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Youth and skills: Putting education to work

Life-skills education in the context of HIV and AIDS

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Life-skills education in the context of HIV and AIDS

Three policy messages:

- While LSE is an important component/ingredient of HIV-prevention interventions, particular those focusing on young people, it cannot stand alone and needs to be delivered in combination/through linkages with other servicers and be part of a comprehensive HIV response both within and beyond the education sector.

- LSE needs to be context specific and needs to take into account, often changing, gender, age and geographical dimensions and priorities - one size does not fit all; at the same time, some form of minimum package/standards needs to be identified to allow for easier national and international monitoring and evaluation.

- It is critical that those imparting LSE, be they teachers or other youth or adult educators in either formal or informal settings, are supported in doing so and are both trained in LSE and HIV and AIDS-related themes.

Although there are some recent success stories in efforts to control and curb the AIDS epidemic, including declines in HIV prevalence, particularly amongst young people (see e.g. Ghys et al, 2011), HIV-related knowledge remains stagnant and young people are still becoming infected with HIV. Thus young people aged 15–24 years accounted for 41% of all new HIV infections among adults in 2009; young women are particularly vulnerable, accounting for more than 60% of all young people living with HIV, and 72% of all young people living with HIV in sub-Saharan Africa (UNICEF 2011). In terms of knowledge levels, according to recent global estimates, only 24% of young women and 36% of young men, aged between 15-24, have comprehensive knowledge of HIV, i.e. can correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, far below the global target of reaching 95% by 2010 (UNAIDS, 2011, 2011b). Similar findings are emerging from SACMEQ III (Southern and Eastern African Consortium for Monitoring Educational Quality) – in their survey of 61,396 Grade 6 pupils (with an average age of 13.5) and 8,026 teachers in 2,779 schools across 15 countries[1], they found that around two-thirds of all students did not have the minimum knowledge about HIV and AIDS that was required to protect and promote health. In addition, there was a large gap in knowledge between teachers and pupils and there were major differences in average knowledge about HIV and AIDS across different locations (urban/rural) and different social classes (wealthy/poor), within many SACMEWQ countries[2].

This piece explores the role of life-skills education (LSE) in the context of HIV and AIDS, in particular in relation to its potential for contributing towards HIV prevention efforts amongst young people. LSE within the context of HIV and AIDS can occur both in school and in non-schools settings; target groups for such education include children, youth and adults. Groups particularly at risk of HIV-acquisition, include sex workers, intravenous drug users and men-who-have-sex-with-men. Arguably young people, and particularly young women, can be included in this high risk group; and one key means of reaching them, often even before they become sexually active and/or engage in risky behaviors, is through learning environments.

[1] Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania (Mainland), Tanzania (Zanzibar), Uganda, Zambia and Zimbabwe

[2] For more information see the SACMEQ website and country briefs http://www.sacmeq.org/HIV-AIDS-research.htm

The role of education in HIV prevention. Education has been identified as a key element in HIV prevention; even in the absence of HIV-specific interventions, education was seen to offer an important protection against HIV. The Global Campaign for Education (2004), for instance, estimated that universal primary education alone would prevent 700,000 new HIV infections each year. More recent studies and reviews find similar evidence: in their systematic review, Hargreaves et al (2008), for instance, find a tendency for higher HIV prevalence rates to be associated with the least educated in sub-Saharan Africa. Similarly, in their study in South Africa, Hargreaves et al (2008b) also found that attending school can be associated with lower-risk sexual behaviours; lower HIV prevalence among young men; and that secondary school attendance may influence the kinds of sexual relationships in which young people engage and thereby can also reduce HIV risk. They conclude generally that school attendance may reduce HIV transmission among young people.

The role of HIV and AIDS-related education. Given that education per se is a protective factor against HIV-acquisition, HIV-specific interventions within educational / learning environments, are likely to have an even greater protective effect. And indeed, a number of studies conclude that there is sufficient evidence to support wide-spread implementation of school-based HIV related interventions (e.g. UNAIDS, 2006; Kirby et al, 2006; Ross et al., 2007; Harrison et al, 2010). In their systematic review, for instance, Mavedzenge, et al (2010 and 2011) conclude that school-based, adult-led, curriculum-based interventions showed clear evidence of reductions in reported risky sexual behavior; similarly, Yankah and Aggleton (2008) state that "Overall, effective interventions were shown to have positive effects on knowledge, attitudes, skills and sometimes on behaviours" (pg 468). For young women, who in many countries are particularly vulnerable to HIV and AIDS, a recent literature review concludes that one way to empower them to assert their sexual and reproductive rights is by increasing access to education, particularly secondary education (Hargreaves and Boler, 2006). More broadly it can be argued that HIV and AIDS-related education is critical for young people since it provides them with information before they become sexually active or potentially engage in risk behaviours, including drug use (see also World Bank, 2002 and 2010). For young people who are already sexually active or using drugs, such education can also help protect them through providing information and knowledge about where and how to seek help, information and services.

The role of Life Skills Education (LSE) in the context of HIV and AIDS-related education. Within the HIV discourse, and indeed beyond, over the past decade or so there has been an increasing awareness and growing body of evidence that education, while critical for increasing knowledge about HIV prevention and transmission, is not sufficient in itself to affect behaviours, skills and attitudes (e.g. Kirby, 2001; UNAIDS, 1997; Yankah and Aggleton, 2008). Alongside such health education, appropriate life skills need to be imparted to provide the additional and complementary attributes to allow individuals to take on board, own, appropriate and put into the action the knowledge acquired. The importance of LSE in the context of HIV and AIDS was also recognised in the UNGASS Declaration of Commitment on HIV and AIDS, the annual high level meeting on HIV and AIDS bringing together all UN member states to discuss responses to HIV and AIDS. During the first meeting, in 2001, and arguably one of the most influential, the declaration was written laying out the political commitments on how to tackle HIV and AIDS. As part of HIV prevention, life skills were identified as part of the education necessary to reduce vulnerability to HIV (see page 21, UN 2001). A core national indicator (number 11) for assessing the coverage of school-based life skills education for HIV prevention was also developed.

Although the literature and approaches to LSE have proliferated in recent years, being applied to a range of themes and contexts, resulting also in challenges in pinning down the concept, agreeing on common definitions and ways of measuring effects and impacts, the UNICEF definition is useful since it encapsulates the essence of LSE and, given its health focus, is fitting for this piece: "This term refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life. Life skills may be directed toward personal actions and actions toward others, as well as actions to change the surrounding

environment to make it conducive to health"[3].

More specifically, in relation to HIV and AIDS, LSE "... are said to facilitate the negotiation of risk and vulnerability in the face of the epidemic. They enable people to communicate openly and freely about sex and drugs, indicating their preferences and what they wish to avoid. They result in clear thinking, having the right attitudes and staying safe" (Yankah and Aggleton, 2008, pg 466). LSE is, therefore, now considered a key part of HIV and AIDS-related education, particularly in relation to HIV prevention. While HIV and AIDS-related education provides information and knowledge, if the ways in which this information and knowledge can be applied is not provided, it becomes meaningless. Similarly providing information and knowledge about technologies (e.g. condoms) and access to services (e.g. HIV testing or needle exchange programs for drug users), but without the ways to use and access them, both the information/knowledge and technologies are likely to become un-used and unapplied. Hence the ways knowledge can be applied, the ways services can be accessed, how to make informed decisions with the knowledge/information that is provided, how to say no to sex, and how to negotiate condom use would all be part of life-skills.

The effects/impacts of LSE in the context of HIV and AIDS-related education. Although there are relatively few rigorously evaluated programmes, Yankah and Aggleton (2008) found a sufficient number in their review to conclude that the majority of programmes had positive impacts on knowledge, attitudes and intentions to change behavior, with longer term evaluations showing more positive effects (see also studies in Mexico, Givaudan et al, 2008; China, Cheng et al, 2008; and Kenya, Dupas, 2011 and Duflo, et al 2011). However, they note that although a few studies did show positive effects on sexual behavior/behavior change, e.g. increased delay of sexual debut, increased condom use at first sex, a decrease in ever having had sex, a reduced number of sexual partners, it was much rarer and was not consistent across studies. Similarly, also partly because only a minority of studies consistently measured skills (e.g. negotiation, decision-making, problem-solving) as an outcome, there was little consistent evidence to show LSE improving abilities and skills. There are, nevertheless, many programmes, some of which are discussed here which, despite not either being rigorously evaluated or evaluated at all, show positive results.

LSE in the context of sexuality education and HIV and AIDS-related education. HIV and AIDS-related education for young people, particularly school-based, is often delivered in a broader context of sexuality education. LSE is a common thread or cross-cutting theme also throughout sexuality education. Sexuality education guidance recently developed by UNESCO, includes, for instance, both HIV and AIDS related themes and those related to LSE (UNESCO, 2009). The remainder of this piece will explore some key components of LSE in the context of sexuality and HIV and AIDS-related education, moving on to consider some challenges and ways forward/recommendations.

Some key components of LSE in the context of sexuality and HIV and AIDS-related education[4]

Ways of delivering LSE. LSE can be delivered through formal or informal settings; it can be school-based or non-school based; it can be delivered completely outside the school, e.g. through drop-in-centers targeting youth, or it can be linked /integrated into the school through, e.g. out-of-school activities but within the school premises or through peer education. It can be delivered through the government/public sector or through the private/CSO sector, or a combination of the two.

Each form of delivery has its merits and drawbacks. A recent study by UNESCO (2011), concludes that to reach a critical mass of young people, comprehensive sexuality education programmes, within which LSE is also taught, should be intra-curricular, compulsory, examinable, integrated into national curricula and scaled up

[3] http://www.unicef.org/lifeskills/index_7308.html

[4] From now on the LSE will be used as an abbreviation for LSE in the context of sexuality and HIV and AIDS-related education.

through the public sector. According to the study, private/NGO run programmes, usually extra-curricular and voluntary, may be small-scale pilot initiatives, unconnected to the national education system, unrecognised by the public sector, and therefore may be not cost-effective, replicable, able to be scaled-up and not be of sufficient duration to have an effect on behaviours. Additionally, they may be difficult to monitor: drop-in-centres, for instance, while they potentially offer a spectrum of services and youth are often able to access them anonymously or when they need them, they are neither structured nor mandatory and because of their very nature, the results and outcomes are difficult to monitor and measure.

However, such often NGO-led pilot programmes, may be useful in providing initial learning experiences which, if successful, could be gradually integrated into the national curriculum – see for instance the examples in Uganda, Kenya and Indonesia (UNESCO, 2011 and Leerlooijer et al, 2011). Additionally, in contexts where teaching sexuality education may be sensitive and/or taboo, this may be the only means to get knowledge and information to young people. Programmes run by youth organisations or delivered using peer educators, which have proved to be an effective means of delivering LSE, since youth feel a greater comfort and openness when talking to their peers - as is seen by the successful Together We Can Programme a partnership with national Red Cross societies and Ministries of health in Tanzania, Haiti and Guyana[5] and the programme in Yemen (Al-Iyrani et al, 2011 and 2011b), through which youth have been mobilized to delivery HIV prevention messages, offer life skills training and provide education and support to youth - may also be more effective since they usually include features such as directly tailored activities, small group sizes and voluntary participation (Kirby et al., 2006). Similarly, school-based programmes may face challenges in reaching high risk and/or marginalised children, particularly since many of these children/young people are not in schools anyway or may drop out at the time that LSE, sexuality and HIV education is taught, and when they need it most, usually at secondary level.

Box xx provides examples of 2 relatively successful programmes, implemented through very different modalities.

Box xx Different models of delivering LSE

Grassroots soccer (GRS) [6] **,** implemented in Zimbabwe, South Africa, Zambia, Tanzania, Malawi, Ethiopia, and Namibia, takes the form of an out of school activity for male and female youth between the ages of 12-18, also involving elements of peer education. Based on the assumption that soccer is an integral part of societies in many parts of the world, that it reaches to all communities and is, therefore, a form of leveler creating connections between different kinds of people, and that soccer stars are both heroes and role models, soccer is used as a means of getting out messages about behavior, the risks of HIV and as such raising awareness and contributing to changing behaviours. Grassroots soccer graduates are also trained to become peer educators and advocates in their communities. Thus the GRS curriculum uses activities and games to provide youth with comprehensive HIV prevention and life skills education; soccer stars are used as HIV educators and spokespeople.

According to the implementers, rigourous monitoring and evaluation has been central to GRS's success. Ten evaluations in seven countries have shown positive impact on knowledge, attitudes, stigma, and communication related to HIV. A 2008 behavioral survey found that 2-5 years after the intervention, GRS graduates in Zimbabwe were nearly six-times less likely than their matched peers to report sexual debut between 12-15 years, four-times less likely to report sexual activity in the last year, and eight-times less likely to report ever having had more than one sexual partner (Kaufman et al, 2010). An

[5] http://www.redcross.org/www-files/Documents/pdf/international/together_we_can_fact_sheet.pdf; http://www.redcross.org/portal/site/en/menuitem.d229a5f06620c6052b1ecfbf43181aa0/?vgnextoid=5ded9891353ab110VgnVCM10000089f0870aRCRD&cpsextcurrchannel=1

[6] http://www.grassrootsoccer.org/

earlier study in Zimbabwe also showed that after participating in the GRS curriculum: i) The percentage of students who could list three people they could talk to about HIV increased from **33%** to **72%; ii)** the percentage of students who knew where to go for help for HIV related problems increased from **47%** to **76%;** the percentage of students who said they would feel comfortable providing emotional support for an HIV positive classmate increased from **52%** to **73%; and t**he percentage of students who believe condoms were effective increased from **49%** to **71%** (Children's Health Council, 2004).

The challenge with GRS, and indeed any other out-of-school activity which delivers education beyond the school and therefore often by-passing teachers, and despite its success in changing attitudes and behaviours in some countries, is that it is not being mainstreamed into the education system. Thus, without having teachers and other educational staff onboard and educated, the sustainability, replicability and scaling-up of such approaches may be more difficult. The evaluations (e.g. Children's Health Council, 2004) also identified this as a challenge and teachers have become a key part of the programme in some countries/programmes.

Living: Skills for Life, Botswana's Window of Hope[7] is a national level HIV and AIDS awareness curriculum that draws heavily on LSE. Created by Education Development Centre (EDC), with support and funding from CDC and PEPFAR, this curriculum was implemented in close partnership with the Botswana Ministry of Health. The objective of the curriculum is to impart knowledge, develop healthy attitudes, and instill skills for healthy decision making. It is viewed as a key component of national HIV prevention efforts, targeting ultimately every primary and secondary school student in the country. Launched in July 2006 and currently being scaled up across the country by the ministry of education, five sets of materials were designed and developed in collaboration with local teachers and other key stakeholders who provided the context and challenges associated with HIV and AIDS in Botswana. This has resulted in materials which are interactive, locally-based, gender-balanced, culturally-sensitive and differentiated for the different levels and ages of learners.

Each set of materials has a Teacher's Guide and Learner Worksheets. The Teacher's Guide provides the teacher with activities on 13 Chapters each addressing a specific life skill area. The activities are presented with procedures guiding the teacher on how to present the lesson in the classroom. The Learner Worksheets present the learners with activities which help them to explore situations and practice healthy responses. The Worksheets are designed to allow learners to use them on their own, with their peers or as part of a classroom activity. Teachers use stories, role-playing, poems, and class discussions to impart knowledge and build skills for healthy decision-making. Topics include self-awareness, goal-setting, managing stress, social responsibility, healthy living, relationships, sexuality, risk reduction, and facts and myths about HIV/AIDS. The materials discuss HIV prevention, promoting abstinence and emphasizing delaying sexual debut. For students ages 15 and older, the program also addresses intergenerational sex and transactional sex, and also discusses and provides referrals for condoms and other prevention interventions.

While there are many positive aspects of this programme, e.g. it was designed with full participation of key stakeholders, it is being scaled-up nationally and teachers' capacities are being built to deliver the course, it currently focuses on in-school children, thus missing out the 10-20% of young people who are out of school. Also, given that it is being scaled up nationally, the extent to which local/regional needs and contexts are being taken into consideration in the scale-up remains unclear (as of yet, no evaluation of effects or impacts of the programme is available).

[7] See http://www.hhd.org/resources/publications/living-skills-life-botswana-s-window-hope

Curriculum considerations. LSE can be delivered through different curriculum modalities: it may be integrated into the curriculum, be included as a standalone subject, or offered as a co-curricular activity. According to a number of authors (e.g. Tiendreberogo, et al, 2003; Senderowitz and Kirby, 2006), successful LSE have a planned and sequenced curriculum across primary and secondary school, incrementally adjusted to the age and stage of the learner. These reviews also suggest that at least 14 hours of teaching is needed per academic year for LSE, although some programmes have included booster sessions; they note the importance of focusing on clear and articulated behavioural goals, providing medically accurate information, personalizing and continually reinforcing key messages, and introducing practical skills and examples for dealing with social pressures or specific situations. The need for programmes to be age appropriate and relevant to the learner's situation is also emphasized. The content of the curriculum needs to include learning around: communication and listening skills; negotiation and refusal skills; decision-making and problem-solving skills; coping and self-management skills, e.g. the ability to manage feelings and stress; the ability to obtain condoms and other preventive measures from service providers, and the ability to negotiate their correct use with sexual partners (Yankah and Aggleton, 2008; see also UNESCO 2009).

Gender considerations when designing and delivering LSE. The needs and priorities of boys and girls are different and hence these differences need to be taken into account both when designing and delivering LSE. This can often result in young people learning in single sex groups, with a teacher or facilitator of the same sex; it also includes making schools more girl-friendly, e.g. paying attention to protecting privacy and safety (separate latrines for girls) and addressing gender and cultural stereotypes in educational materials (see e.g. Dworkin, et al, 2009). One example of this is the Life Skills Plus – Sister 2 Sister Initiative being currently piloted in Malawi, supported by UNICEF (see Box xx).

Box xx: Sister to sister Initiative in Malawi

Based on evidence that the 15-19 year old women are particularly vulnerable to HIV infection in Malawi and that young women tend to learn better and communicate more openly in single sexed learning environments, this programme focuses on young women (though, importantly also acknowledging that young men need this form of training). Its aims are to: i) prevent young women from becoming infected with HIV and dying from AIDS; ii)provide young women with skills to delay sexual intercourse, and/or have protected sexual intercourse with male or female condoms; iii) improve Life Skills: communication, negotiation, critical thinking, problem solving, assertiveness, self-esteem, self efficacy and decision making skills of young women around the sensitive topics regarding sexuality, gender, health and relationships; iv) provide young women with information and skills to assess their personal risk and address peer pressure; and v) provide young women with information and skills required to adopt health seeking behaviours including accessing appropriate health services. The programme is implemented through a peer approach, whereby older young women, 'big sisters' facilitate the training. It is extracurricular, supplements formal in-school life skills curriculum and can also be taught to out of school young women. It uses participatory and reactive approaches.

A proof of concept study has been carried out. Preliminary results suggest that overall, there has been greater increases in knowledge in the areas of sexuality, HIV, condom use, multiple and concurrent partners, age disparate relationships and health seeking behaviours in the experimental groups than the control group. This knowledge was sustained over time. Moreover, knowledge levels continued to increase from baseline through the 6 month final assessment (Bakaroudis, 2011).

Pedagogical approach. The approach used to deliver LSE is different from usual classroom teaching approaches which tend to be more didactic, non-participatory, inflexible and assessment-driven. LSE uses more interactive,

responsive and participatory methods, raising questions rather than providing answers and challenging young people to find new ways of relating to one another (see e.g. UNICEF, 2010).

Linkages and partnerships. LSE is likely to be most effective when it is linked to other services targeting youth. In Estonia, sexuality education is now provided in most schools. A number of factors can explain the positive trends in youth sexual health indicators in Estonia, e.g. the abortion and fertility rates among 15 to 19-year-olds declined by 61% and 59% respectively between 1992 and 2009 and the annual number of registered new HIV cases among 15 to 19-year-olds declined from 560 in 2001 to just 25 in 2009 (see Haldre et al, forthcoming), including increasing availability of modern contraception, changes in attitudes towards adolescent sexuality and reforms in the health and health insurance systems. Nevertheless, the partnerships developed between schools providing sexuality education and Youth Counseling Centres (YCCs) is a key ingredient[8]. Established prior to sexuality education being scaled up in schools, YCCs provide youth-friendly health services[9], and they work alongside schools in offering teachers help, for instance, in handling 'difficult' topics. Schools are also able to refer students to the YCCs. Hence schools-based sexuality education programmes and youth-friendly health services not only complement each other but reinforce and provide multiple avenues for reaching out to youth with sexual health-related messages and information.

External environment considerations. A recent study by UNESCO (2011) shows that in order for LSE to have more potential for being replicated and scaled-up, advocacy is critical. This is particularly the case in settings where sex and sexuality are politically or culturally sensitive issues. In Indonesia, for instance, advocacy activities targeting a range of key stakeholders, e.g. loc al government and educational authority, school management, students, parents and religious and community leaders during the development and implementation of a school-based HIV prevention programme, delivered through LSE, and targeting junior high school students, was key to its success (Pohan, et al, 2011). Through engaging communities and other key stakeholders, ensuring that advocacy is budgeted and planned for, and that it occurs from the beginning and on a continuous basis, adapted as contexts and needs change, ownership can be built and as such sustainability of such processes are more assured (see Samuels et al,2012) (see Box xx).

Box xx The importance of advocacy in the LSE

Family Life and HIV Education (FLHE) curriculum in Nigeria. From an early stage a range stakeholders were involved in discussions around a potential sexuality education programme in Nigeria. In 1999, the National Council on Education approved the integration of the Nigerian Sexuality Education Curriculum into the school system at all levels and gave the directive that appropriate steps be taken to ensure the integration of comprehensive sexuality education into school curricula. The curriculum was then developed through an inclusive, participatory process led by the Nigerian Education Research and Development Council (NERDC), the FME, the Universal Basic Education Commission (UBEC) and Action for Health International (AHI), drawing on perspectives from the 6 geopolitical zones in Nigeria, to ensure national coverage and socio-cultural applicability. In August 2001, the 'National Sexuality Education Curriculum for Upper Primary, Secondary and Tertiary Institutions' was approved.

During programme implementation, in response to concerns from parents, politicians and religious leaders that the curriculum was too explicit, discussions on condoms, contraception and masturbation were removed and the title was changed from 'Sexuality Education' to 'Family Life and HIV Education' (FLHE)*. The programme was first successfully scaled-up in Lagos State and currently, with funding from

[8] For History of the Youth Counselling Centres in Estonia see Part and Pertel, eds 2009.
[9] For more details on features and delivery of youth friendly health services see FOCUS on Young Adults 1999. Making Reproductive Health Services Youth Friendly. Washington, D.C.: Focus on Young Adults. http://www.hiv.gov.gy/edocs/focus_makingRHservicesyouthfriendly.pdf

the Global Fund, is starting to be scaled-up to all primary and junior secondary schools in all the states of Nigeria (Nigeria Federal Ministry of Education, 2011).

While the exclusion of key topics is problematic, particularly in a country with a generalized HIV epidemic and with a large and vulnerable population of young people, the fact that concerns were taken into account, and individual states were allowed to adapt the curriculum to suit their socio-cultural characteristics, meant that despite not being fully comprehensive, many original objectives of the curriculum continued to be met. Additionally, there are discussions underway to try and put these topics back into the curriculum (personal communication). Interestingly the teacher training guide – Family Life and Emerging Health Issues Curricula, Training Guide, for Colleges of Education in Nigeria (2009) - does include these topics so while teachers are being trained in them, it remains unclear to whom they are supposed to impart this knowledge.

*An online version of this curriculum (http://www.learningaboutliving.org/south/about) does mention condoms in passing, nevertheless, it still promotes abstinence above other factors and it is unclear how this online version relates, if at all, to the version of the curriculum which is currently being taught in schools.

Orissa State's (India) ***Adolescent reproductive and sexual health*** *curriculum* is implemented by the state government, targets 13-16 year olds, is intra-curricular and compulsory and is currently being scaled-up to all 30 districts in the State. It is part of a broader nationwide programme, the Adolescent Education Programme (AEP), whose overall aim is to empower young people to respond to 'real-life' situations; it does this through adopting a life skills approach - contents include "making healthy transitions to adulthood .. enhancing self-esteem, establishing and maintaining positive and responsible relationships, understanding and challenging stereotypes and discrimination related to gender and sexuality, prevention of HIV/AIDS and substance abuse" (UNFPA, 2011, p1). Although programme development began in 1998 and was launched in 6 pilot states (Gujarat, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Kerala) in 2002, it was shelved between 2003-2006 due to opposition around the content of the curriculum – it was seen to be too explicit, targeting children who were too young and therefore could potentially encourage promiscuity; it was also viewed as a top- down process, with little consultation with state and district level actors (TARSHI n/d, 2; see also McManus and Dhar 2008). It was reintroduced in 2007 in Orissa post an expert consultation involving a range of stakeholders, including adolescents themselves, in which, amongst other things state level specificities, close involvement of family and community members and providing training and support to teachers was deemed as critical (UNFPA 2009; see also UNESCO, 2011 and Samuels et al,2012). A recent evaluation of the AEP in 5 states including Orissa found that knowledge of HIV and AIDS was higher amongst students and teachers in schools that had been part of the AEP; similarly students and teachers from AEP schools showed, on the whole, less discriminatory attitudes than those from non-AEP schools. However the evaluation concludes that there is scope for improvement in knowledge levels among students, including learning more about the importance of consent driven voluntary HIV testing and the right to confidentiality and other related issues. The evaluation also implies that the programme is going relatively smoothly and enjoying stakeholder support and engagement (UNFPA, 2011).

Challenges and ways forward/recommendations

Challenges

A number of challenges exist at different levels. At global level, while in 2010, 87 out of 140 countries reported on the UNGASS indicator on coverage of LSE, with coverage ranging from 100% to 0% (UNAIDS, 2011; see also the UNGASS Country progress reports[10]), given that it is self-reported and, as of yet, there are no

[10] See http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/ for the current 2010 country

standard/agreed global guidelines for what constitutes LSE in the context of HIV, what is actually being taught and reported on remains relatively unknown. The fact that only approximately 60% of countries are reporting on this indicator, with many also reporting very low coverage, may imply lack of commitment to this indicator, partly due to problems of definition but also it may be perceived as donor driven (see Table xx for overview of countries by region reporting). Finally, since HIV is still viewed by many ministries of education as being the responsibility of the health ministries, the reporting on this indicator and indeed its implementation, may be seen as not their domain (see also Boler and Aggleton, 2004).

Table xx Countries by region reporting on coverage of LSE

Region	Number of countries reporting*	Range of coverage of countries reporting	Mean coverage of countries reporting
Sub-Saharan Africa	26/43	0.06%-100%	55.32%
E. Asia	1/2	100%	100%
S. and SE. Asia	10/22	0.14%-100%	28.23%
Oceania	3/6	7.8%-100%	69.26%
E. Europe and C. Asia	9/11	0%-100%	59.45%
W. and C. Europe	9/18	4.69%-100%	63.72%
Middle East and N. Africa	4/9	4.26%-100%	38.87%
Caribbean	12/12	8.43%-100%	68.26%
Central and S. America	13/17	0-100%	55.37%

*Reporting years include 2007, 2008, 2009 and 2010.
Adapted from UNAIDS, 2011

Given the often sensitive nature of discussing topics around sexuality education and HIV and AIDS, LSE can be seen as an alternative to discussing these more sensitive issues. This, however, has then allowed countries and programmes to sideline and not tackle such issues. Similarly, some schools and teachers may be reluctant to teach sexuality education and HIV and AIDS-related education in particular, even if it is in curriculum, thus they may get around it by calling it LSE. This reluctance stems from a number of factors including the perception that teaching sexuality education will encourage promiscuity and hasten the onset or frequency of sexual activity, a perception not based on evidence, with evidence to the contrary, i.e. sexuality education programmes delay the onset or frequency of sexual activity and increases condom use (e.g. Kirby, et al, 2006b; Magnani et al., 2005).

The content of LSE can also be problematic when it does not sufficiently address components of sexuality and HIV and AIDS-related education necessary in a context when youth may be already sexually active (see e.g. Dupas, 2011). In many countries abstinence is a part of LSE which is clearly insufficient when youth are already sexually active. Lacking also can be topics around the risks of pregnancy and abortions, topics which would be critical in countries with high rates of often unwanted teenage pregnancies

Other constraints include that teachers may often not be appropriately or sufficiently trained to deliver LSE more generally, and in particular sexuality and HIV and AIDS-related education – they may lack the capacity, support and confidence to teach. Similarly, teachers may be unwilling and unable to change their more usual/traditional and didactic approaches to teaching. At the same time learners may also not be accustomed to this different approach and may find the delivery if LSE challenging and uncomfortable. How to bridge these 2 forms of teaching and learning processes needs further exploration. The physical environment may also often not be appropriate to teaching LSE - classes in developing countries, particularly those in high HIV-prevalence settings, are invariable large with limited space for interactive learning. Additionally, classes may consist of

progress reports.

students with very different age ranges. Thus not only may the teaching be inappropriate to certain age groups, but with such large classes and potentially facing problems of control, teachers may find it easy to revert to more traditional methods and approaches for teaching.

In many countries, with already overcrowded curricula, LSE can be seen as a non-essential subject, frequently bolted onto the main curriculum, not included in general curriculum planning and review processes, and often dropped in favour of compulsory and examinable subjects. Additionally, with education being increasingly assessment driven, given that LSE is both difficult to monitor given its inherent participatory nature, and to measure its impact in a short time frame, it goes against this trend.

More generally, many LSE curricula have been criticized for being applied as a form of blue-print in different parts of the world without taking into account that young people are not a homogenous category, that needs and priorities in relation to sexuality and HIV and AIDS-related education will vary by age, gender and country context (see e.g. Mavedzenge, et al. 2011b).

Ways forward / recommendations

Local context is critical - one size does not fit all. LSE needs to reflect the wide and changing range of young people's circumstances including age, gender and geography and it needs to respond to local contexts and priorities. LSE should also be designed incorporating the perspectives of young people. 'The World Starts with Me' programme originally developed in Uganda was then tailored and adapted for the Indonesian context (see UNESCO 2011 and Leerlooijer et al, 2011); see also the examples of Nigeria and Orissa for ensuring local context specificity and perspectives of young people.

Wider structural factors also need to be considered. The individual is part of the whole and family, community and power structures that often govern relationships between people and therefore influence the ability to apply learnings from LSE, should not be neglected. Additionally, taking a long-term perspective is important, including considering how politics, economics, gender norms, may shape outcomes. Again, the programmes in Nigeria and Orissa are examples where wider processes of politics and culture affected initial outcomes, but once fuller stakeholder engagement and ownership occurred, implementation and scale-up became more

A minimum package/minimum standards are necessary. Despite the need to be context specific, it is also important that minimum standards and a minimum package for LSE in the context of sexuality and HIV and AIDS-related education, is developed, clarifying which skills should be taught, why and how they should be taught, i.e. the pedagogical framework. This will allow for, amongst other things, easier global and national level monitoring.

Linkages and partnerships are critical. While LSE has a valuable role to play within sexuality and HIV and AIDS-education programs, it needs to be carried out in combination and link with other approaches and processes, which include those beyond the education sector and which deal with issues of HIV prevention amongst young people. The example of Estonia shows how the close partnership between schools and youth friendly health service, can help explain some of the positive outcomes in sexual health indicators, including HIV and AIDS.

Building local ownership through advocacy is critical. As was seen in the examples in Nigeria, Orissa (India), Indonesia and also Yemen (Al-Iryani, et al, 2011, 2011b), developing LSE in conjunction with a range of stakeholders including teachers, parents, and religious and community leaders is key for the success of such kinds of programmes.

Inclusion in curriculum review and development processes. For LSE to be given equal recognition as other subjects it needs to be included in curriculum review and development processes, as part of a nationally owned

and developed approach. This was often lacking in many programmes (see the exmaples of Kenya and Indonesia in UNESCO 2011) and therefore, along with limited national ownership, such subjects were not taken up furhter by national education processes and systems.

Different pedagogical frameworks need to be bridged. There is need to explore more fully how the different pedagogical approaches and processes involved in more mainstream subjects versus LSE can be bridged, i.e. how participatory and more interactive approaches which are usually a key aspect of LSE can be applied in systems which are more hierarchical, non-participatory and assessment driven.

Training teachers is critical. Not only do teachers need to be trained in sexuality and HIV and AIDS-related education, but also in LSE and ways of delivering these subjects using participatory and interactive approaches. Also critical is ongoing support, mentoring and capacity building of teachers. This was identified as a key component in all the LSE programmes described above, see in particular ***Living: Skills for Life, Botswana's Window of Hope;*** it was also identified as key short-coming when it was not carried out sufficiently.

Researching and evaluating over long-term timeframes is necessary. To evaluate the effects or impacts of LSE in the context of sexuality education and HIV and AIDS-related education, studies with longer-term follow-up periods (1 year plus) are necessary. Only within these longer time-frames could the effects in terms of behavior change start being visible. See for instance the studies by Maticka-Tyndale et al. (2004) and Ross et al (2007). Additionally, it is critical that results are disaggregated by, amongst other things, sex and age.

Learning and building on successful programmes is critical. Finally, building-on, replicating and scaling-up successful stories should be actively encouraged, including the programme experiences identified in this paper.

The LSE approach to sexuality education and HIV and AIDS-related education is not a quick fix. Findings show that while it can achieve results in some areas, it is less effective in terms of behaviour change and is not, therefore, the panacea for all ills. More thought is needed on how to adapt to different contexts and for different groups of young people and how they can be implemented over a long time frame to be able to have an effect on behaviours, particularly those related to HIV acquisition. Similarly, they cannot be implemented in isolation from other approaches and processes, both within the education sector and beyond. Instead they need to be considered within a wide array of approaches including those tackling underlying and structural factors which render some people more vulnerable and marginal than others.

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