Chapter 4.3

HIV PREVENTION EDUCATION

MAIN OBJECTIVES

- **To teach learners how to avoid becoming infected with HIV.**
- **To help learners recognize symptoms and to encourage those infected to seek appropriate medical care and counselling.**
- **To teach learners how best to help people living with HIV within their own families and communities.**

CONTEXT

The AIDS pandemic has grown to a global phenomenon over the past three decades. The overwhelming majority of people with the human immunodeficiency virus (HIV) live in the developing world. In 2008, approximately 334 million people globally were estimated to be living with HIV. As many as 95 per cent of those living with HIV do not know that they carry the virus, which contributes to its rapid spread. Every day, more than 15,000 people are infected with HIV. In 2008 alone, 2 million died in the AIDS epidemic. These results have been devastating in all affected communities. Notably, chronic emergency and disaster-prone countries and regions have been the most directly affected.

"Sub-Saharan Africa accounts for two-thirds of all infected people. South and South-East Asia have the second highest number of infected people" (www.avert.org/worldstatinfo.htm).

Unprotected sexual intercourse and intravenous drug use account for the majority of HIV infections globally. Today, virtually every country in the world is affected by HIV, but 90 per cent of people living with HIV are in the developing world. Women are at particular risk. Lack of awareness and information, poverty and/or intimidation makes it difficult for many, especially women, to request that their partners use condoms during intercourse.

"For every four men infected with HIV, six women are infected. While women and young children are physically more vulnerable to HIV and AIDS, it is now recognized that HIV and AIDS are a wider social and economic issue firmly rooted in power imbalances in gender relations in all social classes. These power imbalances are more acute in resource-poor countries and regions." (Elliott, 1999.)

There are close relationships between emergency situations, displacement and HIV. In both acute and prolonged emergency situations, as well as in the reconstruction phases, infection rates are likely to increase. At the same time, the loss or disruption of social and health services tend to reduce treatment and support for victims.

In conflict situations, widespread violence and changing front lines are often associated with incidences of mass rape, including systematic rape as a military or terrorist strategy to demoralize opponents. Forced sex is associated with higher HIV infection rates than consensual sex. Soldiers are often poorly informed and/or in denial about the risk of HIV. Moreover, soldiers (both local and international) and the presence of large military camps/

HIV AND AIDS AND NATURAL DISASTERS: THE CASE OF HONDURAS

"Before hurricane Mitch, Honduras had one of Latin America's highest HIV infection rates, ranking third behind Guyana and Belize. Conservative estimates suggested that some 40,000 people, mainly in the 15–29-year age bracket, were infected ... Mitch had a number of effects on the prevalence of HIV, and on the treatment and support of people with HIV/AIDS. The health infrastructure was severely damaged, while health workers focused predominantly on tackling health problems directly linked with the disaster, such as malarial infections caused by the collapse of sanitation systems. NGOs suspended HIV prevention programmes in favour of providing food, shelter and short-term palliative care. Staff were also called on to participate in national efforts to prevent epidemics.

Mitch also had other effects related to pre-existing social and economic conditions. In its wake, child labour increased and the number of girls and young women involved in sex work grew. Children made homeless and forced onto the streets of the country's cities were at increased risk of sexual exploitation and violence. Population movements within the country and across its borders increased as people looked further afield for work. Particularly vulnerable groups such as sex workers relocated to areas with high levels of sex tourism, such as San Pedro Sulas, La Ceiba, Comyagua and Tegucigalpa. For women and children, sexual violence has been exacerbated by the pressures of homelessness and relocation to new and unfamiliar areas."

Source: Artiles quoted in Smith (2002: 9).

bases often lead to the institutionalization of prostitution – which could lead to increasing the rate of HIV infection. In emergencies, especially chronic emergencies where impoverished communities have lost their normal livelihoods and families are broken apart, women and girls may turn to prostitution as a key survival strategy – thereby increasing their risk of contracting HIV. Poor medical services lead to infection through re-use of contaminated syringes, etc. Refugees and internally displaced people (IDPs) who are dependent on humanitarian assistance for food and other services are vulnerable to sexual exploitation by military/ peace-keepers, aid workers and others persons in positions of power, which may increase the risk of HIV infection.

Weakened health services in conflict-affected areas make it difficult to advocate protective behaviour and spread contamination. Infections and diseases from other sources, engendered by the general collapse of health services, are the cause of the disruption of vital AIDS services. In situations of widespread violence, open wounds and contact with contaminated blood may increase the spread of HIV.

Generally, natural disasters do not disrupt national HIV prevention and care systems. However, local budgets might be diverted away from these programmes to more pressing disaster response activities, as in the case of Hurricane Mitch, and local clinics may be damaged or destroyed.

The breakdown in traditional structures and norms that may accompany refugee outflows and other mass displacements may affect longstanding sexual norms and practices, leading to higher numbers of sexual partners at earlier ages and higher HIV infection rates. The typical disruption of health and social services that accompanies these emergencies only makes matters worse. Without effective outreach and wide community understanding,

the AIDS epidemic will continue to spiral out of control. Basic community education on HIV prevalence and safe behaviour to help people avoid becoming infected are primary responses to gaining control of this problem. "In the decade ahead, HIV/AIDS is expected to kill ten times more people than conflict. In conflict situations, children and young people are most at risk – from both HIV/AIDS and violence" (Lawday, 2002: 1).

The illness or death of teachers, whether from AIDS or not, is especially devastating in emergency situations, where there is often already a shortage of educational services, and in rural areas where schools depend heavily on one or two teachers. Moreover, skilled teachers are not easily replaced. Teacher absenteeism may be increased by HIV and AIDS, as the illness itself causes increasing periods of absence from class. Teachers with sick families also take time off to attend funerals or to care for sick or dying relatives and teacher absenteeism also results from the psychological effect of the epidemic (World Bank, 2002). When a teacher falls ill, the class may be taken on by another teacher, be combined with another class or left untaught.

With regard to HIV education, "schools have been successful in helping young people acquire the knowledge, attitudes and skills needed to avoid infection. Education, when it is appropriately planned and implemented, is one of the most viable and effective means available for stopping the spread of HIV infection" (Aldana and Jones, 1999: 9). Notably, children between the age group 5–14 have the lowest HIV prevalence in the population. This means that whilst they are an extremely vulnerable group, they also represent a key target for HIV education. Schools are a priority setting for HIV and AIDS education because they:

- Provide an efficient and effective way to reach large portions of the population, including young people, school personnel, families and indirectly community members.
- Can provide learning experiences, linkages to services, and supportive environments to help reduce infections and related discrimination.
- Reach students at influential stages in their lives when lifelong behaviours are formed.

Many people living with HIV face prejudice, discrimination or even seclusion from their communities. Education is a central means of distributing information about the disease, and helping people with HIV and AIDS contribute to the lives of their families and communities.

SUGGESTED STRATEGIES

Summary of suggested strategies
HIV prevention education

1. Take steps to strengthen the education ministry's/ies' capacity for skills-based health education for HIV prevention and related issues.
2. Conduct or facilitate a review of HIV and AIDS education programmes being carried out under government auspices, through civil-society organizations and external agencies and NGOs, for the emergency-affected populations, and establish a working group on this topic.
3. Provide guidance to educational authorities in emergency-affected areas and to civil-society organizations on the conduct of HIV and AIDS education programmes.
4. Provide resources and train teachers for HIV and AIDS education.
5. In refugee or internal displacement situations where AIDS awareness and prevention education programmes are being implemented in camps, establish programmes for neighbouring populations.

Guidance notes

1. **Take steps to strengthen the education ministry's/ ministries' capacity for skills-based health education for HIV prevention and related issues.**

- Does the education ministry already have capacity in this area?
  - Review the capacity/level of current functioning taking into consideration that the emergency will pose new challenges.
  - Is the education ministry collaborating with the ministry of health?
- There is an opportunity to benefit from international experience of HIV education, in emergencies and in normal situations. Are external donors interested in supporting the strengthening of ministry capacity in this area?
  - How can international experience with HIV and AIDS in emergencies and in normal situations be drawn upon?
  - Seek assistance for staff training.

2. **Conduct or facilitate a review of HIV and AIDS education programmes being carried out under government auspices, through civil-society organizations and external agencies and NGOs, for the emergency-affected populations, and establish a working group on this topic.**

- What HIV and AIDS education programmes already exist, and who is funding them?
- How are programmes being delivered?
  - Is it via formal or informal education, e.g. talks, posters, videos, drama presentations, leaflets, television shows or other media broadcasts?

- If it is via formal education, are programmes integrated across the core curriculum and/or within school health education?

- Consider the following when looking at the content of HIV prevention programmes:
  - Are the programmes founded on statistical facts and figures?
  - Is the information appropriate for the grade and level at which it is delivered?
  - Are local cultural and religious beliefs taken in to consideration?
  - Does the content project accurate understanding of the nature, means and likely causes of infection and include training in behavioural skills for responsible sexual behaviour to avoid HIV and other sexually transmitted infections (STIs), pregnancy, alcohol or drug abuse?
  - Does the content include sessions in empathy and information on what is appropriate care for persons who are infected with HIV?
- Are participatory teaching methods encouraged as a teaching strategy?
  - Does the teaching methodology enable students to recognize their attitudes and feelings about HIV and people living with HIV?
- Who is delivering the programme – teachers, peer educators, health workers, etc?
  - What kind of training have facilitators undergone?
- Are any counselling services provided?

3. Provide guidance to educational authorities in emergency-affected areas and to civil-society organizations on the conduct of HIV and AIDS education programmes, including elements such as those listed below.

(See also the 'Tools and resources' section of this chapter for information on the possible content of HIV and AIDS programmes, as well as for ways to promote effective HIV and AIDS education for behaviour change.)

- In the acute phase of an emergency, consider the use of multiple channels for HIV and AIDS awareness, especially where regularly attended school programmes cannot be assured. Consider the use of community education, radio, television, leaflets, or other mechanisms to convey information on HIV and AIDS and safe practices. (To prevent the spread of HIV, it may also be equally important, if not more so, to reach soldiers with these messages.)
- Involve all stakeholders in the design of HIV and AIDS education programmes.
  - Before starting new educational programmes on HIV and AIDS, involve teachers, community leaders, women's groups and youth in focused discussions or workshops related to HIV and AIDS education.
    - Since the discussion of sexual practices and HIV is always culturally sensitive, great care must be used at the beginning of this process to provide a sense of ownership to teachers and the larger community.
    - Teachers, peer educators or group leaders must be trained to facilitate these discussions.
- Assess the need for HIV prevention education for students and for the broader community.
- What are the facts related to HIV prevalence and risk in the displaced community, the surrounding community, the country or area of origin and the host country (in refugee situations)?
  - What specific risk behaviours exist?

- What knowledge, attitudes, belief, values, skills and services positively or negatively influence behaviours and conditions most relevant to HIV and other sexually transmitted infections (STIs)? (See also the 'Tools and resources' section for examples of the types of knowledge, attitudes, beliefs and skills that are needed to prevent HIV transmission.)
- Can an HIV prevention/awareness programme be directly implemented in schools?
- What alternatives are possible if full inclusion into the curriculum is not possible (after-school or weekend activities, holiday programmes, etc.)?
- Does the community support education related to HIV and AIDS awareness and prevention, 'safe sex' and care for and/or rights of people living with HIV?

HIV EDUCATION PROGRAMMES FOR ADOLESCENTS

Save the Children Fund (UK) has carried out adolescent education programmes on reproductive health and HIV in South East Asia. Some important messages emerged:

- Personalize the AIDS problem so that all are aware of the fact that everyone is at risk in different ways.
- Involve programme recipients in planning to ensure sustainability and accordance with certain rights of the child.
- Include components of self-esteem building based on the premise that "young people will only protect themselves if they have a sense of their own worth".
- Encouragement from adults is essential. Children are likely to confront HIV more effectively if not limited by adult restrictions.

Source: Pfeiffer (1999).

  - What types of educational activities does the community want/support? (Community participation requires a series of open discussions where the elements and ramifications of HIV and AIDS education programmes are openly and frankly discussed.)
    - Inclusion in the formal school curriculum?
    - Workshops or non-formal education on these themes?
- Consider establishing school health teams (see also the *Guidebook, Chapter 4.2,* 'Health and hygiene education') to coordinate and monitor health promotion policies and activities, including those related to HIV and AIDS.
  - Potential members of the teams include: teachers, administrators, students, parents and health-service providers.
  - The involvement of parents and teachers will help ensure that programmes are developed in a culturally appropriate manner.
- Consider involving youth in all stages of HIV and AIDS education programmes, including their planning, implementation and evaluation.
  - Young people's involvement is critical since they get much of their sexual health knowledge from their peers.
    - Peers can convey messages about what is – and what is not – safe sexual behaviour.
    - Young people can use language and arguments that are relevant and acceptable to their peers.
    - Young people have credibility with their peers and may be able to offer applicable solutions to prevention problems.
  - For peer education to work, peer educators need training and supervision.

- Those trained as peer educators may benefit from improved self-esteem and skills and attitudes with regard to sexuality and health.

- Identify modifications required in the current curriculum to ensure inclusion of HIV awareness and prevention issues. (See also the Guidebook, Chapter 4.1, 'Curriculum content and review processes.')
  - Can HIV prevention/life skills be taught as a separate subject? This will take persuasion but may be possible where decision-makers are sincerely concerned about building an AIDS-free future. (See the 'Tools and resources' section for a discussion of where to place life-skills based education in the curriculum.)
  - If HIV prevention is not taught as a separate subject, can one particular subject (health or biology, for example) be designated that will allocate one specified period per week to this topic?
    - "Education to prevent HIV/STI and related discrimination should be combined with education about life skills, reproductive health and alcohol/substance use so that the learning experiences will complement and reinforce each other" (Aldana and Jones, 1999: 22).
  - Are there curriculum writing revision groups in existence who can be trained to include elements of HIV education as well?
    - Consider involving students, parents, teachers, representatives of ministries, curriculum developers, school personnel, persons living with HIV, and community leaders at key stages of curriculum development.
    - Determine which outside groups are already working on HIV awareness/prevention/life skills and seek to collaborate with them.

- Can existing HIV and AIDS programmes be adapted for use in the current environment? When reviewing the curriculum, consider whether the curriculum:
  - Integrates HIV education across the core curriculum and/ or within comprehensive school health education.
  - Provides all students, at each grade level, with age- and gender-appropriate learning experiences, and considers cultural and religious beliefs.
  - Includes information about the prevalence of HIV/STI among young people in the nation/area and the extent to which young people practise behaviours that place them at risk of infection.
  - Sets objectives that reflect the needs of students, based on local assessment and relevant research.
  - Includes scientifically accurate information about the prevention of HIV infection.
  - Includes behavioural skills for responsible sexual behaviour to avoid HIV/STI, pregnancy and alcohol and drug use.
  - Includes learning experiences to promote empathy for and appropriate care of persons who are infected with HIV.
  - Addresses the use of effective teaching strategies (using participative methods).
  - Provides opportunities for parents and the community to learn about and reinforce education about HIV/STI.
  - Helps students recognize their attitudes and feelings about HIV and people living with HIV.

4. Provide resources and train teachers for HIV and AIDS education.

- Identify resources required for implementation of the accepted programme. (See also the 'Tools and resources' section for some challenges related to implementing skills-based health education.)

- What consumable resources are required? These should be a minor part of the budget so that the programme remains sustainable even in the event of budget cuts.

- How will suitable teachers be identified and made available – will new teachers be hired or will teachers be selected for training from the existing staff?

EFFECTIVE LIFE-SKILLS PROGRAMME PROVIDERS		
CAN BE …	**SHOULD BE PERCEIVED AS …**	**SHOULD HAVE THESE QUALITIES …**
• Counsellors • Peer leaders • Social workers • Health workers • Teachers • Parents • Psychologists • Physicians • Other trusted adults	• Credible • Trustworthy • High status • Positive role model • Successful • Competent	• Competent in group processes • Able to guide and facilitate • Respectful of children and adolescents • Warm, supportive, enthusiastic • Knowledgeable about specific content areas relevant to adolescents • Knowledgeable about community resources

Source: Education International and the World Health Organization (2001).

- How much training and in-school mentoring of teachers is required? (See additional points on training below.)

- How will the programme be funded and for what period?
  - After the initial start up phase, ensure the sustainability of the programme by including the necessary teachers and other resources in the normal education budget.

- What technical support is required?
  - Who will supply it?
  - What linkages can be made with local health providers (e.g. for referral of students for medical care or testing) or other organizations supporting HIV prevention (e.g. for condom distribution)?
- Provide awareness training for all educational administrators and other education workers not directly involved in the HIV and AIDS education programme.
  - It is essential that all schoolteachers and education personnel be trained on HIV prevention and education. They need to know:
    - The rationale for implementing HIV/STI education.
    - Accurate information about HIV/STI prevention.
    - Accurate information about sexual behaviour, beliefs and attitudes of young people.
    - Accurate information about alcohol and substance use in relation to HIV/STI prevention.
    - How to refer students with sexual health problems to appropriate services.
  - They need to have:
    - Opportunities to examine their own standards and values concerning sexuality, gender roles and substance use. Codes of conduct should prohibit sexual relationships between education personnel and students.
    - Practice using various methods to impart knowledge, develop attitudes and build skills related to HIV/STI prevention and responsible sexual behaviour.
    - Conflict management and negotiation skills.
- For teachers and other education workers who will be directly responsible for HIV education, ensure that their training includes the use of participatory methods. The training should be participatory and include:

- Training objectives and content that meet the identified needs of teachers.
- Follow-up sessions or some other way periodically to provide updates on HIV and other important health problems.
- Practice to increase teachers' comfort when discussing sexual behaviour, intravenous drug use and slang terms.
- Ways to deal sensitively yet firmly with cultural and religious traditions that perhaps hinder discussion about sex and sex-related matters in the school.
- The use of participatory techniques and skill-building exercises.
- Referral skills and ways to access health and social services.
- Methods to asses the impact and effectiveness of the training, with revisions in the training format made as needed.

- In returnee situations, make use of returning teachers who have been trained in HIV and AIDS education.
  - Consider using the knowledge and experience of trained returnee teachers to help establish education for HIV prevention and general community health in the curriculum of the home country.

5. In refugee or internal displacement situations where HIV awareness and prevention education programmes are being implemented in camps, establish programmes for neighbouring populations.

- Ensure that there are parallel education programmes in the host community to ensure mutual reinforcement and common behaviour modifications to minimize the spread of HIV.
  - What related programmes exist in the general community?

- Are the concept areas and attitudes similar?
- Do the programmes encompass and cater to members of all social groups (e.g. girls/women, youth, minority groups, religious, cultural groups, etc.)?

TOOLS AND RESOURCES

1. Some basic facts about HIV and AIDS

What are HIV and AIDS?

The human immunodeficiency virus, or HIV, attacks the body's immune system. By weakening the body's defences against disease, HIV makes the body vulnerable to a number of potentially life-threatening infections and cancers. HIV is infectious, which means it can be transmitted from one person to another. AIDS stands for 'acquired immunodeficiency syndrome' and describes the collection of symptoms and infections associated with acquired deficiency of the immune system. Infection with HIV has been established as the underlying cause of AIDS. The level of HIV in the body and the appearance of certain infections are used as indicators that HIV infection has progressed to AIDS (www.ispub.com/journal/the-internet-journal-of-health/volume-4-number-1-20/article/basic-facts-about-hiv-and-aids.html).

How is HIV transmitted?

People can be exposed to HIV in the following three ways:

- Unprotected sexual contact, primarily through unprotected vaginal or anal intercourse with an infected partner. Worldwide, sexual intercourse is the leading mode of HIV transmission. Oral sex is much less likely than vaginal or anal intercourse to result in the transmission of HIV. Women are more likely to contract HIV from men than vice versa. Among females, the risk is greatest for adolescent girls and young women, whose developing reproductive systems make them more likely to become infected if exposed to sexually transmitted infections (STIs), including HIV.
- HIV is transmitted most easily through the introduction of HIV-infected blood into the bloodstream, particularly through transfusion of infected blood. Most blood-to-blood transmission now occurs as a result of the use of contaminated injection equipment during injecting drug use. Use of improperly sterilized syringes and other medical equipment in health-care settings can also result in HIV transmission.
- Transmission from a mother with HIV infection to her child, during pregnancy, during delivery or as a result of breastfeeding.

How is HIV **not** transmitted?

HIV is the most carefully studied infection in history. Overwhelming evidence indicates that you *cannot* become infected in any of the following ways:

- Shaking hands, hugging or kissing.
- Coughing or sneezing.
- Using a public phone.
- Visiting a hospital.

- Opening a door.
- Sharing food, eating or drinking utensils.
- Using drinking fountains.
- Using toilets or showers.
- Using public swimming pools.
- Getting a mosquito or insect bite.
- Working, socializing, or living side by side with people living with HIV.

How can I avoid becoming infected?

HIV infection is entirely preventable. Sexual transmission of HIV can be prevented by:

- Abstinence.
- Monogamous relations between uninfected partners.
- Non-penetrative sex.
- Consistent and correct use of male or female condoms.

Additional ways of avoiding infection:

- Injecting drug users should always use new needles and syringes that are disposable, or those that are properly sterilized before reuse.
- For blood transfusion, blood and blood products must be tested for HIV and blood safety standards are implemented.

Source: Adapter from UNAIDS (2004) and UNAIDS (2005).

2. What knowledge, attitudes, beliefs, values and skills related to HIV transmission are needed?

KNOWLEDGE **Students will learn that:**	**ATTITUDES/BELIEFS/VALUES** **Students will demonstrate:**	**SKILLS** **Students and others will be able to:**
YOUNG CHILDREN		
• HIV is a virus some people have acquired • HIV is difficult to contract and cannot be transmitted by casual contact, such as shaking hands, hugging or even eating with the same utensils • People can be HIV-infected for years without showing symptoms of this infection • Many people are working diligently to find a cure for AIDS and to stop people from contracting HIV infection	• Acceptance, not fear, of people living with HIV and AIDS • Respect for themselves • Respect between adolescent males and females – tolerance of differences in attitude, values and beliefs • Understanding of gender roles and sexual differences • Belief in a positive future • Empathy with others • Understanding of duty with regards to self and others • Willingness to explore attitudes, values and beliefs • Recognition of behaviour that is deemed appropriate within the context of social and cultural norms • Support for equity, human rights and honesty	• Acquire practical and positive methods for dealing with emotions and stress • Develop fundamental skills for healthy interpersonal communication

KNOWLEDGE Students will learn that:	ATTITUDES/BELIEFS/ VALUES Students will demonstrate:	SKILLS Students and others will be able to:
PRE-ADOLESCENTS		
• Bodily changes that occur during puberty are natural and healthy events in the lives of young persons, and they should not be considered embarrassing or shameful • The relevance of social, cultural, and familial values, attitudes and beliefs to health, development and the prevention of HIV infection • What a virus is • How viruses are transmitted • The difference between AIDS and HIV • How HIV is and is not transmitted	• Commitment to setting ethical, moral and behavioural standards for oneself • Positive self-image by defining positive personal qualities and accepting positively the bodily changes that occur during puberty • Confidence to change unhealthy habits • Willingness to take responsibility for behaviour • A desire to learn and practice the skills for everyday living • An understanding of their own values and standards • An understanding of how their family values support behaviours or beliefs that can prevent HIV infection • Concern for social issues and their relevance to social, cultural, familial and personal ideals • A sense of care and social support for those in their community or nation who need assistance, including persons infected with and affected by HIV • Honour for the knowledge, attitudes, beliefs and values of their society, culture, family and peers	• Communicate messages about HIV prevention to families, peers and members of the community • Actively seek out information and services related to sexuality, health services or substance use that are relevant to their health and well-being • Build a personal value system independent of peer influence • Communicate about sexuality with peers and adults • Use critical thinking skills to analyse complex situations that require decisions from a variety of alternatives • Use problem-solving skills to identify a range of decisions and their consequences in relation to health issues that are experienced by young persons • Discuss sexual behaviour and other personal issues with confidence and positive self esteem • Communicate clearly and effectively a desire to delay initiation of intercourse (e.g. negotiation, assertiveness) • Express empathy toward persons who may be infected with HIV

KNOWLEDGE Students will learn:	ATTITUDES/BELIEFS/ VALUES Students will demonstrate:	SKILLS Students and others will be able to:
ADOLESCENTS		
• How the risk of contracting HIV infection can be virtually eliminated • Which behaviours place individuals at increased risk of becoming infected with HIV • What preventive measures can reduce risk of HIV, STI and unintended pregnancies • How to obtain testing and counselling to determine HIV status • How to use a condom appropriately	• Understanding of discrepancies in moral codes • A realistic risk perception • Positive attitude towards alternatives to intercourse • Conviction that condoms are beneficial in protecting against HIV/STI • Willingness to use sterile needles, if using intravenous drugs • Responsibility for personal, family and community health • Support for school and community resources that will convey information about HIV prevention interventions • Encouragement of peers, siblings and family members to take part in HIV prevention activities • Encouragement of others to change unhealthy habits • A leadership role to support the HIV prevention programme • Willingness to help start similar interventions in the community	• Refuse to have sexual intercourse if they so choose • Assess risk and negotiate for less risky alternatives • Seek out and identify sources from which condoms can be obtained • Appropriately use health products (e.g. condoms) • Seek out and identify sources of help with substance use problems, including sources of clean needles or needle exchange

Source: Aldana and Jones (1999: 19-21).

3. Promoting effective HIV and AIDS education for behaviour change

The activities and methods used for teaching about HIV and AIDS are sometimes as important as the content of the information.

Methods could include:

- Instruction: providing an explanation and rationale for learning the new skill.
- Modelling: providing an example of effective enactment of the behaviour by a credible model.
- Practice: role-playing potential risk-inducing situations to practise the new behaviour.
- Feedback: using feedback on performance from group leader and fellow group members to support and reinforce behaviour changes.

Source: Kalichman and Hospers (1997).

4. Where to place life-skills-based education in the curriculum?

A major policy issue is where to place life skills for HIV prevention in the curriculum. Experience suggests that it needs a special place, within a 'carrier subject' in the short term and as a separate curriculum element in the longer term. The advantages and difficulties associated with different approaches are shown below.

Approach (1): 'Carrier' subject alone

In this approach, skills-based education is integrated into an existing subject, which is relevant to the issues, such as civics, social studies or health education.

Conclusion: good short-term option.

ADVANTAGES	DISADVANTAGES
• Teacher support tends to be better than for infusion across all subjects. • Teachers of the carrier subject are likely to see the relevance of the topic to other aspects of the subject. • Teachers of the carrier subjects are likely to be more open to the teaching methods and issues being discussed due to their subject experience. • Training of selected teachers is faster and cheaper than training all, for the infusion approach. • Cheaper and faster to integrate the curriculum components into materials of one principal subject than to infuse across all. • The carrier subject can be reinforced by infusion through other subjects.	• Risk of an inappropriate 'carrier' subject being selected, e.g., biology is not as good as health education or civic education because the social and personal issues and skills are unlikely to be addressed adequately by science teachers.

Approach (2): Separate subject

In this approach, skills-based education is taught as a specific subject, perhaps in the context of other important issues, such as health education or health and family life education.

Conclusion: good longer-term option.

ADVANTAGES	DISADVANTAGES
• Likely to have teachers who are focused on the issues, who are more likely to be specifically trained (but this is not guaranteed). • Most likely to have congruence between the skills-based content and the participative teaching methods needed in the subject, rather than shortcutting and omission of content, which may occur with 'infusion' or 'carrier subject' approaches.	• The subject may be attributed very low status and not seen as important, especially if not examinable. • Requires additional time to be found in already overloaded curriculum.

Approach (3): Integration/infusion across subjects

In this approach, skills-based education is included in all or many existing subjects through regular classroom teachers.

Conclusion: least effective option.

ADVANTAGES	DISADVANTAGES
• A 'whole schools' approach can be taken. • Utilizes structures that are already in place and is often more acceptable than a separate course of sex education. • Many teachers involved – even those not normally involved in the issue. • High potential for reinforcement.	• The issues can be lost among the higher status elements of the subjects. • Teachers may maintain a heavy information bias in content and methods applied, as is the case with most subjects. • Very costly and time consuming to access all teachers, and influence all texts. • Some teachers do not see the relevance of the issue to their subject. • Potential for reinforcement seldom realized due to other barriers.

Source: Adapted from UNICEF (n.d.).

Recent guidelines from UNESCO (*International Guidelines on Sexuality Education: An evidence informed approach to effective sex, relationships and HIV/STI education* – 2009) offer additional guidance to support national authorities and health professionals to develop and implement school-based sexuality education programmes and materials.

5. Some challenges to implementing skills-based health education

1. **Health care providers, youth workers and teachers are often expected to help adolescents develop skills that**

they themselves may not possess. Programme providers may need help building assertiveness, stress-management, and/or problem-solving skills for themselves before being able to teach these skills in the classroom. Therefore, an important component of any training programme is the inclusion of activities in which potential providers can also address their own personal needs.

2. **There is a need to train adults in using active teaching methodologies**. Skills-based health education encourages participation by all students and, as a result, can create classroom dynamics with which some teachers are not familiar. Research, however, has found that teachers who were initially uncomfortable with the idea of using participatory methodologies in their classrooms overcame their reluctance after practising these methods during training sessions. Provider confidence is essential to the success of skills-based education.
3. **Programme providers may feel uncomfortable addressing the sensitive issues and questions that may arise**. Some providers may feel unprepared to communicate with their students about sensitive topics such as sexual and reproductive health, violence and relationships. They also may not know where to go to access additional information on these topics. Again, training teachers prior to implementation on how to best address and respond to questions or comments about sensitive topics is the key to overcoming this challenge. Providers should also be encouraged to interact and meet with one another throughout the school year to share ideas and suggestions.
4. **Programme providers are underpaid and overworked**. Programme providers may not have the morale or energy

to learn new teaching methodologies. Therefore, providers need to understand how skills-based education can have immediate and long-lasting benefits not only on their students' lives but also on their own personal and professional lives. Training programmes should include activities which help teachers build skills that they can use in their daily lives, e.g. to improve relationships, avoid sexual violence or harassment, or overcome alcohol or drug use. Studies have shown that skills-based education programmes can indeed improve attendance and morale among providers (Allegrante, 1998).

5. **Teachers are often asked to implement many different curricula and instructional efforts, without a clear understanding of the relationships among them and the relative benefits of each**. A lack of coordination between school administrators, curriculum coordinators and health and education sectors can result in a number of competing curricula. This can prove to be frustrating to overworked teachers who may start to view new programmes as just another addition to their existing workload. Key to overcoming this challenge is a close collaboration between all involved, including teachers, so that there is a clear understanding of how new curricula can realistically be used to complement what is already being implemented.

Source: Education International and the World Health Organization (2001).

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