A Strategic Approach:
HIV & AIDS and Education

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Acknowledgements

Table of contents

Acronyms

ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
DFID	Department for International Development (UK)
EC	European Commission
EDC	Education Development Center, Inc.
EFA	Education For All
EFA/FTI	Education for All/Fast Track Initiative
EI	Education International
GCE	Global Campaign for Education
GIPA	Greater Involvement of People Living with HIV
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
IEC	Information, Education and Communication
ILO	International Labour Organization
MDG	Millennium Development Goal
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Plan for AIDS Relief
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization

Foreword

A Strategic Approach: HIV & AIDS and Education is an urgent call to all of us to advocate for and support the effective engagement of the education sector in national responses to the AIDS epidemic.

Education is empowering. It facilitates the acquisition and use of knowledge, competencies, attitudes and behaviours that are essential for healthy lifestyles. In addition to supporting learning throughout life, it enhances public accountability, promotes inter-generational dialogue and leads to better use of available services, especially health and social protection.

Education can address the social, cultural and economic conditions that contribute to increased vulnerability; it can also modify the behaviours that create, increase or perpetuate the risk of HIV infection. Well-planned and implemented HIV education is associated with delayed sexual debut, fewer sexual partners and more widespread and consistent use of condoms. It also contributes to an improvement in attitudes toward people living with HIV and can reduce stigma and discrimination.

Much has been learned in the past 25 years about the AIDS epidemic and effective responses. We now know that there are no shortcuts. To ensure true universal access to HIV prevention, treatment, care and support, comprehensive strategies are required that involve rights-based and evidence-informed approaches; the inclusion of affected communities; and attention to the structural and social factors that drive the epidemic, including gender inequality and stigma and discrimination. These strategies require multi-sectoral contributions and balanced attention to prevention, treatment, care and support; in this regard, education is a key platform.

The strategic framework presented in this document speaks to the needs of all of those involved in planning, implementing and assessing the education sector's response to the AIDS epidemic. Based on what is known, it presents priority actions that should be central to all education sector responses to prevent HIV infection and to mitigate the impact of AIDS. It encourages all of us to "know your epidemic" and to tailor our responses to the epidemiological situation — being mindful that the epidemic evolves and that our responses must evolve with it.

As we move forward to implement this strategic approach, it is essential to support the coordination and partnerships required to make an impact and, above all, to scale up and expand our engagement for a sustained universal response to the AIDS epidemic.

Michel Sidibé
Executive Director,
UNAIDS

Executive summary

This document updates the 2003 Joint United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team (IATT) on Education publication, *HIV/AIDS and Education: A Strategic Approach*. It presents a strategic vision of the important role that education must play in addressing HIV, identifies key priorities for responding to HIV and AIDS through education, puts forward two central objectives for education responses, and outlines how the response should be tailored to the local epidemiological situation and other contextual factors.

Countries around the globe are facing very different circumstances, with the AIDS epidemic at differing stages and the educational responses varying in strength. Each country needs to address HIV and AIDS head on, with firm and carefully tailored efforts to avert and limit the consequences of the epidemic. There is substantial evidence that education can play a critical role in the response to HIV and AIDS simply by doing 'more of what it is doing already and doing it better'.

We now have evidence of the important role that education plays in offering protection against HIV. School-going children and young people are less likely to become infected than those who do not attend school, even if HIV and AIDS are not included in the curriculum.

Education reduces the vulnerability of girls, and each year of schooling offers greater protective benefits. Where offered, well-planned and well-implemented education on life skills or sex and HIV has increased knowledge, developed skills, generated positive attitudes and reduced or modified sexual behaviour. Finally, education offers a very cost-effective means of prevention against HIV.

The first line of the response should therefore be to provide more and better schooling. A second and complementary line of response can then be to introduce specific actions tailored to the epidemic, such as providing HIV and sexuality education. In highly-affected settings, educating parents and learners about HIV treatment, care and support should also be prioritised.

The AIDS epidemic has hit many countries and communities harder than was ever expected, and continues to make a devastating impact. While in many places this has led to significant setbacks in economic and social developments, there have been a number of promising responses in some countries. Community and societal mobilisation has grown, and there is much greater political commitment to HIV and AIDS. The focus on universal access has resulted in an impressive scaling up of financing, of programmes and of access to both

prevention and treatment. Many people are finally waking up to the fact that the AIDS epidemic affects everyone.

There are also indications that, in some contexts, efforts at prevention are producing results in terms of behavioural choices, and there is the potential to learn and build on this. As well as offering protection against HIV, we know that education can also play a critical role in supporting and caring for those affected by HIV and AIDS. Yet the education system is also being undermined by the epidemic, as teachers and pupils struggle to cope with the affects of HIV and AIDS. Since Education for All (EFA) is both necessary for addressing HIV and AIDS and threatened by its spread, education must continue to be an important and prominent component of national responses.

At the same time, it is also clear that education cannot on its own bring about the wide-reaching changes needed to stop and to reverse the spread of the epidemic. The key to success lies in combined action. This means working together across sectors and boundaries to influence and change the individual behaviours that spread the disease, while developing environments that make preventive action the preferred behaviour for both individuals and groups.

This publication provides a strategic framework for the critically important role that education must play in addressing HIV and AIDS. It targets decision-makers and practitioners in the education sector as well as colleagues who work on HIV and AIDS responses in other sectors. It can be used as an advocacy tool to build commitment to the role of education in the HIV and AIDS response and to generate multisectoral partnerships for implementation. It presents objectives that are central to all education sector responses to HIV and AIDS, and provides examples of priorities for action in two major areas, namely HIV prevention and the mitigation of impact. It highlights the importance of tailoring the response of the sector to: a) the epidemic dynamics; b) the social, cultural and economic context of the country (taking into account any regional differences); and c) the characteristics of populations at higher risk of exposure to HIV. It also presents some suggested priorities for the education sector in different epidemiological settings.

It is hoped that this document and the practical examples contained in it will guide decision-makers and other stakeholders across countries and contexts in deciding on key priorities and in ensuring that HIV and AIDS are addressed in a comprehensive, mainstreamed and coordinated way.

Introduction

This document briefly outlines what is known, and what needs to be learned, about scaling up education sector responses to the AIDS epidemic

1. Background to this document

This document revises and updates the 2003 United Nations Joint Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team (IATT) on Education publication, *HIV/AIDS and Education: A Strategic Approach*. The publication aims to provide policy-makers in the education field and beyond with a strategic vision of the critically important role that education must play in addressing HIV and AIDS. It can also be used as an advocacy tool to build commitment to the role of education in the HIV and AIDS response and to generate multisectoral partnerships for implementation.[1]

This document briefly outlines what is known, and what needs to be learned, about scaling up education sector responses to the AIDS epidemic. It argues that the education sector response must be an integral part of overall national HIV and AIDS efforts. The document also establishes priority actions. It focuses mainly on school-based learning, although its principles are equally applicable to other learning environments. Finally, it stresses the need to understand the complexity of the changes needed and of the challenges that remain.

2. HIV and AIDS: the situation today

Almost three decades after the first cases were reported, AIDS has developed into one of the most devastating challenges the world has ever faced. Despite some progress in treatment, there is no hope for a cure or vaccine in the near future. As of 2007, 33 million people worldwide are estimated to be living with HIV. Half of them are women and two million are children under 15 years of age. Sub-Saharan Africa remains the most adversely affected region. It is home to 66 per cent of those living with HIV and to nine out of ten children who have lost one or both parents to AIDS. In sub-Saharan Africa, AIDS is the leading cause of death, and almost 60 per cent of adults living with HIV in 2007 were women (UNAIDS, 2008b).

Worldwide, by far the most common means of HIV transmission continues to be unprotected sex with an infected partner.[2] In countries with low or concentrated epidemics (i.e. where HIV prevalence is less than one per cent in the general population), transmission is often linked to unsafe sexual intercourse in the context of sex work or between men, whereas in generalised epidemics (i.e. settings where HIV prevalence in the general adult population is above one per cent), sexual networking in the general epidemic with low and inconsistent condom use is sufficient to sustain the epidemic (although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV). Sharing contaminated syringes and needles for injecting drug use is also a major mode of transmission in many countries. Other transmission routes include: mother-to-child transmission during pregnancy, at birth or through breast milk; and, more and more rarely, the transfusion of infected blood and blood products.

3. Progress in the response

The latest UNAIDS Report on the Global AIDS Epidemic (UNAIDS, 2008b) provided reason for cautious optimism for the first time. The report indicates that the 'six fold increase in financing for HIV programmes in low- and middle-income countries [between] 2001-2007 is beginning to bear fruit, as gains in lowering the number of AIDS deaths and preventing new infections are apparent in many countries' (UNAIDS, 2008b: 3). There is evidence that, globally, HIV prevalence is stabilising,[3] and there are localised reductions in prevalence in some countries. There has also been a reduction in AIDS-related deaths, which is partly due to expanded access to antiretroviral therapy (ART) and to improved coverage of ART for HIV-positive pregnant women, for prevention of mother-to-child transmission of HIV. Recent studies among young people in ten countries in sub-Saharan Africa and the Caribbean demonstrate significant reductions in some forms of sexual behaviour that place people at heightened risk of exposure to HIV (UNAIDS, 2008b: 3).

This progress cannot and should not lead to complacency. The same UNAIDS report cautions that progress remains uneven and that 'the epidemic's future is still uncertain, underscoring the need for intensified action to move towards universal access to HIV prevention, treatment, care and support' (UNAIDS, 2008b: 3). Little is known about what has driven the modest recent gains or whether they can be sustained. Moreover, while some countries have made progress in reducing new infections and containing epidemics, HIV prevalence is growing in many other countries.[4] There are worrying indications of rising incidence of sexually transmitted infections (STIs) and HIV in many countries, including in many high-income countries where the epidemic was believed to be under control. Within countries, shifts in the epidemic's main modes of transmission have also led to increasing HIV prevalence rates among certain population groups, including among young people (UNAIDS, 2008b). The task at hand is, therefore, to ensure a scaled-up and sustained response that builds on lessons learned and identified good practice.

4. A growing effort

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) put forward a framework for national and international accountability in relation to the epidemic. Each government pledged to pursue a series of targets relating to prevention, care, support and treatment, impact alleviation and children orphaned and made vulnerable by HIV and AIDS. There have been substantial and important developments since then. These developments are highlighted below and illustrate an increased awareness of and political commitment to addressing HIV and AIDS globally, regionally and at the country level.

An exponential increase in financial resources available for HIV and AIDS

New funds have been established, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Fund for AIDS Relief (PEPFAR). Philanthropic organizations, including the Bill and Melinda Gates Foundation, have also increased their contributions to the response. Funding in low- and middle-income countries has thus risen from roughly $300 million a year from all sources in the late 1990s (Piot, 2006) to US$10 billion in 2007 (UNAIDS, 2007b). However, funding for HIV prevention (including through school-based interventions) has increased at a slower rate than the resources for treatment, care and support. Moreover, while the overall increase is substantial, funding is still woefully short of what is required for comprehensive programming to move towards universal access to prevention programmes, treatment, care and support.[5]

To meet universal access by 2010

- 1.5 million primary and secondary school teachers need to be trained
- 19 million orphans and vulnerable children need to be supported
- Access to ART needs to quadruple between 2008 and 2010
- 13 million sex workers need to be reached
- Health services must be significantly strengthened
- Social impediments to scale up (such as stigma, social marginalisation and disempowerment of women) must be addressed
- Available financial resources for HIV must quadruple by 2010

Source: UNAIDS, 2007b

Improved access to treatment

The number of people receiving antiretroviral drugs in low- and middle-income countries has increased 10-fold in only six years, reaching almost 3 million people by the end of 2007 (UNAIDS, 2008b). Nevertheless, approximately 70 per cent of those medically eligible for ART in low- and middle-income countries lacked access to the drugs in 2007 (WHO/UNAIDS/ UNICEF, 2008). It has become clear that there are many challenges beyond those of securing additional financing for treatment,[6] not least because of capacity and health system constraints and because the continued roll-out of ART requires a commitment to lifelong treatment with corresponding increases in costs.

Stronger commitment to coordination, harmonisation and alignment

The 'Three Ones' principle – One agreed HIV and AIDS Action Framework, One National AIDS Coordinating Authority, and One agreed country-level Monitoring and Evaluation System (UNAIDS, 2005b), the Paris Declaration on Aid Effectiveness (OECD, 2005), and the establishment of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (UNAIDS, 2005a) all illustrate a growing commitment to coordination, harmonisation and alignment. As a result, some organizations have made significant changes in approaches, staffing and funding mechanisms. However, major organizational and practical challenges remain in this area.

Recognition that approaches need to match the nature of the epidemic

The move to 'know your epidemic' has given rise to a better understanding of the structural drivers of the epidemic (including stigma and discrimination, human rights violations, gender, homophobia and other inequalities) and the development of interventions that focus on providing prevention information, services and support to the people most vulnerable and critical to the dynamics of the epidemic (see UNAIDS, 2007c).

Increasing support for combination prevention

The challenges of finding biomedical solutions, such as vaccines and microbicides to the epidemic, and increased understanding of approaches that have produced promising results, have highlighted the importance of combination prevention (Piot *et al.*, 2008; UNAIDS, 2008a). Combination prevention promotes the simultaneous use of diverse behavioural, biomedical and structural HIV prevention actions and tactics to address the drivers of the epidemic and to reach the groups at higher risk of exposure to HIV. Elements of combination prevention include: information on HIV; access to (male and female) condoms and harm reduction measures; behavioural change such as waiting longer to have sex, being faithful, and reducing multiple partners and concurrent relationships; biomedical strategies such as male circumcision and the prevention of mother-to-child transmission of HIV; treatment of HIV, STIs and other viruses; and attention to social justice, gender and human rights.

Combination prevention strategies recognise that effective HIV responses address both immediate risk contexts and underlying social dynamics that make people vulnerable to HIV. Education, ready access to services and commodities, and social change strategies are all necessary elements of effective HIV prevention programmes.

Source: UNAIDS, 2008a: 15-16

The importance of education

Much has been learned in recent decades about HIV and AIDS, about the drivers of the epidemic, about the role and importance of education, and about the actions that need to be taken

1. What education can do

Access to quality education protects against HIV

Education's contribution to HIV prevention is often understood to mean that the education system needs to do something specific – such as offering HIV and AIDS education – in order to contribute to reducing HIV transmission. However, there is ample evidence that education in itself – even in the absence of HIV-specific interventions – offers an important measure of protection against HIV and AIDS, simply by doing 'more of what it is doing already and doing it better' (Kelly, 2006b:1), in other words by ensuring that children all have access to good quality, equitable education. The Global Campaign for Education (GCE) has estimated that universal primary education would prevent 700,000 new HIV infections each year (GCE, 2004). Good quality education that focuses on empowerment within safe

and protective environments and that creates a circle of support within the community can have a sustained impact on reducing vulnerability and behaviours that create, increase or perpetuate risk. It can do so by: providing information and skills and developing values that allow young people to make healthy decisions about their lives; increasing young people's connectedness and security; and giving them the possibility to make independent choices and to be economically productive (Bankole *et al.*, 2007; Guiella and Madise, 2007; Hogan, 2005; World Bank, 2002; Kelly, 2000).

Therefore the first line of the response should be to provide more and better schooling, through such key interventions as:

■ Ensuring that children have access to learning opportunities from an early age. This means having access to early childhood education, ensuring that children can continue to go to school beyond primary education, and addressing the particular barriers that prevent girls from going to school.

■ Developing and implementing good quality curricula that are relevant to individual and societal needs and to the local context.

■ Improving teacher training and support to enhance delivery of basic education and to foster gender-responsive teaching.

■ Removing financial barriers to education i.e. through the elimination of school fees and reducing hidden costs (e.g. books and uniforms).[7]

■ Improving the school environment to make schools safe and supportive.

■ Strengthening management and supervision.

■ Developing a strong working relationship between schools and communities.

A second and complementary line of response can then be to introduce specific actions tailored to the reality of the epidemic, such as providing HIV and sexuality education, and, in generalised and hyper-endemic settings, involving the school in educating parents and learners about HIV treatment, care and support. The following section reviews key evidence on what education can do and considers the particular role of schools in this respect.

Education can reach large numbers of children and young people

In the majority of countries, children between the ages of five and thirteen from diverse backgrounds spend time in school, and most young people will have at least some years of schooling. Schools offer the advantage of being able to reach children in their formative years, influencing their attitudes and future behaviours. In highly-affected countries and settings, schools can also play an important role as centres of care and support for those infected with HIV and affected by HIV and AIDS (UNICEF *et al.,* 2003; UNESCO, 2008d; Media in Education Trust, 2006; Ministers of Education of East and Southern Africa, 2005).

Education reduces the vulnerability of girls in very important ways

Education offers important protection from HIV infection to girls in particular. Education appears to play this role by building young women's self-esteem and capacity to act on HIV prevention messages, improving their economic prospects, influencing the power balance in relationships, and affecting their social and sexual networks (Hargreaves and Boler, 2006). This underscores the importance of ensuring that countries meet their EFA goals and that particular attention is paid to the factors that prevent girls from participating in education.

The higher the level of education, the greater the benefits

There is a clear link between school attendance and higher levels of education and later sexual debut. Studies have shown that girls who have completed secondary education have a lower risk of HIV infection and practice safer sex than girls who have only finished primary education (Hargreaves and Boler, 2006). This underscores the importance of putting in place strategies that ensure that young people, and particularly girls, have access to all levels of education.

Education can reach those who are not in school

Education can reach those who are out of school by partnering with local stakeholders and organizations to offer access to learning opportunities. The involvement of communities in the management of schools and in decisions around the HIV response can be very instrumental in ensuring that young people who do not go to school are also reached. The active participation of young people in designing and implementing such interventions is essential.

HIV and AIDS education impacts on HIV-related knowledge, skills and behaviour

Well-planned and implemented life skills or sex and HIV education interventions, even when provided for short periods, have been found to: increase knowledge; develop skills (i.e. self efficacy to refuse sex and obtain male and female condoms) and positive attitudes required to change risk behaviours (such as values about sex and pressuring someone to have sex); and reduce sexual risk behaviours among the sexually active (Bankole *et al.*, 2007; Paul-Ebhohimhen, Poobalan, van Teijlingen, 2008; Gallant and Maticka-Tyndale, 2004; Magnussen, Ehri, Ejere and Jolly, 2004; Speizer, Magnani and Colvin, 2003; Kirby, Laris and Rolleri, 2005; Kirby, Obasi and Laris, 2006). HIV and AIDS education reduces the risk of HIV by delaying the age of first sexual encounter, increasing male and female condom use, reducing the number of sexual partners among those already sexually active, promoting the early treatment of STIs, facilitating access to confidential and voluntary counselling and testing (VCT), and reducing other behaviours that increase risk such as drug use, in particular injecting drug use.

Education can reduce stigma and discrimination

A review of HIV and AIDS interventions in schools in Africa has confirmed the potential of education to bring about an improvement in attitudes towards people living with HIV. The review found attitudinal changes in all programmes where they were measured, with school students showing greater acceptance of people living with HIV or AIDS regardless of the programme form, duration, content or target population (Gallant and Maticka-Tyndale, 2004).

Education provides a very cost-effective means of HIV prevention

By ensuring access to quality education for all, countries can avoid escalating health-care, social and economic costs associated with rising HIV prevalence and AIDS-related impact (World Bank, 2002). Experience has shown that schools can be central to the HIV response, playing a critical role in four important and related ways, namely by:

❶ Implementing and monitoring policies that address HIV and AIDS issues at the school level, involving teachers, education staff and students – in particular those who are infected or affected by HIV and AIDS.

❷ Providing HIV- and AIDS-related knowledge and skills to all children and young people, especially those who are most vulnerable and most at risk, both in and out of school.

❸ Supporting activities that reduce overall vulnerability to HIV, for example, by ensuring learning environments that are enabling and protective, and by reaching out to those most vulnerable or most at risk such as: girls; young people who use drugs; young migrants, asylum seekers, refugees, and internally displaced persons; and young people whose economic circumstances cause them to exchange sex for money, drugs or material benefits.

❹ Linking young people, teachers and education staff to relevant social support and health services to ensure their psychosocial and physical well-being and development.

2. Achievements

Recent years have seen increasing efforts on the part of stakeholders in the education sector to protect individuals and communities from HIV and AIDS. Key achievements include:

■ Increased understanding and commitment to the importance of strengthening education's 'first line of response' to the pandemic, namely addressing HIV and AIDS by doing more of what education systems are supposed to do and doing it better. This includes efforts to enlarge the provision of education, to increase girls' enrolment, to improve transition rates from primary and secondary and to improve the quality of education.

■ Continued development of education sector policies and strategies. A substantial number of countries have now finalised, or are in the process of finalising, HIV and AIDS policies and strategies for the education sector,[8] and an increasing number of countries now also have specific workplace policies that address HIV and AIDS.

■ Increased commitment to the importance of joint funding and coordinated sector action at the country level through, for example, sector wide approaches (SWAps), United Nations Development Assistance Frameworks (UNDAFs), and EFA Fast Track Initiative (FTI) support for education sector plans. The establishment of coordination structures for HIV and AIDS within education ministries,[9] with a specific role in supporting the identification of priorities, has also facilitated responses and supported monitoring and evaluation.

■ Development of approaches for the integration of gender-responsive HIV- and AIDS-related content and life skills (including addressing multiple and concurrent partners, transactional sex, intergenerational sex and drug use) into curricula and teacher training. According to the 2004 Education Sector HIV/AIDS Global Readiness Survey (UNAIDS IATT on Education, 2005), 55 out of 71 participating countries reported addressing HIV in the curriculum at the primary level, and 62 countries at the secondary level. Important challenges remain in implementation (see next section) and coverage. A recent report from the Guttmacher Institute (Biddlecom *et al.*, 2007), presenting information collected among young people across Africa, highlights that, while the large majority of teenagers think it is important for sexuality education to be taught in schools, at best less than half of adolescents receive any school-based education of this kind.

■ Increased recognition of the importance of holistic school-based approaches. These approaches link teaching and learning about HIV-related information and life skills, with child protection issues and care and support services for pupils and staff infected with and/or affected by HIV in a coordinated manner (UNESCO, 2008d and 2008f; Media in Education Trust, 2006; UNICEF *et al.*, 2003). Countries are increasingly including comprehensive school health and nutrition frameworks in national education policies and plans for HIV and AIDS and for life skills-based education (see Jukes, Drake, and Bundy, 2007; UNESCO, UNICEF, and World Bank, 2000; and UNICEF *et al.*, 2003).

■ Expanded efforts to address the HIV-related prevention, treatment and care needs of teachers and education staff and to ensure their involvement in the response. Teachers' unions, for example in East and Southern Africa, have played a key role in providing in-service training on prevention to members; producing information, education and communication (IEC) materials; and developing workplace policies that also address HIV and AIDS (UNESCO and EI, 2007). In highly-affected countries, HIV-positive teachers' networks, groups and associations have been established to provide support for teachers by teachers. In this context, a number of countries (e.g. Kenya, Malawi, Tanzania and Uganda) have seen important increases in the number of teachers willing to disclose their HIV status, to lobby for their rights and to address stigma and discrimination (World Bank, 2008).

EFA commitments with respect to HIV and AIDS

At the Sixth Meeting of the High-Level Group on EFA, ministers, heads and top officials of multilateral and bilateral agencies and leaders of civil society organizations committed to:

- Linking education sector planning with commitments to achieving universal access, care, treatment and support by 2010.

- Reducing stigma and discrimination.

- Addressing the impact of HIV and AIDS on the education sector.

- Adopting anti-discriminatory workplace policies.

- Developing and strengthening life skills education to promote awareness of HIV and AIDS.

- Ensuring orphans and vulnerable children have access to, and complete, quality basic education.

- Ensuring access to care and support and treatment for teachers and staff.

- Fostering comprehensive education responses through cross-sectoral partnerships.

Source: UNESCO, 2006

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3. On-going challenges

The progress highlighted in the previous section testifies to the scope and scale of efforts that are being made within the education sector. Nevertheless, the AIDS epidemic continues to pose serious challenges, undermining broad progress in development and in poverty reduction, threatening basic human rights and seriously affecting the prospects of attaining the Millennium Development Goals (MDGs) and the EFA goals. Interventions aimed at addressing the pandemic need to take account of these challenges, as well as of opportunities in the sector. The most important of these are summarised below:

■ Globally, enrolment in education is expected to increase by 34 per cent (or 32 million students) between 2000 and 2015. This increase represents an opportunity to extend more and better schooling to all children, and to introduce HIV prevention and support activities to a substantial number of children and young people. And it is also a challenge since, by 2010, it is expected that 10 per cent of all children in school will be orphaned by conflict, by AIDS or by other diseases (Fredriksen, 2005).[10]

■ UNAIDS estimates that young people between 15 and 24 years of age account for 45 per cent of all new HIV infections (UNAIDS, 2008b), justifying enhanced efforts to prevent infection among young people both in and out of school. Experience has demonstrated that diversified approaches are required to address the behaviours that drive the disease in a given context (UNAIDS, 2006a).

■ Overall, knowledge levels related to HIV are low, and young females are less likely than young males to have an accurate, comprehensive knowledge. Only 30 per cent of males and 19 per cent of females aged 15-24 in developing countries have comprehensive and correct knowledge about HIV and how to avoid transmission (UNICEF, 2008).

■ Girls and young women remain disproportionately vulnerable to HIV infection. In sub-Saharan Africa, 75 per cent of young people (aged 15-24) living with HIV in 2007 were female (UNAIDS/WHO unpublished estimates in UNICEF, 2008; see also UNAIDS, 2008b). The proportion of women living with HIV is growing in almost all regions of the world, including Latin America and the Caribbean, Asia and Eastern Europe (UNAIDS, 2007a). Actions to address gender and power dynamics within education and prevention approaches are therefore crucial in containing the spread of the epidemic.

■ The number of children orphaned by AIDS continues to increase. In 2007, the number of children who have lost their parents to AIDS in sub-Saharan Africa alone was estimated to be nearly 12 million (UNICEF, 2008; UNAIDS, 2008b, Annex 1). While all orphans are vulnerable to HIV infection due to a weakened family 'safety net', orphaned girls tend to be more vulnerable to exploitation of all kinds (including, for example, child labour and sexual exploitation) (UNAIDS IATT on Education, 2004).

■ Growing numbers of children living with HIV are in need of care, support, social protection and continuing education that take into account these children's additional needs for treatment literacy, positive prevention messaging and the elimination of stigma and discrimination (UNICEF, 2008; UNESCO, 2008i).

■ The epidemic is undermining institutional capacity to protect the health and development of children and young people. Recent studies in sub-Saharan Africa show that HIV affects teacher turnover rates and puts severe strain on the management of education systems (Badcock-Walters *et al.*, 2003; Grant, Gorgens and Kinghorn, 2004; Risley and Bundy, 2007).

■ Even where curriculum approaches are in place, there is still little evidence that these are implemented fully and consistently, and that they are being delivered by teachers who have been adequately trained, or associated with learning outcomes that measure knowledge and impact.[11] In many settings, curriculum content is still too general or too technical to address the specific drivers of the epidemic or to promote behaviour change.

■ There are still too many isolated interventions and partners working outside common frameworks, as well as difficulties accessing predictable and sustainable funding (UNAIDS IATT on Education, 2008a and 2008b, UNESCO 2008d; Clarke, 2008). In this context, it is important to note that education systems, and the partners involved, could still make significant progress in improved monitoring and evaluation of the impact of interventions and in ensuring that approaches are evidence-based.

4. Key principles for an effective education response

Recognising the importance of education and the challenges faced by the sector are the first steps to identifying priority actions. The following section puts forward ten key principles shown to be critical to the education sector response to HIV and AIDS.[12]
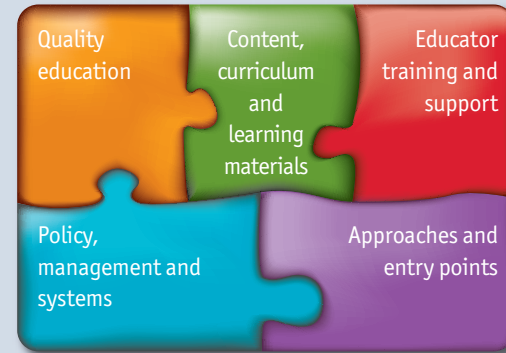
❶ Ensuring education is accessible, inclusive and of good quality

The young people who are most at risk of HIV infection are often those who are not currently in school. Therefore, an important thrust of the response to HIV and AIDS must be to ensure that all children and young people have access to and can complete a full cycle of basic, high-quality education and that they have realistic opportunities for continuing on to secondary education. Specific actions will be needed to address the economic and social barriers that prevent girls from going to school and from progressing through the system, such as: maintaining separate sanitation facilities for girls and boys; providing scholarships and other incentives such as school uniforms and school feeding programmes; and increasing the number of female teachers, managers and decision-makers to act as role models. In this context, all efforts must be made to guarantee that educational environments are safe settings that promote equality, tolerance and respect, justice and dignity. Ensuring that national plans and education systems give priority to achieving EFA goals is critical.

❷ Adopting a comprehensive education sector approach

HIV and AIDS can only be adequately addressed through a multisectoral, comprehensive approach that promotes and protects human rights, such as the approach advocated by the UNAIDS initiative EDUCAIDS, led by UNESCO, which is applicable across educational settings and which is illustrated in the figure on this page (UNESCO, 2008b and 2008c). This will require context-tailored attention to prevention, care and support (including access to treatment), impact mitigation, workplace issues and management of the response. Teachers' rights and needs must also be addressed, and legislation and administrative rules adopted and enforced to combat stigma and discrimination against learners and staff.

Towards a comprehensive education sector response: EDUCAIDS components

| Quality education | Content, curriculum and learning materials | Educator training and support |
| Policy, management and systems | | Approaches and entry points |

Source: UNESCO, 2008b

❸ Mainstreaming HIV and AIDS into the education system

Mainstreaming ensures that addressing HIV and AIDS is not an add-on or isolated activity but an integral part of education sector policy, strategies, curricula, actions and monitoring and evaluation efforts. It also means that HIV and AIDS should not be seen as a separate issue, but as part of overall educational plans and priorities, including those related to life skills, social skills, health and nutrition. Mainstreaming should be a joint effort with teachers' organizations and other key stakeholders including the health sector and the National AIDS Programme (UNAIDS IATT on Education, 2008b).

4. Adapting to the context and characteristics of the epidemic

Education sector interventions need to consider the context of (and within) countries, taking into account differences between districts and regions, between rural and urban areas, and between population characteristics (such as vulnerable or displaced groups). Social, economic, cultural and political factors affect the spread of the epidemic and its impact and will thus require a periodic assessment. These contextual factors must guide the strategic response to the AIDS epidemic in each country. This issue is discussed more comprehensively in the section, *Getting the balance right*.

5. Involving key stakeholders

For policies and programmes to be successful, it is essential that the concerns and experiences of key stakeholders are comprehensively taken into account in the design and implementation of interventions. This includes in particular young people, people living with HIV, teachers, administrators, parents and community leaders (UNESCO, 2008e).

The involvement of young people is essential. Planning must take into account the complex social settings in which children and adolescents live. Interventions must incorporate the knowledge, experience and concerns of children and adolescents, which can only be achieved through their active participation in planning and implementation. The Greater Involvement of People Living with HIV (GIPA) at all levels of the response – and in particular of young people living with HIV – is similarly critical. Their involvement is important for addressing stigma and discrimination, as well as dispelling myths and misconceptions. It is also critical for ensuring that those living with HIV are equal partners in the very process that should support them and aim to meet their needs.

Involving teachers, as one of society's most valuable assets, is also key. Good quality education, as well as effective education about sex, relationships and HIV & AIDS requires a meaningful investment in their professional development and a space for teachers to voice their concerns.

Finally, it is also vital to recognise and support the role of the family and the community and to place HIV and AIDS within the range of their broader concerns such as employment, land ownership, violence, gender issues and drug use. Community resistance should not be assumed. Community members, including parents and religious leaders, are often keen to be informed and involved, and there is evidence that community-based initiatives involving key stakeholders can overcome opposition or resistance to HIV and AIDS education (Adamchak, 2005; ActionAid, 2003; Rosen, Murray and Moore, 2004; Mturi and Hennink, 2005; Greene *et al.*, 2002; UNAIDS IATT on Young People, 2008).

6. Recognising the right to know, to do, to be and to live together

The right to know means that education should include access to a full range of information and resources that will enable young people to know how to protect themselves and others from infection. Contrary to what policy-makers, parents and communities at times wish to believe, many young people are sexually active from their mid teenage years onwards – with the peak vulnerable years being the ages of 15-24.[13] Early interventions, starting at the primary level of schooling (and before onset of adolescence or dropping out of school), are therefore critical and potentially life-saving.

Education must comprehensively cover such issues as relationships and sexual networks (including same-sex sexual relations), reproductive health and rights, male and female condoms, drug abuse, male circumcision, and mother-to-child transmission of HIV. Education needs to develop young people's skills and value systems to guide them to make informed positive decisions, independent of peer and social pressures, on issues such as having sex, using drugs, or undertaking other high-risk behaviours.

Finally, learning to live together includes expressing positive and inclusive attitudes towards people living with HIV, towards people most vulnerable to HIV infection, and other affected groups. Education ministries have a responsibility to ensure that the right to know, and the support for attitudinal and behavioural choices, are understood and respected throughout the education sector by key stakeholders, parents and community/religious leaders.

8 Implementing programmes that are coordinated, to scale, harmonised and aligned

Piecemeal and short-term efforts, well-intentioned as they may be, will not suffice. National education sector plans and strategies for combating poverty and for addressing HIV and AIDS must constitute the basis for all HIV and AIDS interventions in education. Actions should fall within the 'Three Ones' principle (UNAIDS, 2005b). Harmonisation among cooperation partners to implement common arrangements, simplify procedures and reduce transaction costs should also be an important priority. Leadership, advocacy and broad participation are essential.

HIV and AIDS interventions in the education sector need strong coordination and partnership with other sectors and stakeholders. Mechanisms to ensure communication and dialogue between stakeholders in the education sector and those outside need to be in place and monitored. As part of coordination efforts, the education sector needs to collaborate and create school-community partnerships to: address stigma and discrimination; build livelihood and employment skills; and facilitate access to services including youth-friendly confidential VCT, early and effective diagnosis and treatment of STIs, reproductive health services, and prevention and treatment of substance abuse. Where such services and facilities do not yet exist, efforts should be made to create them with the active involvement of other partners and of young people themselves.

7 Reaching all learners, both in and out of school

In many countries, the majority of children and young people who are most at risk, and therefore most need to learn about HIV prevention, have never been to school or are no longer in school (UNESCO, 2008). This underlines the importance of addressing vulnerabilities at early levels in school-based interventions, but also the importance of efforts to reach out-of-school youth. The boundaries between formal and non-formal systems of education can be blurred, particularly where community education is the norm. Ministries of education and national authorities, therefore, play a critical role in developing and supporting non-formal education on HIV and AIDS, as do youth service organizations. In this context, HIV prevention among young people must take a broad outreach approach to ensure information, resources and services are available in places, at times, and in formats appropriate for young people out of school. For those already engaging in high-risk behaviours (i.e. multiple sexual partnerships including concurrent relationships, intergenerational sex, unprotected male-to-male sex, sex work or injecting drug use), additional and more targeted responses are required, in coordination with other service providers.

In many countries, the majority of children and young people who are most at risk, and therefore most need to learn about HIV prevention, have never been to school or are no longer in school

9 Enhancing awareness and commitment and strengthening the capacity to respond

Advocacy is essential to gaining commitment from all stakeholders, and in particular from senior decision-makers who play a pivotal role in moving the response forward and in overcoming resistance. Advocacy needs to take place both within the sector to support the mainstreaming of HIV and AIDS in the education response, and with external stakeholders to ensure the centrality of education in the national response to HIV and AIDS and to generate key partnerships for the response (UNESCO and EDC, 2005). Awareness-raising needs to go hand-in-hand with capacity-building and organizational strengthening of ministries, teachers' unions, teacher training colleges and other organizations to ensure that human and financial resources are in place to address HIV and AIDS.

10 Informing decision-making and action with evidence

Recent years have seen increased activity around HIV prevention, treatment, care and support, but there has also been a proliferation of approaches. It is vital that the scarce resources for HIV and AIDS should be used effectively and that solid evidence should be collected to guide decision-making on which specific approaches, strategies, and messages to scale up. Ministries of education need to be equipped to monitor and assess impact and to ensure that decision-making is informed by successful practices. All stakeholders must commit to advancing the evidence base on HIV & AIDS and education and to ensuring that lessons from research and practice inform policy reform and decision-making.

The Accelerate Initiative

In 2002, the IATT established a working group with the specific objective of accelerating the education sector response to HIV and AIDS. The working group identified sectoral leadership, information sharing, capacity building and coordination as key areas for support and has put in place sub-regional and national workshops to address these needs. Between November 2002 and 2007, education teams from 29 countries in Africa sought the assistance of the working group.

A Strategic Framework

This strategic framework identifies a series of key priorities for responding to HIV and AIDS within the education sector, with a particular focus on reaching children and young people through school-based efforts and supporting those who educate them. It speaks to the needs of all of those involved in planning, implementing and evaluating the education sector's response to the epidemic.

1. Objectives

This strategic framework puts forward two key sets of objectives that should be central to all education sector responses to HIV and AIDS. The balance between these objectives will be a function of the specific epidemic dynamics and social context of the country (see section, *Getting the balance right*). The first set of objectives is concerned with the prevention of HIV infection and requires the simultaneous reduction of contextual and societal vulnerability, and of individual risk-taking. The second set of objectives addresses the mitigation of the impact of HIV and AIDS, which is particularly important in generalised and hyper-endemic epidemic scenarios where educational processes and systems face considerable challenges.

Suggestions for general and specific priorities pertaining to each objective are outlined below. The final section (*Getting the balance right*) translates these priorities into suggested actions for different epidemiological scenarios.

Objective 1:
Prevention

Much progress has been made by governments in scaling up responses to ensure universal access to HIV prevention programmes, treatment, care and support by 2010. In particular, access to treatment has expanded rapidly. However, HIV prevention efforts are not keeping pace[14] and need to play a much more prominent role in HIV and AIDS approaches. There is still a low uptake of HIV and AIDS education in certain countries and regions – including in many countries in Asia.

All HIV prevention efforts must adhere to the premise of promoting, protecting and respecting human rights, including gender equality. Two key elements need to be addressed, namely:

■ The social, cultural, economic and political conditions that contribute to increased vulnerability, and

■ The reduction of individual risk.

Both are based on the premise that information is necessary, but that knowledge alone is not sufficient to protect young people against HIV infection or to reduce stigma and discrimination. Education must provide information and build skills for informed decision-making, as well as facilitating access to essential services. The following section outlines the role that education must play in doing both.

Vulnerability reduction: protection and empowerment

Vulnerability occurs when 'people are limited in their abilities to make and effect free and informed decisions' (UNICEF, 2000). The factors listed in the text box on this page all affect the degree to which individuals and communities are vulnerable.

Singly, or in combination, these factors render some groups systematically more vulnerable to HIV than others. These groups will vary by country and within countries, but often include children and young people living in extreme poverty; girls and women; children and young people exploited sexually, economically or in other ways; children and young people discriminated against and marginalised on grounds of gender, ethnicity, sexuality, disability and HIV status; young migrants, refugees and asylum seekers; young men who have sex with men (MSM); and young people who use drugs. (See also UNAIDS Inter-Agency Working Group on HIV/AIDS, Schools and Education, 2001). During conflict, several factors contribute to increased HIV vulnerability, particularly of women, girls and young people. These include loss of livelihoods and lack of access to basic services; increased sexual violence against women and girls; breakdown of social networks and institutions that usually provide support and regulate behaviour; disruption of health and education services reducing access to HIV prevention commodities, information and HIV-related treatment and care (UNESCO and UNHCR, 2007).

HIV- and AIDS-related vulnerabilities are present in the majority of schools and educational settings, as well as in communities. This includes physical, psychological and gender-based violence perpetuated by teachers and other school staff and that between students both in and outside of the school setting (Pinheiro, 2006). Girls are often disproportionately affected and at risk of gender-based violence (Clarke, 2008; Jukes, Simmons, Bundy, 2008; USAID, 2003; see also text box, next page).

Factors that impact on vulnerability

- Lack of political will and commitment to addressing HIV
- Poverty and inequalities
- Stigma and discrimination
- Access to good quality education
- Access to basic health and social services
- Gender roles and expectations
- Social and cultural marginalisation
- Living with a disability
- Violence and conflict
- Family breakdown and community/social disintegration

Gender-based violence in the school setting

Recent research in more than ten countries in Africa and Asia found that the violence faced in and around schools was a significant factor in forcing girls out of the education system and included:

- sexual harassment in the school environment;
- corporal punishment and public shaming by school authorities and teachers;
- patriarchal practices, cultures and traditions, such as early marriage;
- the exclusion of married and/or pregnant girls and young women;
- fear of and actual violence on the route to school;
- poverty leading to vulnerability, to trafficking and transactional sex, especially with older men;
- excessive household burdens and child labour.

Source: ActionAid, 2007

It is clear that efforts in HIV education and prevention will work best where schools are safe places for learning. Bullying, violence, harassment, discrimination and sexual abuse must be recognised in schools, and appropriate steps taken to remedy them. Training and measures to ensure a supportive, safe and healthy working and learning environment – including the implementation of codes of conduct to define and ensure respect for ethical behaviour among staff and students – can be powerful tools. Involving parents and communities is essential to ensuring that these measures are taken seriously and enforced.

Similarly, efforts are required to address risk-taking and vulnerability of educators and other education sector staff. It is critical that pre- and in-service training of teachers equips them with knowledge and skills on HIV prevention and that they are professionally and institutionally supported when instructing about sex, drugs and health. This includes ensuring that teachers gain the skills to promote participatory and peer-based, cultural, gender-sensitive and rights-based approaches to HIV and AIDS within the relevant developmental and socio-economic contexts (see text box, next page).

By acting swiftly to provide needed services, countries and communities will reap benefits not only for HIV- and AIDS-related vulnerability, but also for a range of other health and development concerns

The central role of teachers in prevention

The World Health Organization (WHO), Education International (EI) and the Education Development Center (EDC) have produced a widely-used skills-building resource for teachers used by teachers' unions around the world as part of the EFAIDS programme. This combines efforts to ensure EFA goals are reached and also aims at equipping teachers and education systems with the means to address HIV and AIDS.

This book is based on the premise that teachers need to examine their own vulnerability, attitudes and knowledge as a prerequisite to HIV prevention among children and young people. Through the exercises in this book, teachers are equipped with skills to ensure that HIV prevention is discussed and supported by administrators, teachers, parents and communities. The book also includes participatory learning activities that teachers can use to help children and young people acquire prevention skills.

Source: WHO, EI, EDC, 2004

Many factors heightening young people's vulnerability to HIV derive from the erosion of care and protection that was previously provided by families and communities. By acting swiftly to provide needed services, countries and communities will reap benefits not only for HIV- and AIDS-related vulnerability, but also for a range of other health and development concerns.

Education in general, and HIV and AIDS education programmes specifically, can effectively reduce vulnerability and empower learners by:

■ **Increasing literacy and general educational levels.** This enhances a sense of connectedness and security, contributes to poverty reduction, improves economic prospects and provides access to trusted adults.

■ **Tailoring interventions to the nature and drivers**[15] **of HIV transmission.** This is a precondition for addressing those behaviours and conditions that facilitate transmission among learners and education staff.

■ **Providing a range of options to enable learners to make informed choices on behaviours to avoid,** such as unprotected sex and needle sharing. This requires addressing the nature and dynamics of human relationships and developing attitudes that will support risk reduction behaviours.

■ **Promoting respect for human rights**, including the rights of sexual and other minorities and people living with or at risk of HIV, and addressing stigma and discrimination. This is important in limiting the spread of the disease, and building care and support for those infected and affected.

■ **Promoting skills development** to enable learners to put into practice understanding and knowledge gained. Skills development is also necessary for people to interact with others, including people living with HIV, in non-discriminatory, considerate and supportive ways.

■ **Reducing cultural and social vulnerability,** which, depending on the context, may include providing protection and support to young people, orphans, women and girls, disabled people, ethnic or religious minorities, sex workers, MSM, injecting drug users, migrant workers and refugees.

■ **Establishing safeguards,** including legislation, administrative regulations and school-based practices to prohibit teacher-student sexual relations and sexual harassment in the workplace.

■ **Responding to basic needs**, such as nutrition, through school feeding or school health programmes.

■ **Developing strong linkages with communities and with care and support services** (such as health, youth and social action) to ensure a supportive environment for those who are at risk or in need of care and support, and to overcome resistance. It is also an important entry point for addressing stigma and discrimination and other social behaviours that increase the vulnerability of certain groups.

■ **Combining long-term efforts to reduce social exclusion with more specific HIV and AIDS vulnerability reduction measures.** Long-term efforts will include, for example, legal and policy measures guaranteeing the provision of education and health services, strengthening mechanisms to document and respond to human rights violations. Specific HIV and AIDS vulnerability reduction measures might include: ensuring safe and supportive learning environments; improving access to youth-friendly health services; and supporting community action, among others.

■ **Ensuring strategies to promote education and to address HIV and AIDS are multi-pronged, long-term, sustainable and coordinated** so that vulnerability can be reduced, rather than implementing single 'one-off' approaches.

Education to reduce vulnerability is ...	
A learning/teaching issue	Children and young people need to be meaningfully involved in the planning, implementation and evaluation of interventions to ensure relevance and effectiveness, and to empower them with the knowledge and skills to reduce their vulnerability to HIV infection. Teachers, educators, youth workers, health-care workers and others require training and support to help them deal with their own attitudes and understanding of vulnerability.
A societal issue	Education needs to broadly involve and engage the community, since the factors that enhance vulnerability will involve reviewing societal values and norms.
A human rights issue	The education sector must ensure that all learners are able to exercise their right to education, regardless of their HIV status; that learning environments promote respect for human rights; and that efforts are taken to promote protection and empowerment of vulnerable groups.
A legal issue	Discrimination, which enhances vulnerability and affects access to health, education and other social services, is amenable to legal redress.
An issue of democracy and citizenship	Social dialogue, connectedness and solidarity are essential to any response to reduce vulnerability.
An infrastructural issue	Health, education and social services require strengthening if they are to play their proper role in promoting a reduction in societal vulnerability.

Reduction of individual risk-taking

Risk is defined as the probability that a person may acquire HIV infection (UNAIDS, 2007c). Most people at risk of HIV infection have little to no access to basic prevention and/or for various reasons are either unable to take action to protect themselves or deliberately choose not to do so. For example, only nine per cent of high-risk sex acts worldwide are undertaken with a condom, and in the most heavily-affected countries of sub-Saharan Africa, only 12 per cent of men and 10 per cent of women know their HIV status (UNICEF, WHO, UNAIDS, 2007).

Good quality HIV and AIDS education programmes must take a broad approach to HIV and AIDS by dealing comprehensively with issues within society – such as substance abuse, corruption, environmental degradation – that contribute to the spread of the epidemic. This is important to enhance the relevance and effectiveness of the programmes, but also to offset AIDS fatigue and narrow AIDS isolationism, ensuring instead that HIV and AIDS are part of overall efforts to address issues that individuals and communities feel strongly about.

Good quality HIV and AIDS education programmes can reduce risk by building knowledge and skills to initiate and sustain behaviours that protect individuals from HIV. These include delaying the age of first sexual encounter, increasing the consistent use of condoms among young people who are sexually active, limiting the number of sexual partners, and addressing the risks associated with alcohol and injecting drug use.

Risk reduction is based on the premise that information is necessary, but that knowledge alone is not sufficient to protect young people against HIV infection. In addition to knowledge, youth-centred teaching and learning is needed to help young people acquire HIV-specific life skills, to reduce stigma and discrimination and to promote values and attitudes (for example, related to people living with HIV, gender, sexuality and sexual rights).

Over the years, a plethora of approaches to HIV and AIDS education has arisen. Today there is a wide range of prevention strategies, reflecting the search for successful approaches as well as ideological influences on donor support and on programming. This has included a substantial move towards abstinence-only approaches, for which little empirical evidence

of success exists (see Boler and Ingham, 2007; Underhill, Operario and Montgomery, 2007) and a polarisation of different approaches along ideological lines. There is a continued need for strong evidence-based technical guidance to ensure that the most effective approaches take the lead, and for expanded access to essential prevention services, particularly among populations at higher risk of exposure to HIV.

For the purpose of the present document, it is important to bring to the forefront the characteristics of those programmes that have been shown to be particularly effective.[16] Such programmes must recognise what has now been clearly established by numerous research studies, namely that the inclusion of sex and sexuality-related content will not encourage young people to become sexually active at an earlier age, will not increase the frequency of intercourse and will not increase the number of sexual partners (Biddlecom *et al.*, 2007; Smith, Kippax and Aggleton, 2000; Kirby *et al.*, 2007). Rather, well-designed HIV and AIDS education interventions in a large number of programmes and implemented in a variety of settings in both developed and developing contexts have been shown to reduce the frequency of intercourse, reduce the number of sexual partners, and increase condom and contraceptive use (UNAIDS, 1997; Kirby, Laris and Rolleri, 2005; Kirby *et al.*, 2006). Replication of such programmes has successfully produced similar behavioural effects, provided that all activities were implemented as designed (Kirby, Laris and Rolleri, 2005).

Effective prevention programmes

Research has found that programmes that reduce sexual activity and lead to increased condom use focused on:

- Knowledge, including knowledge of sexual issues, HIV, STIs and pregnancy
- Perception of HIV risk
- Personal values about sex and abstinence
- Attitudes towards condoms
- Perception of peer norms and behaviour about sex
- Confidence in the ability to refuse sex and use condoms
- Intention to abstain from sex or reduce number of partners
- Communication with parents and other adults about sex, condoms, or contraception

Source: Kirby, Laris and Rolleri, 2005

In summary, experience has shown that, for HIV and AIDS education to be effective in reducing individual risk-taking, programmes need to:

- **Start from an evidence-based assessment** of risk behaviours and knowledge gaps by looking at data on HIV and AIDS, STIs, pregnancy, cultural practices, and reported sexual behaviour among young people.

- **Start early**[17] before young people are sexually active (and before large numbers of children drop out of school), and develop progressively in a logical sequence throughout the educational experience so that children and young people are prepared to deal with the issues they may face as they grow up.[18] Interventions must be tailored to the age, sexual experience, sexual orientation, gender, and cultural context of the learner. Particular approaches may need to be developed to cater for the reality of age-diverse classroom settings (Lloyd, 2007).

- **Include content in one or more compulsory subjects** to ensure implementation (with clearly outlined expected results and outcomes) and sufficient attention to the topic. To maximise impact, lessons should be linked to and reinforced through knowledge, skills and attitudes acquired in other curriculum topics.

- **Focus on a select and small number of specific behaviours** implicated in HIV transmission in the specific context and give clear and consistent messages about protective behaviours to reduce HIV-related risk.

- **Be allocated sufficient time and resources**, with staged and complementary booster modules in subsequent years.

- **Be regularly monitored** by education stakeholders in terms of learning outcomes and behaviour change, in particular to ensure that such outcomes are used to guide future curriculum development.

- **Use clear and understandable language and deliver content in an age-appropriate and culturally sensitive manner**. This includes frank, respectful and scientifically accurate discussion of sex and HIV, (including of same sex issues and of the risks associated with different sexual practices), condoms, sex work and other aspects of sexuality. It also includes ensuring that education focuses on the broad context of relationships and of inter-personal commitments so as not to reduce discussion to abstract talk about sex and biological functions.

- **Use participatory and interactive approaches**, which allow children and young people to explore values and attitudes and to gain new skills and knowledge. Involving staff from health clinics or other external service providers for activities around topics that teachers may find difficult to cover can be very effective (Biddlecom *et al.*, 2007).

- **Ensure skills development** so that learners are able to act on the information they receive and adopt healthy and safe behaviours. This should include demonstrations of positive communication, of the male and female condom, and negotiation and decision-making skills.

- **Be an integral part of appropriate pre- and in-service teacher training**, including how to teach about sex and sexuality, and be given institutional support and recognition. Training must include content that allows staff in schools to identify early warning signs of risk, such as harmful drug use, and to refer appropriately.

- **Actively engage parents and communities** so as to ensure that what is learnt is reinforced elsewhere and to address possible resistance (see box on overcoming barriers).

- **Be reinforced through complementary strategies and activities** in schools and communities that seek to reduce vulnerability and risk (e.g. organizing sports activities, addressing bullying, involving parents in school improvements, etc.). Peer education in and outside of classroom settings can be effective to this end.

- **Provide services and/or link to local health centres and other community organizations** so that students and staff can access or be referred to other prevention and care services for: access to sexual and reproductive health (SRH) services, including male and female condoms; VCT and ART when appropriate; psychosocial support; and help with substance abuse. It is important to note in this context that girls are often much more immediately afraid of pregnancy than HIV. However, often HIV prevention programmes do not integrate the full range of family planning issues that would motivate girls (Lloyd, 2007).

(See also: Kirby, Laris and Rolleri, 2005; UNESCO, 2008b; Gordon, 2008)

Addressing barriers and overcoming resistance

Barriers and resistance to the implementation of HIV and AIDS education can be caused by a range of factors such as: lack of political will and commitment; insufficient awareness of the problem and denial (often exacerbated by lack of studies and data); cultural and social resistance to teaching these topics; misunderstanding, suspicion and opposition on the part of societal gatekeepers (i.e. cultural, community and religious leaders); insufficient training or absence of training for staff who need to deliver programmes, and lack of time.

Overcoming these barriers is no easy task. It is unfortunately also one of the areas in which there has been relatively little research and documentation of best practices.

Strategies that have shown some success include:

- Identifying and mobilising opinion leaders who can be 'champions' for HIV and AIDS education.

- Using creative approaches that tap into popular cultural activities such as music, film, sports, theatre or peer education.

- Conducting advocacy and sharing information with key stakeholders, including demonstrating the benefits of well-designed sex and HIV & AIDS education.

- Integrating and infusing HIV and AIDS into existing structures and activities, including extracurricular events for young people.

- Ensuring access to and use of high quality training, and developing excellent teaching aids and instructional materials for discussions and activities.

- Incorporating values clarification modules in teacher training so that teachers can address their own concerns.

- Bringing health professionals or other non-governmental organization (NGO) staff into schools to deliver the more sensitive content, when necessary.

Source: UNESCO, 2008b; Family Health International, 2007; ActionAid, 2003

Education to reduce risk is ...

A learning/ teaching issue	The active participation of children and young people in the planning, implementation and evaluation of interventions is critical to help them personalise information, develop self-efficacy and skills, and support their peers to reduce risk-taking behaviours. Teachers, educators, youth workers, health-care workers and others require training and support, good quality curricula and materials, and the knowledge, attitudes and skills to protect themselves and others from HIV infection.
A human rights issue	Children and young people have the right to knowledge, skills and services that will enable them to protect themselves and others against infection.
A cultural issue	Schools and education systems socialise new generations into the norms that influence and regulate citizenship, economic activity and personal relationships. To do so successfully, the messages that are being sent have to be sufficiently appropriate to the cultural context and drivers of the epidemic to be assimilated by learners and effective in their impact.
A community issue	Schools and education systems are part of the local community, and should seek to engage with its concerns and needs, including threats to individual and social well-being such as HIV and AIDS and other harmful social matters such as substance abuse or environmental degradation.
An inter-sectoral issue	Schools are not the only place in which children and young people learn. Education about HIV and AIDS can, and does, take place in a variety of settings. Working together, within and across settings, lends coherence to prevention messages and approaches.

We want to be artists, teachers, doctors – even get married and have kids... But achieving these goals will only be possible when we receive the attention we need, when we are guaranteed the medicines that we need, when we are accepted in schools.

Source: Keren Dunaway at the Opening Ceremony of the 2008 International AIDS Conference, Mexico City (UNAIDS, 2008a)

Objective 2:
Mitigation of impact

HIV and AIDS have profound consequences for schools and education. First, HIV and AIDS affect the **demand** for education. The intensification of the epidemic will often mean that there are fewer children to educate (as HIV affects the fertility of infected women and cuts short the lives of others). Children (especially girls) enrolled in school may be removed to care for sick relatives or to take on other family responsibilities. Household incomes and savings may be depleted, affecting capacity to pay for schooling. Beyond this, adults may see little value in investing in education for their children when the future seems bleak. For example, in Swaziland as early as 2004, school enrolment was reported to have fallen by 36 per cent as a result of HIV and AIDS, with girls being the most affected (United Nations Office for the Coordination of Humanitarian Affairs – OCHA, 2004). In Guatemala, studies have shown that more than a third of children orphaned by AIDS drop out of school (Fasokun in Oduaran and Bhola, 2006).

The impact of HIV and AIDS on the cost of education

The AIDS epidemic increases the costs of:

- Training and deployment/posting for replacement teachers and other staff.
- Substitute staff to cover for absent or sick personnel.
- Payments of death and funeral benefits, including premature payment of terminal benefits.
- Ensuring access to education for orphans and vulnerable children (i.e. through bursaries, scholarships and other supplementary measures).
- Teacher training to include HIV and AIDS education, and the development and dissemination of the necessary materials.
- Additional management costs for the establishment of HIV and AIDS units or AIDS-in-the-workplace training and programmes.

Source: Shaeffer, 1994; Kelly, 2006a

Education systems in highly-affected countries must undergo substantial change to forestall the impact of the disease on the scale and quality of education provision. Similarly, education systems need to make changes if they are to play an effective role in the provision of HIV and AIDS education. In particular, teacher education and the organization of educational institutions may require restructuring in highly affected countries in order to meet radically changed circumstances.

Second, the capacity of the education system **to supply** schooling decreases. Although there is some debate about the extent of the impact, there is evidence that HIV and AIDS – particularly in countries experiencing generalised or hyper-endemic epidemics (see section, *Getting the balance right*) – is having an impact on service provision. For example, in Lesotho and Malawi, around one-third of all teacher attrition is due to terminal illness (likely HIV-related) (UNESCO, 2007). Other estimates have predicted that, in highly-affected countries, AIDS-related deaths among teachers could add four to five per cent to annual attrition rates in the sector (Grant *et al.*, 2004). This situation is compounding challenges to hiring, retaining and training adequate numbers of teachers. It is estimated that, in order to reach EFA goals, the world will need more than 18 million new primary education teachers, compared with the 26 million available in 2004. A further major challenge in this respect is teacher deployment, since HIV infected teachers and/or their families will wish to be posted in areas where they have close and adequate medical (and ART-providing) facilities. HIV- and AIDS-related costs are also impacting on the supply of education.

Balancing the supply and demand for education can be difficult even in the absence of the HIV epidemic. But the unevenness of the supply and demand for education is exacerbated as HIV and AIDS erode human capacity and compromise educational outcomes. Supporting and, where necessary, replacing skilled professionals who are affected by the disease must be a major priority, especially in countries where governments depend heavily on a small number of highly trained individuals for public management and core social services (Kelly, 2000).

Third, the **quality** of education is compromised as already scarce human and material resources are stretched even further. In heavily-affected areas, there will be fewer teachers working; and those who are employed may be less motivated and frequently absent as they respond to family trauma or illness. In addition, the loss of central and provincial administrators/ managers, in-school mentors and teacher educators in universities and teacher training colleges will affect the quality of planning, training and support (UNAIDS IATT on Education, 2006c). In this context, non-formal and community education play an increasingly important role in reaching young people. However, access, coverage and quality control are often even more challenging in these settings.

Children affected by and especially vulnerable to HIV and AIDS

HIV and AIDS have a devastating impact on children. Children who are particularly vulnerable include those who:

- Have parents who are HIV-infected or suffering from AIDS
- Are leading or living in child-headed households
- Are living in families that are caring for orphans or other additional family members due to HIV and AIDS
- Have been orphaned by AIDS
- Are living in communities severely devastated by HIV and AIDS
- Live with HIV since birth
- Have been newly infected with HIV
- Are at risk of HIV infection due to lack of economic or gendered power.

Source: UNAIDS IATT on Education, 2008b

While education cannot, in itself, mitigate the impact of the epidemic, actions to strengthen the education system, and to ensure that both school and out-of-school education contribute more effectively to HIV prevention can help communities and nations respond to the pandemic. This includes efforts to adapt schools to the needs of learners by:

- **Modifying schedules and programmes** to better accommodate the additional responsibilities of learners affected by HIV and AIDS.

- **Ensuring, as rights-based institutions, that young children and education staff are not discriminated against** and that they have opportunities to express themselves with regard to their (often negatively) changing situations.

- **Promoting environments** where learning from and caring for one another are practised daily.

- **Identifying the differential impact of HIV and AIDS on girls and boys** and taking appropriate and proactive measures to address these differences in all settings.

- **Adding livelihood training and life skills to the curriculum** to help young heads of households learn the essential skills of running a home and maintaining a family.

- **Linking with social protection and other services** that can support teachers, children and young people psychologically, socially and economically.

- **Facilitating access to treatment education,** including education about ART, how to access and take medication, and the need to follow treatment regimens (UNAIDS IATT on Education, 2006b).

- **Functioning as centres of care and support** for those affected by HIV and AIDS.

Similarly, for educational services to respond to the impact of HIV and AIDS, effective programmes must address staff and systems issues by:

- **Putting in place, monitoring and reviewing policies** that address workplace issues at systemic and institutional levels and make adequate provisions to support those affected and infected by HIV (see box, next page).

- **Implementing workplace HIV education and prevention programmes** for teachers and school staff that address staff's own vulnerability and the impact that HIV and AIDS are having on them, their families, their institutions and their communities.

- **Promoting the establishment of associations** of HIV-affected or infected teachers and ensuring they are supported.

- **Regulating teacher deployment and transfers** to prevent the creation of additional vulnerabilities caused by high rates of staff mobility, placement in isolated areas, and separation from spouses or partners.

- **Establishing in-service supervision, support and mentoring opportunities** for teachers, particularly those working in isolated settings or those with less experience.

- **Promoting the active engagement of teachers' unions and networks of positive teachers** in advocacy, and the design, implementation and monitoring and evaluation of interventions to support access to prevention, and to treatment, care and support for affected staff.

- **Supporting the establishment of training programmes** for head teachers, inspectors, boards of governors, parent-teacher associations and other stakeholders on school management in an AIDS environment.

Source: ILO/UNESCO, 2006a, 2006b; UNESCO, 2008a

While education cannot, in itself, mitigate the impact of the epidemic, actions to strengthen the education system, and to ensure that both school and out-of-school education contribute more effectively to HIV prevention can help communities and nations respond to the pandemic

The important role of workplace policies

Workplace policies aim to address the impact of HIV and AIDS on education. Such policies seek to:

- Promote workplace prevention, education and training programmes
- Address unequal gender and student/staff (or learner) relationships that impact on vulnerability
- Eliminate stigma and discrimination
- Ensure access to care, treatment and support for staff and students
- Manage and mitigate the impact of HIV and AIDS on educational institutions
- Promote safe, healthy and non-violent work and study environments
- Instill respect for the rights and responsibilities of staff and students

Source: ILO and UNESCO, 2006a, 2006b

2. Priorities

This part of the framework sets out a number of general priorities for the education sector based on the issues highlighted above, followed by specific suggestions on prevention and mitigation priorities. These priorities should be used as a basis for discussion and should guide the elaboration of more detailed plans of action that take into consideration the specific epidemiological and country context (see section, *Getting the balance right*). Collaboration is central to meeting these priorities. The education sector cannot be responsible for providing condoms, drug prevention services, and VCT, but can work with partners to ensure access to these key commodities and services.

First of all, this section puts forward priorities that are of relevance to both prevention efforts and to mitigation of the impact of HIV and AIDS. This includes a number of actions that need to take place at a systemic and overarching level of planning, coordination, monitoring and research.

Priorities of relevance to both prevention and mitigation

- **Ensure access to high quality education**. This must include measures to reduce the social and economic barriers to accessing and staying in education; actions to reduce stigma and discrimination; activities target ed at improving community awareness about the value and right to education; and programmes to ensure that schools foster coping and caring for those affected by the epidemic.

- **Mainstream HIV and AIDS in national education sector plans and policies.** These plans must be costed, resourced, implemented and monitored.

- **Establish adequately staffed structures for the coordination of the response** within the ministry of education, clearly identify responsibilities of the staff concerned, and ensure that a capacity-building plan is implemented for staff with responsibility for HIV and AIDS interventions at planning, managerial, implementation and monitoring levels.

- **Put in place, support and monitor mechanisms for coordination and mutual accountability** of all internal and external partners involved in the education response. Education ministries must take the lead in education responses in collaboration with teacher organizations, but at the same time create space and support education coalitions, community-based organizations, youth service organizations, parents and communities.

- **Ensure that the compulsory part of the curriculum includes comprehensive skills-based sex and drug use education** with focused attention on HIV & AIDS and sexual and reproductive health and rights (SRHR). The curriculum should also address tolerance, peace and how to live together (including gender issues), so as to capitalise on education's potential to combat stigma and discrimination.

- **Conduct pre-and in-service training for teachers** that equips them with knowledge, skills and attitudes on HIV and AIDS, allowing them to teach young people, to involve parents, communities and other stakeholders, and to assess and act on their own vulnerability.

- **Develop strong linkages with care and support services** provided by other sectors/ stakeholders (e.g. health, youth, social action, sports, culture, media) to provide a supportive environment for those who are at risk or in need of care and support.

- **Systematically and periodically review progress** on prevention and mitigation as part of the overall monitoring and evaluation of the education system. Provide this information to stakeholders in the sector and to those involved in the national HIV and AIDS response and use it as a means to lobby for stronger recognition and support to the interventions in the education sector.

- **Identify and provide support to key areas of prevention and mitigation research** and ensure that this research informs decision-making and action.

At a second level, the next box highlights priorities that are specific to prevention efforts. These should be put in place in addition to the general priorities above, which will also contribute to the prevention effort. Priorities specific to prevention will include identifying drivers of the infection and using these as a basis for developing curricula and interventions that address the behaviours that facilitate the spread of the disease. As in most low-prevalence countries, a large majority of infections occur in the context of unsafe sex in the sex industry, unsafe male-to-male sex and unsafe injecting drug use. Prevention in these contexts will require addressing these risk behaviours through targeted HIV prevention, drugs and sexuality education.

Prevention-specific priorities

- **Identify the drivers of the infection and transmission patterns** as a precondition for addressing behaviours that facilitate transmission among learners and education sector staff.

- **Identify priority programmes for addressing factors that make children, young people and adults (including teachers) vulnerable to HIV**, ensure that these are integrated in the education response as appropriate, and liaise with other sectors on areas that fall outside the specific responsibility of the education sector and/or that require joint action. Develop specific programmes and approaches for especially vulnerable groups, and mainstream information and skills-building that addresses key behaviours driving the epidemic (including unprotected male-to-male sex, unprotected sex in the context of sex work and unsafe injecting drug use) into training and curriculum activities.

- **Develop a specific strategy and plan of action to raise awareness** regarding HIV and AIDS among senior- and middle-level management of the ministry of education and its partners and ensure that the plan is funded and implemented.

- **Identify**, as part of the above action, **leaders in the sector who can effectively advocate** for an enhanced response and ensure that these individuals receive the necessary support in this important role.

- **Ensure prevention efforts are informed by theoretical approaches and empirical evidence** of what works.

- **Identify capacity gaps** in the design, implementation and monitoring of prevention efforts, build capacity of internal and external stakeholders and ensure that gaps are addressed.

- **Ensure access** to male and female condoms, SRH services, VCT, ART and other interventions such as drug prevention programmes.

- **Build capacity** of government, teacher, non-governmental and civil society organizations to identify and put in place specific prevention activities.

- Work closely with communications and media professionals to **address issues of stigma and discrimination** and to **ensure that HIV and AIDS are addressed from a broad human rights perspective** and that prevention messages provided through education are reinforced.

- **Ensure sufficient priority and funding** is given to the development of baselines, to the monitoring of prevention interventions (including longitudinal studies where appropriate), and to the assessment of outcomes and impact. Also ensure that evidence of what works is amply disseminated and discussed.

Finally, on the mitigation side, priorities include ensuring that the education system takes into account the impact of the disease on its workforce (e.g. in terms of teacher absenteeism, retention, and attrition) and on learners (e.g. by adapting the functioning of schools to the needs of children and young people who are impacted by the disease). In highly-affected countries, this will include profound changes to enable schools and alternative programmes to provide education and support.

Mitigation-specific priorities

- **Monitor the patterns of education provision** (in terms of enrolment, performance, teacher attrition, etc.) and put in place specific actions to address areas that are identified as problematic.

- **Adjust the functioning of schools to the situation**, including by:
  - Modifying/adapting class schedules to address the needs of those learners who are affected by HIV or otherwise vulnerable;
  - Adding livelihood training and life skills to curriculum for young heads of households;
  - Linking with social services specialised in supporting affected children and young people;
  - Functioning as centres of care and support.

- **Ensure access to, and completion of, high quality education** for children in families affected by HIV and AIDS, children living with HIV, orphans and other vulnerable children.

- **Ensure that the special needs of children living with HIV are addressed**, that they receive the necessary support to ensure adherence to their drug regimen, that school demands take into account their special circumstances, and that special attention is paid to their sexual and reproductive health as they approach and pass through the years of puberty and early adolescence.

- **Review teacher education and training** to ensure teachers are prepared to meet needs of children living with HIV & AIDS and orphans. This training may, for example, support teachers to identify those that are most in need, to promote child protection and safety, and to make appropriate referrals to psychosocial, health, protection and other services.

- **Put in place workplace policies and programmes** that address prevention as well as the impact of HIV and AIDS on teachers and other staff in the context of a non-discriminatory work environment.

- **Provide care and support for affected and infected teachers and other education sector staff**, or ensure appropriate referrals. This should include access to ART for affected teachers and education sector staff.

- **Build capacity** of government, teachers, non-governmental and civil society organizations to identify and put in place specific mitigation activities.

All of these actions – for prevention or mitigation – require a solid evidence base, human and financial resources, and capacity-building to facilitate the attainment of EFA goals. Ministries of education, in partnership with other sectors, have an important role to play in ensuring that the data necessary for diagnosis and planning is collected, that HIV and AIDS are properly reflected in national action plans, and that capacity is built so as to put in place effective HIV prevention programmes and, where relevant, to mitigate the effects of HIV and AIDS on the demand for, and supply, quality and cost of, education. External partners have the responsibility of providing support for the implementation of such plans in a coordinated, harmonised and aligned manner.

3. Getting the balance right

The two objectives that form the basis of this strategic framework are critical and complementary. A combination of both objectives needs to be pursued in many educational settings. However, in order to tailor the specific response of the sector, priorities will need to be guided by: a) the epidemic dynamics; b) the social, cultural and economic context of the country (taking into account any regional differences); and c) the characteristics of populations at higher risk of exposure to HIV. In particular, it is critical that interventions are based on what children and young people already know and that they are planned, implemented and monitored with the participation of key stakeholders.

Three key questions for prioritisation

1) Where, among whom and why are HIV infections occurring?

2) How fast are infections moving?

3) What are the drivers of the epidemic?

Source: UNAIDS, 2007c

It is also important to realise that the epidemic is very likely to evolve over time from one scenario to another depending on the factors that are driving the epidemic and on the nature and quality of the response by key sectors such as education and health. This means that, in practice, some of the distinctions between epidemic scenarios (such as the cut-off point between general and hyper-endemic epidemics) may need to be interpreted with flexibility.

The different epidemic scenarios are highlighted in the table below, which also gives an overview of suggested priority areas for the education sector in each of these settings. These are indicative and will need to be adjusted in accordance with local needs and circumstances.

Where HIV is generalised, every workplace, school and community setting must be used for intensive HIV prevention activities.

Source: Global HIV Prevention Working Group, 2008:11

Low level

- HIV prevalence among general population < 1%.
- HIV prevalence has not spread significantly in any sub-group (UNAIDS, 2007c). Risk is diffuse (low levels of partner exchange or of non-sterile injecting equipment) or virus only recently introduced.

Concentrated

- HIV prevalence high in population sub-groups.
- Epidemic is fuelled by key risk behaviours, in most cases: unsafe injecting drug use; unprotected male-to-male sex; and unprotected sex in the context of sex work.
- Virus is not circulating at high levels among the so-called 'general population' (UNAIDS, 2007c).

Generalised

- 1-15% of pregnant women attending antenatal clinics are HIV-positive.
- HIV is present among general population and spreading widely (UNAIDS, 2007c).

Hyper-endemic

- Virus has spread to over 15 % of adult population and very large numbers of people are living with HIV.
- Drivers of epidemic: include early sexual debut; low understanding of risk; high levels of intergenerational sex; multiple and concurrent partnerships among men and women; gender-based inequalities; extreme poverty, stigma and discrimination; violence and human rights abuses; inconsistent condom use and low availability/acceptability of condoms; and low levels of male circumcision (UNAIDS, 2007c).

At all levels, a priority focus on ensuring quality education for all

Key elements of the education response

- Collaborating/staying informed about strategic information (i.e. research and surveillance data) related to the progression and impact of HIV and AIDS.
- Focusing on basic information and skills among children and young people with additional vulnerabilities and high-risk behaviours, with particular attention to prevalent modes of transmission (injecting drug use, men who have sex with men,

commercial sex work, etc.) and facilitating access of those who are at risk and vulnerable to services (including HIV and substance abuse prevention, treatment and care programmes).

- Integrating HIV and AIDS information and skills across school and teacher curricula to ensure young people are aware of their SRHR and to empower them to make good choices about their health.

- Ensuring that education promotes an environment of tolerance and respect for all children, young people and adults, regardless of their sexual orientation, and that it contributes to reducing stigma and discrimination, to reducing gender and other inequalities, and to promoting human rights.

All of the above and also

- Monitoring and constantly strengthening the links of the education sector with other service providers to ensure that the main risk behaviours are comprehensively addressed in information to children and young people and that those who are at risk and vulnerable have free and equitable access to counselling and testing, and referrals.

- Ensuring education is an integral part of the national response to HIV and AIDS and that the sector actively participates in planning and reviewing of progress.
- Supporting HIV and AIDS mainstreaming into national education plans through capacity building and organizational strengthening.
- Targeting managers and other leaders in the sector with advocacy to generate awareness, to strengthen knowledge

and enhance commitment to addressing the issue and seek to engage external leaders in lobbying for a stronger education response.

- Regularly gathering and analysing data to understand drivers of risk behaviours as part of the overall monitoring and evaluation of the education sector and ensuring this feeds into decision-making and revised/updated approaches.

All of the above and also

- Ensuring a comprehensive approach to HIV and AIDS that encompasses attention to prevention, care and support (including access to treatment), impact mitigation, workplace issues and management of the response.
- Ensuring an enhanced focus on all young people, with comprehensive sex and HIV education programmes based on life skills, covering delay of sexual debut, sexual orientation, sexual risk behaviour, condom use, HIV testing, reduction of concurrency and number of partners, drug use, male circumcision, prevention of mother-to-child transmission and gender and other inequalities.

- Ensuring that, in teacher training on HIV prevention, teachers are made aware of their own vulnerability and that teachers are provided with the knowledge and skills to adopt risk-reductive behaviours.
- Actively encouraging community and parental involvement in decisions and actions aimed at reducing vulnerability and risk among young people and promoting social change in the community, linked to in-school programmes for HIV awareness, including on key issues of vulnerability of girls and risks of intergenerational sex, segmented needs of young people who are out of school, and reducing stigma and discrimination.

- Working with other sectors to meet the demand for care and protection for children and young people.
- Collaborating with health systems to make SRH services, including VCT, available to learners and staff.
- Establishing or linking to services and support for teachers and other education sector staff, including supporting networks of teachers living with HIV.
- Monitoring longer term impact (such as teacher morbidity, mortality, attrition and absenteeism and attendance of orphans and other vulnerable children) and planning for human capacity.

All of the above and also

- Taking exceptional action to mobilise predictable and sustainable funding for the response.
- Refocusing strategies and scaling up interventions with absolute priority to risk reduction including treatment literacy as well as ensuring access to treatment, SRH services, care and support and additional health and nutrition services for children affected by HIV and AIDS.

- Giving priority to effective coordination, harmonisation and alignment of actions.
- Sustaining and deepening efforts to address the impact of AIDS on education systems including expanded training and support for educators and replacing staff lost to AIDS.

- Intensifying intersectoral actions to address the drivers of the epidemic, including harmful social norms and laws, gender inequality and neglect of human rights.

The way forward

The AIDS epidemic has impacted on human development, particularly in highly-affected settings, by deepening poverty among vulnerable households and communities, weakening capacity of institutions and systems, destroying human capital and straining families and social networks. Yet there is evidence that efforts by countries to prevent new infections and to mitigate the impact of the epidemic are beginning to bear fruit, as, globally, HIV prevalence is stabilising and there are localised reductions in prevalence in some countries. Financing for prevention, treatment, care and support services has expanded exponentially, and much has been learned about developing, scaling up and coordinating effective programmes.

There is also substantial and growing evidence of the important role that education plays in offering protection against HIV and in contributing to efforts to support and care for those affected by HIV and AIDS. Education plays a critical role in the response to the epidemic by providing information and skills and developing values that allow young people to make healthy decisions about their lives; increasing young people's connectedness and security; and giving young people the possibility to make independent choices and to be economically productive. Well-planned and implemented life skills or sex and HIV education interventions have been found to increase knowledge; develop skills and positive attitudes required to change risk behaviours; and reduce sexual risk behaviours among the sexually active.

However, challenges remain and education alone cannot bring about the wide-reaching changes required to halt and to reverse the spread of the epidemic. The key to success lies in combined and coordinated action. This means working across a range of sectors and with relevant stakeholders to reduce individual risk-taking by building knowledge and skills to initiate and sustain behaviours that protect individuals from HIV; to promote protection and empowerment to reduce the social, cultural, economic and political conditions that contribute to increased vulnerability; and to mitigate the impact of HIV and AIDS on individuals, families, communities and institutions.

This document is a plea for advocacy and for action for renewed and scaled up commitment to the education response. Debate, information and understanding, informed at all stages by what research and science tells us, are our best resources against the disease. It is the purpose of this strategy to use these resources to enable maximum impact.

International commitment to address the epidemic is real. Stakeholders are mobilising at all levels, in some cases with impressive speed. This document aims to serve as a support and interface to this cooperation between countries and agencies, and to build the understanding and commitment required for a successful and strategic response to HIV & AIDS and education.

Notes

1   The UNAIDS IATT on Education was established in 2002, arising out of the UNAIDS Working Group on Schools, HIV/ AIDS and Education. The overall goal of the IATT on Education is to improve and accelerate the education response to HIV and AIDS. Its specific objectives are to promote and support good practices in the education sector related to HIV and AIDS and to encourage alignment and harmonisation within and across agencies to support global and country level actions. An overview of the range and scope of the IATT's work to date can be found at www.unesco.org/aids/iatt and in Annexes 1 and 2 of this report.

2   According to UNAIDS, 2006a (Chapter 6), over 75 per cent of all HIV infections are caused by sexual transmission.

3   The absolute number of people living with HIV, however, continues to increase because of ongoing accumulation of new infections and longer survival times. (See UNAIDS, 2007a.)

4   This is the case, for example, in Indonesia, Mozambique the Russian Federation and Viet Nam. (See UNAIDS, 2007a.)

5   For example, under the phased scaling-up of universal access proposed by UNAIDS, US $28.4 billion would be necessary by 2010, which is almost triple the amount available at present. If the scale up continues at the present rate, funding is projected to reach US $15.4 billion by 2010 – only half of what would be necessary (UNAIDS, 2007b). Moreover, UNAIDS cautions that volatile funding flows, often reflecting priorities that are not shared by governments, are a constant challenge to the implementation of national AIDS plans (De Lay, Greener and Izazola, 2007).

6   These challenges include limited knowledge of HIV status due to low availability/uptake of voluntary counselling and testing (VCT); other weaknesses in health systems; low access to health services, particularly among populations with higher risk of exposure to HIV including men who have sex with men, sex workers and injecting drug users; limited diagnostics and drug formulations for children; and poor individual and community understanding of treatment (Board on Global Health, 2005).

7   A persuasive study regarding the impact of removing financial barriers to education found, in a randomised trial, that providing school uniforms (and thus eliminating an important school cost) led to decreased pregnancy rates (Duflo, Dupas, Kremer and Sinei, 2006).

8   Copies of national education sector policies and strategies on AIDS can be found on the UNESCO HIV and AIDS Clearinghouse. See: http://hivaidsclearinghouse.unesco.org

9   For example, the 2004 Education Sector HIV/AIDS Global Readiness Survey (UNAIDS IATT on Education, 2005) found that nearly three-quarters (72 per cent) of ministries participating in the survey had management structures or committees to direct, guide and monitor the sector's response. These results need to be interpreted with some caution however, because only a limited number of education officials were consulted in each country and subsequent contact with a number of countries has highlighted that the responses may have been overly optimistic

10   There is evidence of a vicious cycle, whereby young children dropping out of school at a young age to enter the workforce in order to support parents affected by HIV and AIDS themselves become more vulnerable to HIV (ILO, 2006). See section on vulnerability reduction (Objective 1: Prevention).

11   For example, research in 11 Asian countries showed an emphasis of HIV prevention education on biological rather than social factors, and a neglect of the subject in primary schools (Smith et al., 2003). This study also found that teacher training on HIV and AIDS tended to be in-service and limited.

12   All UNAIDS IATT on Education Members (listed at the beginning of this document) have committed to these guiding principles for their approaches and interventions in education and HIV & AIDS.

13   For example, in recent Demographic and Health Surveys conducted in 11 sub-Saharan African countries (Benin, Burkina Faso, Cameroon, Guinea, Kenya, Mali, Madagascar, Mozambique, Tanzania, Uganda and Zambia) between 51-82 per cent of young women and 32-72 per cent of young men of the same age reported having sexual intercourse before the age of 18. In all but one of these countries, more young women reported having sex by this age; the opposite is true in Latin America and the Caribbean. Data from Benin, Burkina Faso, Cameroon, Guinea, Mali, Madagascar, Mozambique, Tanzania, Uganda and Zambia (Demographic and Health Data taken from: MEASURE DHS. Macro International. Country Profiles on Youth. http://www.measuredhs.com/topics/Youth/ctry_profiles.cfm. (See also Lloyd, 2005.)

14   For every person who began ART in 2006, the Global HIV Prevention Working Group estimates that six people were newly infected (Global HIV Prevention Working Group, 2007).

15   According to UNAIDS (2007c), the term 'driver' (of the epidemic) refers to the 'structural and social factors, such as poverty, gender inequality and human rights violations that are not easily measured that increase people's vulnerability to HIV infection' (p. 10).

16   See Kirby, Laris and Rolleri, 2005; UNESCO, 2008b; Gordon, 2008; Senderowitz and Kirby, 2006.

17   Prevention programmes implemented at primary level have been shown to be more effective in changing knowledge and behaviours, particularly with respect to abstinence and use of condoms, because they reach children before they become sexually active (Gallant and Matricka-Tyndale, 2004).

18   For formal education this means starting at primary level and continuing through to tertiary education. It also means including content in non-formal education programmes where children and young people with additional vulnerabilities can also be reached.

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Annex 1 Overview of IATT Actions

The activities undertaken by the UNAIDS IATT on Education seek to strengthen policy and programmatic action in the area of education and HIV & AIDS, to enhance coordination in support of the attainment of the EFA goals, and to contribute to the achievement of the MDGs related to quality primary education, gender equity and HIV and AIDS. They are entirely consistent with policies and strategies of the members of the IATT and with the various international commitments that agencies have subscribed to.

Core strategic areas of the IATT in recent years include:

- **Supporting the mainstreaming of HIV and AIDS in education policies, plans and programmes**, for example, by ensuring that HIV and AIDS are adequately mainstreamed in the EFA/FTI endorsement process, and by developing practical tools to support the mainstreaming of HIV and AIDS in education plans by development agencies (UNAIDS IATT on Education, 2008a).

- **Generating awareness and mobilising commitment** to the education response among stakeholders within and beyond the sector by advocating for the importance of a comprehensive education response to HIV and AIDS. The IATT has sought to be present at important international and regional events, such as those organized by the Association for the Development of Education in Africa (ADEA), international and regional AIDS conferences, and meetings on major education initiatives such as EFA-FTI.

- **Examining and strengthening existing tools for monitoring and evaluation** through the production of a number of publications. This has included, for example, a global survey to assess the readiness of the education sector to respond to HIV and AIDS (UNAIDS IATT on Education, 2005) and technical support to the EFA Global Monitoring Report to address HIV and AIDS issues systematically when reporting on progress, identifying promising programme and policy experience, and mobilising commitment.

- **Production, wide dissemination and support for use of technical resources on key areas of the response** (see Annex 2), including HIV and AIDS treatment education, girls' education for HIV prevention, and quality education. These documents serve as important references and guidelines to a range of organizations working in and with the education sector. Many of these materials have been launched at regional and global events and translated into various languages.

- **Organization of symposia and internal meetings** for its members twice a year to encourage discussion around important developments in the education and the HIV & AIDS response and to work towards its overall goals.

Annex 2 IATT Technical Products

IATT-commissioned technical products aim to advance the evidence base and to inform decision-making and strategy development. Materials are available on the IATT website, www.unesco.org/aids/iatt, or can be ordered free of charge from info-iatt@unesco.org and include:
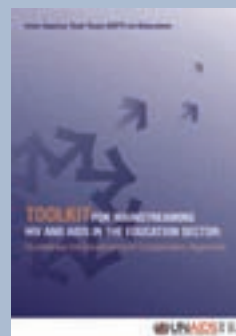
UNAIDS IATT on Education. 2008. *Improving the Education Response to HIV and AIDS: Lessons of Partner Efforts in Coordination, Harmonisation, Alignment, Information Sharing and Monitoring in Jamaica, Kenya, Thailand and Zambia.* **Paris, UNESCO.**

This report synthesises case study exercises undertaken to examine the quality, effectiveness and coordination of the education sector's response to the HIV epidemic in four countries – Jamaica, Kenya, Thailand and Zambia. In each country, stakeholders assessed: critical achievements and gaps in the education sector response to HIV and AIDS; the evolution and effectiveness of coordination mechanisms and structures; progress toward harmonisation and alignment; information-sharing on HIV & AIDS and education; key resources for the response; and monitoring and evaluation.

This report presents the overall findings from the study and makes recommendations for the UNAIDS IATT on Education and its partners to improve coordination in support of country level and global actions. Detailed information on the results for each country is included in appendices of this report.

Available in English (only) at: http://unesdoc.unesco.org/images/0015/001586/158683E.pdf

UNAIDS IATT on Education. 2008. *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies.* **Paris, UNESCO.**

This toolkit aims to help education staff from development cooperation agencies, including both development- and humanitarian-oriented multilateral and bilateral agencies, as well as NGOs and other civil society organizations, to support the process of mainstreaming HIV and AIDS into education sector planning and implementation. It provides resources and support to assess the progress countries have made with respect to HIV and AIDS mainstreaming; to identify entry points; and to establish priorities for advocacy and action. It is designed to be used as a reference tool or a resource for training and discussion, depending on the local needs and context.

Available in English at: http://unesdoc.unesco.org/images/0015/001566/156673E.pdf
Available in French at: http://unesdoc.unesco.org/images/0015/001566/156673F.pdf
Available in Spanish at: http://unesdoc.unesco.org/images/0015/001566/156673S.pdf

UNAIDS IATT on Education. 2006. *Review of the Evidence: Girls' Education and HIV Prevention.* **CD-Rom. Paris, UNESCO.**

This CD-Rom aims to expand the evidence base on the link between girls' education and HIV prevention. It contains more than 100 recent resources produced by members of the UNAIDS IATT on Education and other leaders in the education, gender and HIV and AIDS communities. Included on the CD-Rom are policy documents, case studies, reports, tools, curricula and other materials from a range of settings and in several languages. Resources included on this CD-Rom: demonstrate the importance of girls' education as a strategy for reducing the vulnerability of girls to HIV infection; provide examples of progress to date and suggestions for how the education sector can better meet the needs of girls; and advocate for intensified action around girls' education as part of national responses to HIV and AIDS.

UNAIDS IATT on Education. 2006. *Education Sector Readiness to Respond to HIV and AIDS/L'état de preparation du secteur éducatif face au VIH et au SIDA/La capacidad de respuesta del sector de la educación para afrontar el VIH y el SIDA.* **CD-Rom. Paris, UNESCO.**

This CD-Rom includes the findings of the first international survey of education sector readiness to manage and mitigate the impact of HIV and AIDS. Ministries of education in 71 countries and civil society organizations in 18 countries identified the responses taken to date and defined areas for future work and partnership. Recommendations are also included to influence future responses in the sector.

UNAIDS IATT on Education. 2006. *Education Sector Global HIV & AIDS Readiness Survey 2004: Policy Implications for Education and Development.* **Paris, UNESCO.**

This report documents the outcomes of the first international survey of education sector readiness to manage and mitigate the impact of HIV and AIDS. It synthesises the responses of ministries of education in 71 countries and civil society organizations in 18 countries regarding: ministerial HIV and AIDS structures; enabling environment for an effective response to HIV and AIDS; HIV and AIDS mainstreaming; workplace issues and human resources; workplace HIV and AIDS programmes; HIV and AIDS and the curriculum; responses aimed at those infected and affected by HIV and AIDS; partnership development in response to HIV and AIDS; research guiding the response to HIV and AIDS in the education sector.

The report interprets disagreements, identifies both the challenges and opportunities that present themselves, and addresses issues of operational importance. Finally, the report concludes by identifying policy implications and providing recommendations to influence future responses in the education sector.

Available in English at: http://unesdoc.unesco.org/images/0014/001446/144625e.pdf
Available in French at: http://unesdoc.unesco.org/images/0014/001446/144625f.pdf
Available in Spanish at: http://unesdoc.unesco.org/images/0014/001446/144625s.pdf

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

This paper presents a framework for quality education that demonstrates how education systems can and must change in their analysis and conduct in relation to HIV and AIDS. It summarises the ten dimensions of the framework, considers how HIV and AIDS manifests itself in relation to these quality dimensions and summarises some practical applications of how education has responded and can respond to the pandemic from a quality perspective. A more detailed annex to the paper provides evidence on the manifestations of the pandemic on education systems, and how systems have responded in practical ways. Some general conclusions are drawn and a final section promotes some practical and strategic actions in support of quality education that reflects and responds to HIV and AIDS.

Available in English at: http://unesdoc.unesco.org/images/0014/001461/146115e.pdf
Available in French at: http://unesdoc.unesco.org/images/0014/001461/146115f.pdf
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Available in Arabic at: http://unesdoc.unesco.org/images/0014/001461/146115a.pdf
Available in Chinese at: http://unesdoc.unesco.org/images/0014/001461/146115c.pdf

UNAIDS IATT on Education. 2006. *HIV and AIDS Treatment Education: A Critical Component of Efforts to Ensure Universal Access to Prevention, Treatment and Care.* **Paris, UNESCO.**

This paper signals ways that the education sector can play a role along with others engaged in efforts to achieve universal access to prevention, treatment and care. It considers some key strategies, including how to effectively engage and prepare communities and how to involve key constituencies and in particular people with HIV and those on treatment. The paper elaborates on the link between prevention and treatment, re-examines the harmful effects of stigma and discrimination and explores how these factors impede progress in prevention and expanding treatment access. In addition, the paper suggests some possible future directions, underscoring areas of particular priority.

Available in English at: http://unesdoc.unesco.org/images/0014/001461/146114e.pdf
Available in French at: http://unesdoc.unesco.org/images/0014/001461/146114f.pdf
Available in Spanish at: http://unesdoc.unesco.org/images/0014/001461/146114s.pdf

UNAIDS IATT on Education. 2005. *Report on the Education Sector Global HIV/AIDS Readiness Survey 2004*. **Paris, UNESCO**.

This report is based on a groundbreaking survey of the capacity and readiness of vulnerable or affected countries to manage the impact of HIV and AIDS on their education systems. The survey captures the responses of ministries of education from 71 countries and civil society interactions in 18 countries with regard to: ministerial HIV and AIDS structures; enabling environment for an effective response to HIV and AIDS; HIV and AIDS mainstreaming; workplace issues and human resources; workplace HIV and AIDS programmes; HIV and AIDS and the curriculum; responses aimed at those infected and affected by HIV and AIDS; partnership development in response to HIV and AIDS; research guiding the response to HIV and AIDS in the education sector. The survey was conducted by the Health Economics and HIV/AIDS Research Division's Mobile Task Team on Education, at the University of KwaZulu-Natal on behalf of the UNAIDS IATT on Education.
Available in English (only) at: http://unesdoc.unesco.org/images/0013/001399/139972e.pdf

UNAIDS IATT on Education. 2003. *HIV/AIDS and Education: A Strategic Approach*. **Paris, UNESCO International Institute for Educational Planning.**

This report is the first edition of the present document and identifies key priorities for a scaled-up response to the epidemic on the part of schools and the education system more generally. It has been written with key policy-makers in mind, both those in ministries of education and in development organizations, and those working in related fields. Much of the strategy is directed at the formal educational system, as the fundamental institutional foundation for HIV prevention education on a large scale. However, recommendations are also provided for the community and informal sectors, as many of those most at risk are not in formal education and because the epidemic impacts upon the ability of educational institutions to deliver.

Out-of-print; to be replaced by the current publication.

UNAIDS IATT on Education. 2004. *The Role of Education in the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS.* **Paris, UNESCO International Institute for Educational Planning.**

This report describes the contribution of education to the protection, care and support of orphans and other vulnerable children, as set out in the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS. Intended to provide guidance for investments and interventions, it presents the broad lines of action considered necessary for education-related responses to orphans and other children made vulnerable by HIV and AIDS. In particular, this paper draws upon and seeks to logically relate education responses to the overlapping commitments made in the United Nations General Assembly Special Session on HIV/ AIDS (2001), the Millennium Development Goals, Education for All, and the Convention on the Rights of the Child.
Available in English at: http://unesdoc.unesco.org/images/0013/001355/135531e.pdf
Available in French at: http://unesdoc.unesco.org/images/0013/001355/135531f.pdf
Available in Spanish at: http://unesdoc.unesco.org/images/0013/001355/135531s.pdf

This publication provides a strategic vision of the critically important role that education must play in addressing HIV and AIDS. It targets decision-makers and practitioners in the education sector, as well as colleagues who work on HIV and AIDS responses in other sectors. It can be used as an advocacy tool to build commitment to the role of education in the HIV and AIDS response and to generate multisectoral partnerships for implementation. It identifies key priorities for responding to HIV and AIDS through education, puts forward two central objectives for education responses, and outlines how the response should be tailored to the local epidemiological situation and other factors.

This publication was developed by the UNAIDS Inter-Agency Task Team (IATT) on Education. Formed in 2002, the IATT on Education is convened by UNESCO and brings together UNAIDS Cosponsors, bilateral agencies, private donors and civil society organizations with the purpose of accelerating and improving a coordinated and harmonised education sector response to HIV and AIDS.

For more information about the IATT on Education, visit www.unesco.org/aids/iatt