / 34	17.3 / 16.2	7/5	94*	93*	31*	29*
	Lesotho	31	50	58	38	5y /10y	n/a	7/5	115***	118***	33	36
	Malawi	15	75	66	71	18 / 20	17.1 / 17.7	6/5	49**	n/a	36*	31*
	Mozambique	13	n/a	n/a	n/a	32y / 13y	16.0y / 18.5y	5/7	92	79	12	9
	Namibia	22.5	77	86	n/a	6y/na	18.7y /na	7/5	112	113	62	65
	Nigeria	5.8	na	na	na	21 / 11	18.1 / 19.6	6/6	35	n/a	n/a	n/a
	Senegal	0.5	50	38	33	13y / 7y	18.8y /na	6/7	75	70	18*	14*
	Seychelles	n/a	n/a	n/a	n/a	n/a	n/a	6/5	n/a	n/a	n/a	n/a
	South Africa	20.1	n/a	n/a	78	7 /na	17.8 / na	7/5	111	108	87	91
	Swaziland	33.4	61	63	63	n/a	n/a	7/5	125*	121*	n/a	n/a
	Tanzania	7.8	64	62	62	17 / 14	17.4 / 17. 5	7/6	63*	63*	6*	5*
	Uganda	5	83	68	na	21 / 8	16.7 / 19.4y	7/6	136	129	n/a	n/a
	Zambia	21.5	78	59	79	22 / 32	16.6 / 16.0	7/5	78	76	24*	21*
	Zimbabwe	33.7	73	73	na	5 / 8	18.9 / 19.5	7/6	95	93	44	42
East Asia / the Pacific (n=11)	Brunei	n/a	n/a	n/a	n/a	n/a	n/a	6/7	104	102	82	85
	Cambodia	2.7	64	64	55	3 / na	21.9 / na	6/6	110	103	19	13
	China	0.1	n/a	n/a	n/a	n/a	n/a	5/6	114	114	68	58
	India	0.8	57	59	71	n/a	18/21	5/7	n/a	n/a	n/a	n/a
	Indonesia	0.1	40	23	na	6 / na	20.4 / na	6/6	110	109	57	56
	Malaysia	0.4	n/a	n/a	n/a	n/a	n/a	6/7	98	99	70	74
	Mongolia	0.1	79	77	43	n/a	n/a	4/6	99	101	70	77
	Myanmar	n/a	n/a	n/a	n/a	n/a	n/a	5/6	89	89	39*	38*
	Philippines	0.1	70	54	n/a	2 / na	n/a	6/4	113	113	77	81
	Thailand	1.8	n/a	n/a	n/a	0 / 2y	na / 19y	6/6	95	93	82	80
	Vietnam	0.3	63	60	34	n/a	n/a	5/7	106	102	67	64
Latin America and the Caribbean (n=7)	Bahamas	3.5	n/a	n/a	n/a	n/a	n/a	6/6	n/a	n/a	n/a	n/a
	Brazil	0.7	n/a	n/a	n/a	10y / 34y	18.7y / 16.7y	4/7	155	150	108	114
	Chile	0.3	97	74	n/a	n/a	18.6 / 17.4	4/6	103	101	85	86
	Colombia	0.4	n/a	n/a	n/a	9 / na	18.4 /na	5/6	112	112	70	73
	El Salvador	0.6	n/a	n/a	n/a	10 / na	18.7/ na	6/6	109	107	54	n/a
	Haiti	6.1	55	46	n/a	14 / 34	18.2 /16.7y	6/7	n/a	n/a	n/a	n/a
	Peru	0.4	34	34	n/a	7 / 19	19.6 / na	6/5	127	126	86*	82*

Sources and comments on data:

1) UNAIDS, December 2002
2) DHS data (1998-2001), in UNICEF/UNAIDS/WHO. 2002
   y: year of data collection and/or age range differ from standards
3) Global Education Digest 2003, Comparing Education Statistics Across the World, UNESCO, 2003. Unless otherwise mentioned, 2000/2001 data.
   * : UIS estimate (UNESCO Institute for Statistics 2003)
   ** : most recent data available from 1990
   ***: policy change (introduction of free universal primary education

Table 2.1 : HIV/AIDS policies and strategic plans (national and specific to the education sector)

Region	General HIV/AIDS policy	HIV/AIDS policy and strategic plan specific to the education sector				
	Policy or/and Strategic Plan (level 1)	HIV/AIDS education policy (level 2)	HIV/AIDS strategic plan (level 3)	HIV/AIDS education and strategic plan (levels 2+3)	Comprehensive approach (levels (1+2+3)	No Education HIV/AIDS Policy/ Framework or no data available
Sub-Saharan Africa (n= 18)	(n=18) *Angola* *Benin* Botswana *Cameroon* [1)] Ghana Kenya Lesotho Malawi Mozambique Namibia Nigeria Senegal S. Africa Swaziland Tanzania [1)] Uganda Zambia Zimbabwe	(n=11) Botswana Kenya Lesotho Malawi Namibia Mozambique[2)] Nigeria S. Africa Uganda[2)] Zambia Zimbabwe	(n=13) Botswana Ghana *Kenya* Lesotho Malawi Mozambique Namibia Nigeria Senegal S. Africa Uganda Zambia Zimbabwe	(n=11) Botswana *Kenya* Lesotho Malawi Mozambique[2)] Namibia Nigeria Uganda[2)] S. Africa Zambia Zimbabwe	(n=11) Botswana *Kenya* Lesotho Malawi Mozambique[2)] Namibia Nigeria Uganda[2)] S. Africa Zambia Zimbabwe	*(n=5)* *Angola* *Benin* *Cameroon*[1)] Tanzania [1)] *Swaziland*
East Asia/Pacific (n=11)	(n=10) *Cambodia* *China* [3)] *Indonesia* India [1) 3)] *Malaysia* [4)] *Mongolia* [1) 5)] *Myanmar* *Philippines* [1)] *Thailand* *Vietnam*	(n= 4) *Cambodia* [2)] *China*[3)] *Indonesia* *Vietnam* [2)]	(n=3) *Cambodia* *Indonesia* *Thailand*	(n=2) *Cambodia* [2)] *Indonesia*	(n=2) *Cambodia* [2)] *Indonesia*	*(n=6)* *Brunei* India [1)] *Myanmar* *Mongolia* [1) 5)] *Philippines* [1)] *Vietnam*
Latin America Caribbean (n=7)	(n=7) Bahamas [1)] Brazil Chile Colombia [1) 6)] *El Salvador* Haiti Peru	Brazil Chile [6)]	Brazil *Haiti*	Brazil	Brazil	(n=4) Bahamas [1)] Colombia [1) 6)] *El Salvador* Peru

Sources: Policies and strategic plans, country reports and regional reviews.
NB: For countries in *italics*: secondary sources have been used.

[1)] National policy/strategic plan contains some provisions related to the education system and role and responsibilities of Ministry of education, or provisions are contained in a multi sectorial policy document usually under the leadership of the National AIDS Council
[2)] Education sector policy or/and plan is being developed
[3)] HIV/AIDS policy implemented but only in some states/provinces
[4)] Not yet a policy as such: the Malaysian AIDS Council, a non-governmental organization, has produced the Malaysian AIDS Charter. The Charter covers a range of HIV/AIDS related issues, one of which is school-based education.
[5)] No education policy or strategic plan, but official guidelines and directives provided by the Ministry of Education.
[6)] Policy focuses on sexual and reproductive health, but also includes HIV/AIDS education

Table 2.2 : Level of comprehensiveness of education sector HIV/AIDS policies and plans [1]

Region	8 to 6 dimensions	5 to 4 dimensions	Less than 4 dimensions	No detailed data available
Sub-Saharan Africa (n=18)	(n=9) Botswana Ghana Mozambique Namibia Nigeria S. Africa Uganda Zambia Zimbabwe	(n=5) Kenya Lesotho Malawi Senegal Tanzania		*(n=4)* *Angola* *Benin* *Cameroon Swaziland*
East Asia/Pacific (n=11)	*Cambodia* *Mongolia* *Philippines* Thailand	*China* India *Indonesia* Vietnam	*Malaysia*	*Brunei* *Myanmar*
Latin America Caribbean (n=7)	Brazil		Chile Colombia Haiti *Peru*	*The Bahamas El Salvador*

Sources: National HIV/AIDS policies that includes provisions for the education sector, Education sector policies and strategic plans, country reports and regional reviews.
NB: For countries in *italics*: secondary sources have been used.

[1)] Amongst the ones that have an education specific policy or strategic plan

Table 2.3 : Scope of education sector HIV/AIDS policies and plans

Region	Dim.1: Monitoring process of HIV education policy/plan/ Program	Dim. 2: impact of HIV/AIDS on the education system	Dim. 3: Prevention as a purpose for HIV/AIDS Education	Dim. 4: Inclusion of HIV/AIDS in curriculum	Dim. 5: Support to teachers & education community	Dim. 6: Inclusion of Community resources in school settings	Dim. 7: Stigma and discrimination, Human rights	No detailed data available
Sub-Saharan Africa (n=18)	(n= 12) **all but:** Botswana Tanzania	(n=9) **all but :** Malawi Namibia Senegal Tanzania Zimbabwe	(n=14) **all**	(n=14) **all**	(n=13) **all but:** Malawi	(n=11) **all but :** Kenya Lesotho Senegal	(n=8) Botswana Ghana Malawi Mozambique Namibia Nigeria S. Africa Zimbabwe	*Angola Benin Cameroon Swaziland*
East Asia/Pacific (n=11)	(n= 4) *Cambodia* India *Indonesia Philippines*	(n= 2) *Mongolia* Vietnam	(n= 8) **all but:** *Malaysia*	(n= 7) **all but :** India *Malaysia*	(n= 8) **all but:** *China*	(n=3) India *Philippines* Thailand	(n=4) *Cambodia China Philippines* Thailand	*Brunei Myanmar*
Latin America Caribbean (n=7)	Brazil	Brazil	(n=5) **all**	(n=3) Brazil Colombia Haiti	Brazil *Peru*	Brazil		The Bahamas *El Salvador*

Sources: Policies and strategic plans, country reports and regional reviews.
NB: For countries in *italics*: secondary sources have been used.
No data were available for Angola, Benin, Cameroon, Swaziland, Brunei, Myanmar, Bahamas and El Salvador.

[1)] Amongst the ones that have an education specific policy or strategic plan

Table 3. 1 Inclusion of HIV/AIDS in official curriculum

Region	Primary level	Secondary level	HIV/AIDS not included	In the process of including HIV/AIDS	No detailed data available
Sub-Saharan Africa (n=18)	(n=15) Benin Botswana *Cameroon* Kenya Lesotho Malawi Mozambique *Namibia* Nigeria South Africa Swaziland *Tanzania* *Uganda* Zambia Zimbabwe	(n= 15) Benin Botswana *Cameroon* *Ghana* Kenya Lesotho Malawi *Namibia* Nigeria South Africa Swaziland *Tanzania* *Uganda* Zambia Zimbabwe		**Both levels** *Angola* **Secondary level** Mozambique	**Primary** *Ghana* **Both levels** *Senegal*
East Asia / the Pacific (n=11)	(n= 6) Cambodia India *Indonesia* *Philippines* Thailand Vietnam	(n= 7) *Brunei* Cambodia India *Indonesia* *Philippines* Thailand Vietnam	**Primary level:** *Brunei* Myanmar	**Both levels:** *Mongolia* *China* *Malaysia* **Secondary level**: Myanmar	*Brunei* *Malaysia*
Latin America / Caribbean (n=7)	(n=4) Bahamas Brazil Colombia *Haiti*	(n=5) Brazil Chile Colombia *Haiti* Peru	**Primary level:** Chile Peru El Salvador **Secondary level:** El Salvador		

Sources: official curriculum and syllabi, country reports and regional reviews
NB: For countries in italic secondary sources (country reports and regional reviews) were used

Table 3.2: HIV/AIDS Goals in primary and secondary schools curricula

Region	Goals explicitly mentioned	Goals explicitly mentioned	No goals explicitly mentioned	No goals explicitly mentioned
Sub-Saharan Africa (n=18)	**Primary level** (n=10) Benin Botswana Kenya Lesotho Namibia Nigeria *Senegal* South Africa Zambia Zimbabwe	**Secondary Level** (n=10) Benin Botswana Kenya Lesotho Malawi Namibia Nigeria *Senegal* South Africa Zimbabwe	**Primary** (n=8) Angola* *Cameroon* *Ghana* Malawi Mozambique Swaziland *Tanzania* *Uganda*	**Secondary** (n=9) Angola* *Cameroon* *Ghana* Mozambique* Namibia Swaziland *Tanzania* *Uganda* Zambia
East Asia / the Pacific (n=11)	**Primary** (n=5) Cambodia *Malaysia** Thailand Vietnam Vietnam	**Secondary** (n=9) *Brunei* Cambodia *China** India *Malaysia** *Mongolia* Myanmar* *Philippines* Thailand	**Primary** *China** *Mongolia** *Philippines*	**Secondary** *Indonesia*
Latin America / Caribbean (n=7)	**Primary** Bahamas Brazil	**Secondary** Brazil Chile	**Primary** Colombia *Haiti*	**Secondary** Bahamas Colombia *Haiti* Peru

Sources: official curriculum and syllabi, country reports and regional reviews

NB: For countries in italic secondary sources (country reports and regional reviews) were used

* countries in the process of including HIV/AIDS in their curricula.

Table 3.3 Approaches employed by Region – primary and secondary levels

Region	Stand alone	Main carrier	Cross - curricular	Infused	Extra curricular*	No detailed data available or unclear
Sub-Saharan Africa (n=18)	**Primary** Benin **Secondary** Benin	**Primary** Nigeria South Africa *Uganda* Zambia Zimbabwe **Secondary** *Ghana* Namibia Nigeria South Africa *Uganda* Zimbabwe	**Primary** Angola** Lesotho Malawi Mozambique Namibia Swaziland **Secondary** Angola** Lesotho Malawi Swaziland Zambia	**Primary** Botswana *Kenya* **Secondary** Botswana *Kenya* Mozambique**	**Primary** Botswana Mozambique Namibia South Africa Swaziland *Uganda* Zambia **Secondary** Botswana Mozambique South Africa Swaziland *Uganda*	**Primary** *Ghana* **Both levels** *Cameroon* *Senegal* *Tanzania*
East Asia / the Pacific (n=11)		**Primary** *China*** *Indonesia* *Malaysia* ** Vietnam **Secondary** *Brunei* *China*** *Indonesia* *Myanmar*** Vietnam	**Primary** Cambodia **Secondary** Cambodia *Malaysia*** *Philippines*		**Primary** *Indonesia* **Secondary** *Indonesia*	**Primary** *Philippines* **Both levels** India *Mongolia*** Thailand
Latin America / Caribbean (n=7)		**Primary** Bahamas Chile Colombia **Secondary** Bahamas Chile Colombia Peru	**Primary** Brazil **Secondary** Brazil		**Primary** Bahamas	**Both levels** *Haiti*

Sources: official curriculum and syllabi, country reports and regional reviews

* extra curricular activities are mentioned here only when mentioned in the curriculum framework or by other official documents of MOE as being part of HIV/AIDS education. Extra curricular activities are in general not carried out by school staff, are not taking place during the school schedule, although they may make use of the school premises.

** HIV&AIDS education is in the process of being included in the curriculum

NB: For countries in italic, secondary sources (country reports and regional reviews) were available and used

Table 3.4 Time allocation and status of HIV/AIDS in curriculum at primary and secondary levels

Region	Mandatory [1]	Examinable [2]	Time allocation (in minutes per week)[3]	Data not available
Sub-Saharan Africa (n=18)	**Primary** (n=10) Angola Botswana Lesotho Malawi Namibia Nigeria, South Africa Swaziland Zambia Zimbabwe **Secondary** (n=9) Botswana Lesotho Malawi Namibia Nigeria South Africa Swaziland Zambia Zimbabwe	**Primary** Botswana Lesotho Namibia South Africa Zambia **Secondary** Botswana Namibia Zambia	**Primary** (n=8) Botswana (40) *Ghana* (30) Malawi (80) Namibia (40) South Africa (80) Swaziland (40) Zambia (240) Zimbabwe (30) **Secondary** (n=6) *Ghana* (40) Malawi (80) Namibia (40) South Africa (80) Swaziland (30) Zimbabwe (40)	Benin *Cameroon* Kenya Mozambique *Senegal* *Tanzania* *Uganda*
East Asia / the Pacific (n=11)	**Primary** *Indonesia* *Malaysia* Myanmar **Secondary** *Brunei* *Indonesia* *Malaysia* Vietnam	**Primary** Cambodia **Secondary** *Brunei* Cambodia	**Primary** *Indonesia* (120) **Secondary** *Indonesia* (120)	Cambodia *China* India *Mongolia* *Philippines* Thailand
Latin America / Caribbean (n=7)	**Primary** Chile **Secondary** Brazil Chile			Bahamas Colombia El Salvador *Haiti* Peru

Sources: official curriculum and syllabi, country reports and regional reviews
NB: For countries in italic secondary sources (country reports and regional reviews) were used

[1] "Mandatory" means that the subject in which HIV/AIDS education is included in mandatory, but HIV/AIDS is education is always only one topics among many others included in the subject area.

[2] "Examinable" means that the subject area is examinable, but often HIV/AIDS is not subject to any questions or questions are limited to factual basic knowledge.

[3] Detailed time allocation for HIV/AIDS is not available. Times indicated are total times allocated per week for the main subject area(s) where HIV/AIDS education is included. For instance, for Zambia, 120 minutes per week are for all topics included in Social Sciences, and in Indonesia, time indicated is for Health and Physical Education, but only 40 minutes are for health education, and HIV/AIDS is only one subject of the programme of health education.

Table 4: Subjects where HIV/AIDS is located, at primary and secondary levels

Region	Natural Science	Physical & Health Education	Life Skills	Religious, Moral & Civic Education	Social Studies/ integrated science	Languages	Population & family life education/ orientation	Guidance & Counselling
Sub-Saharan Africa (n=18)	**Primary** Angola Botswana Malawi Nigeria Swaziland **Secondary** (n=5) Benin Botswana Lesotho Nigeria Swaziland *Uganda**	**Primary** (n=7) Lesotho Malawi Nigeria South Africa *Tanzania* *Uganda* Zambia* **Secondary** Lesotho Nigeria S. Africa *Tanzania*	**Primary** (n=15) Angola Botswana *Ghana* Kenya Lesotho Malawi Mozambique Namibia *Senegal* S. Africa Swaziland *Tanzania* *Uganda* Zambia Zimbabwe* **Secondary** (n=14) Angola Botswana *Ghana* Kenya Lesotho Malawi Mozambique Namibia* South Africa Swaziland *Tanzania* *Uganda* Zambia Zimbabwe*	**Primary** (n=7) Angola Benin Botswana Lesotho Namibia Nigeria Swaziland **Secondary** Botswana *Ghana* Namibia	**Primary** Lesotho Malawi Namibia Nigeria Swaziland *Uganda** **Secondary** Benin *Ghana* Nigeria S. Africa Swaziland	**Primary** (n=6) Angola Botswana Namibia Nigeria S. Africa Swaziland **Secondary** Benin Nigeria S. Africa Swaziland	**Primary** Lesotho Nigeria* S. Africa* **Secondary** *Ghana** Nigeria* S. Africa*	**Primary** Botswana Lesotho **Secondary** Lesotho Zimbabwe
East Asia/ the Pacific (n=11)	**Primary** Cambodia *Philippines* **Secondary** *Brunei** Cambodia *Indonesia* *Malaysia* Vietnam	**Primary** (n=7) Cambodia *Indonesia** *Malaysia* *Myanmar* *Philippines* Thailand Vietnam* **Secondary** (n=7) Cambodia *China** India *Indonesia** *Malaysia* *Mongolia* *Philippines*	**Primary**(n=9) Cambodia *China** *Indonesia* *Malaysia* *Mongolia* Myanmar *Philippines* Thailand Vietnam **Secondary**(n=9) Cambodia *China* *Indonesia* *Malaysia* *Mongolia* *Myanmar** *Philippines* Thailand Vietnam	**Secondary** Cambodia Vietnam*		**Primary** Cambodia *Philippines* **Secondary** *Philippines*	**Primary** *Malaysia**	
Latin America / Caribbean (n=7)	**Primary** Chile* **Secondary** Chile* Chile El Salvador	**Primary** Bahamas* Colombia* **Secondary** Colombia Peru		**Secondary** Bahamas Brazil	**Primary** Brazil		**Primary** Colombia* **Secondary** Bahamas* Brazil Columbia* Peru*	

Sources: official curriculum and syllabi, teaching/learning material, country reports and regional reviews

***** main carrier subject as shown in table 3.2

NB: For countries in italic secondary sources (country reports and regional reviews) were used

Table 5: Thematic areas of HIV/AIDS in curriculum at primary and secondary levels

Region / Country	Basic Scientific knowledge	Ways of transmission & prevention	Awareness	Care & Treatment Including ARVs*	Stigma, discrimination solidarity	Information on available services	Gender issues	No data/no detailed information available
Sub-Saharan Africa (n=18)	**Primary** (n=12) Angola Benin Bostwana Kenya Lesotho Mozambique Namibia Nigeria South Africa Swaziland Zambia Zimbabwe	**Primary** (n=11) Angola Benin Bostwana Kenya Lesotho Mozambique Namibia Nigeria South Africa Swaziland Zimbabwe	**Primary** (n=8) Angola Benin Bostwana Kenya Nigeria Swaziland Zambia Zimbabwe	**Primary** (n=9) Angola Benin Bostwana* Kenya Nigeria S. Africa Swaziland Zambia Zimbabwe	**Primary** (n=7) Benin Bostwana Kenya Mozambique South Africa Swaziland Zimbabwe	**Primary** (n=8) Bostwana Kenya Lesotho Mozambique Nigeria Swaziland Zambia Zimbabwe	**Primary** (n=4) Bostwana S. Africa Zambia Zimbabwe	**Primary** *Cameroon* *Ghana* Malawi *Senegal* *Tanzania* *Uganda*
	Secondary (n=10) Angola Benin Bostwana Kenya Lesotho Malawi Nigeria South Africa Swaziland Zimbabwe	**Secondary** (n=10) Angola Benin Bostwana Kenya Lesotho Malawi Nigeria South Africa Swaziland Zimbabwe	**Secondary** (n=7) Benin Bostwana Kenya Malawi Nigeria S. Africa Zimbabwe	**Secondary** (n=6) Benin Kenya Malawi Nigeria South Africa Zimbabwe	**Secondary** Angola Benin Kenya Zimbabwe	**Secondary** n=5) Benin Kenya Malawi Nigeria Zimbabwe	**Secondary** Angola Malawi	**Secondary** *Cameroon* *Ghana* Mozambique Namibia *Senegal* *Tanzania* *Uganda* Zambia
East Asia / the Pacific (n=11)	**Primary** (n=7) Cambodia *China* *Indonesia* *Malaysia* Myanmar Thailand Vietnam	**Primary** (n=7) Cambodia *China* *Indonesia* *Malaysia* Myanmar Thailand Vietnam	**Primary** Cambodia Myanmar	**Primary** Cambodia	**Primary**	**Primary** Cambodia	**Primary** *China* *Malaysia*	**Primary** *Brunei* India *Mongolia* *Philippines*
	Secondary (n=9) *Brunei* Cambodia *China* *Malaysia* *Mongolia* Myanmar *Philippines* Thailand Vietnam	**Secondary** (N=8) *Brunei* Cambodia *Malaysia* *Mongolia* Myanmar *Philippines* Thailand Vietnam	**Secondary** *Brunei* Cambodia Myanmar *Philippines*	**Secondary** Cambodia		**Secondary** *Brunei*	**Secondary** *Mongolia*	**Secondary** India *Indonesia*
Latin America / Caribbean (n=7)	**Primary** Bahamas Brazil	**Primary** Brazil Peru	**Primary** Brazil		**Primary** Brazil			**Primary** Chile Colombia El Salvador *Haiti* Peru
	Secondary Brazil Peru	**Secondary** Brazil Peru	**Secondary** Brazil Peru		**Secondary** Brazil	**Secondary** Brazil	**Secondary** Brazil Peru	**Secondary** Bahamas Chile Colombia El Salvador *Haiti*

Sources: official curriculum and syllabi, teaching/learning material, country reports and regional reviews
NB: For countries in italic secondary sources (country reports and regional reviews) were used

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