HIV and Sexual Health Education in Primary and Secondary Schools

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Findings from selected Asia-Pacific countries
October 2000

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NATIONAL CENTRE IN HIV SOCIAL RESEARCH

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STRUCTURE OF THE REPORT

This report describes and discusses primary and secondary school-based HIV/AIDS and sexual and reproductive health education in selected countries in the Asia and Pacific region. The countries included are Brunei, Cambodia, China, Indonesia, Malaysia, Mongolia, Myanmar, Papua New Guinea, Philippines, Thailand and Vietnam.

The primary aim of the work described was to explore the feasibility of monitoring sexual and reproductive health education in primary and secondary schools in selected countries in the Asia and Pacific region. The data reported, it needs to be emphasised, are partial and exploratory rather than definitive.

For selected countries, and on the basis of returns via postal and e-mail questionnaires as well as interview data, a Country Profile was compiled for each country summarising their school-based reproductive and sexual health initiatives. While detailed profiles are not included in this report, we encourage readers to access them via the website of the National Centre in HIV Social Research (www.arts.unsw.edu.au/nchsr/) in Sydney Australia since they constitute the backbone of this discussion paper.[1]

The report is divided into 3 sections. Section 1 includes the introduction and aims of the study. It also describes the method used in the study. Section 2 discusses the feasibility of monitoring school-based education systems. It includes a brief account of the difficulties encountered in undertaking such monitoring and what would be needed to ensure the timely updating of information. Section 3 offers a summary description and discussion of different countries' policies and practices in regard to school-based HIV/AIDS prevention. The analysis is preliminary in the sense that it will be updated as further information on policy and practice is gathered. The views contained within it are those of the authors alone.

[1] Specific foci of the work were policy, curriculum, delivery of education in classrooms, teacher training, peer education and barriers to delivering sex-related education. The structure of each Profile is generally organised in a similar way.

SECTION 1: INTRODUCTION

BACKGROUND

Schools have long been identified as appropriate environments in which to undertake activities to promote HIV-related risk reduction among young people. Given that in the majority of countries young people between the ages of five and thirteen spend relatively large amounts of time in school, school environments can also provide resource-efficient access to large numbers of young people from diverse social backgrounds.

Across the world, numerous programs and interventions have taken place with young people in schools. Despite this, relatively little is known about the way in which national and local education systems have responded to HIV and AIDS, that is, we know little about *how* HIV and AIDS-related health promotion policies have been actually developed and implemented. For example, it is important to know:

- At what age HIV/AIDS is addressed in the school curriculum
- Whether HIV/AIDS and related prevention issues are addressed within science curricula or health education studies or elsewhere
- What emphasis is given to the modes of sexual transmission of HIV
- Whether and in what ways cultural traditions and ideologies govern the manner in which HIV and AIDS-related concerns are discussed

It was against this background, and with funding from UNAIDS, that this study was undertaken. The aim was to explore the feasibility of monitoring how school education systems in East Asia, South East Asia and the Pacific are responding to HIV and AIDS. The choice of region was deliberate in that the countries concerned varied widely in terms of political structure, the role of government in education planning, and the influence of religion on educational matters.

HIV / AIDS-related health promotion in schools

There is continuing debate about the content of HIV and AIDS-related education programs and how and in what manner they are delivered to school students. It is generally agreed that HIV/AIDS education material should include information on: the nature of the virus, its modes of transmission, the consequence of infection, and the steps that can be taken to protect against infection. More contentious is the inclusion of education relating to interpersonal sexual relations and drug use. In this regard, discussion of the avoidance of disease by the use of condoms or the supply of clean needles and syringes can be particularly problematic.

Within the school curriculum, dealing with HIV/AIDS – particularly aspects concerned with the prevention of HIV-transmission – is complex. Dominant cultural understandings influence the manner in which HIV/AIDS can be talked about, for example, drugs are illegal in many countries and are therefore presented to be shunned and avoided. Sex presents more of an immediate challenge to educators; there being heated controversy, for example, about how sex education should take place and by whom it should be delivered.

Across the world, much HIV-related education takes place within curriculum subjects such as science, biology, and health education. Issues relating to HIV and AIDS may be addressed within the context of citizenship and political studies, religious or moral education, or as part of the work linked to personal and social development and/ or the acquisition of life-skills. A range of factors influences the positioning of HIV and AIDS within the curriculum. These vary from macro-social determinants such as government policy and the influence of formal systems of religion, to meso-level factors influential at the level of school systems, to micro-political influences within individual schools and classrooms.

To the extent that HIV and AIDS is contained within a subject area such as science and biology, the links between it and broader social concerns are likely to be left unexplored. Indeed where HIV/AIDS is positioned as a 'problem' for science, discussion of interpersonal sexual relations and drug use may be downplayed. On the other hand, where HIV-prevention is addressed as an important aspect of HIV/AIDS education, interpersonal and social concerns are likely to come to the fore. Where pupils and learners have the opportunity to influence the

structure, pacing and issues that are addressed in HIV and AIDS-related education, their everyday anxieties, concerns and experiences are more likely to be addressed.[2]

Except in a few countries, HIV and AIDS-related health promotion in schools has focused on the virus and on the avoidance of infection and disease. Only occasionally has HIV and AIDS-related education sought to address broader issues associated with the epidemic, such as the experiences of people living with HIV disease, forms and determinants of HIV and AIDS-related discrimination, and government responses to the epidemic in the form of measures to protect (or deny) the human rights of people living with HIV and AIDS. This is unfortunate since more holistic HIV-related health promotion has the potential to challenge divisive social stereotypes, and redress some of the inequalities generated and reinforced by the epidemic. Such an approach also holds the potential to demonstrate that HIV and AIDS are as much *social* issues as they are biological and medical in character.

There are also differences of opinion regarding mode of delivery, for example, over whether HIV/AIDS and related issues should be addressed via knowledge-based models or via interactive and skills-based modes of learning. Should HIV/AIDS-related health promotion be taught didactically, as a set of 'facts' or should the discussion of HIV-prevention be taught using interactive or student-centred models? In the belief that HIV-prevention is more effective if linked to the practices of the everyday lives of students, some educators have promoted skills-based and student-centred models, while others preferred a knowledge-based, and more didactic mode.

Despite efforts to incorporate HIV and AIDS-related health promotion in schools, debate continues about the kind of activities that should take place and to whom they are targeted. In perhaps the majority of circumstances, health promotion activities have been restricted to efforts to 'educate' pupils and young people about HIV and AIDS. More rarely has a 'whole school' approach been taken in which governors, teachers and other school workers (e.g. caretakers, cleaners, etc) have been included – it being assumed, unproblematically, that 'adults' are already knowledgeable. Even more rare have been efforts to use the school as a base for HIV-related health promotion within the broader community.

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[2] Basil Bernstein's conceptualisation of the school curriculum as differing both with respect to its classification (the extent to which 'subjects' and curriculum contents overlap or are kept separate) and to the framing of particular 'subjects' (the way in which particular content is framed within e.g. science or civics) offers a useful framework by which to make sense of the ways in which issues relating to HIV and AIDS can be addressed in schools.

The remainder of this report focuses on HIV/AIDS school-based education within the broader context of sexual and reproductive health. We choose the context sex, rather than the more inclusive notion of risk, because most of the countries in the Asia and Pacific region have attempted to include sex or reproduction within their school-based education.

The effects of HIV / AIDS and sex education

Regardless of its form or emphasis, HIV and AIDS-related health promotion in schools has been controversial. Many have feared that it might encourage sexual activity among young people who are not sexually active, and increase levels of risk-taking among those who are sexually experienced. Why this fear exists is not entirely clear, save for the folk belief that to talk about sex is to encourage people to participate in it, and the unstated association between sex and HIV and AIDS. Moreover, for many adults, it is perhaps convenient not to have to talk with young people about sexual matters.

Triggered by such anxieties, several national[3] and international[4,5] reviews have examined the relationship between different kinds of education and behavioural outcomes. While these reviews differ from one another in terms of the criteria for study inclusion and focus (on sex education alone, or on sex education and HIV/AIDS), they conclude that most HIV and/or sex education does *not* increase levels of promiscuity among young people or lead to increased risk of pregnancy and STDs. Moreover, there is evidence that well designed programs of HIV and/or sex education can delay the onset of sexual activity, reduce the number of sexual partners and reduce unplanned pregnancy and HIV/STD rates.

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[3] Kirby, D. (1995) *A review of education programs designed to reduce sexual risk-taking behaviours among school-aged youth in the United States.* ETR Associates: Santa Cruz (CA).

[4] Grunseit (1997) *Impact of HIV and sexual health education on the sexual behaviour of young people: A review update.* Geneva: UNAIDS.

[5] Aggleton, P., Baldo, M., Grunseit, A., Kippax, S., and Slutkin, G. (1997) Sexuality education and young people's sexual behaviour: A review of Studies. *Journal of Adolescent Research.* 12(4): 421-453.

Some definitions

The term sex education can take on many meanings and these meanings need to be kept separate – at least at an analytic level. For the purposes of this report, we distinguish three broad kinds of sex education: that which focused on anatomy, biology and physiology; that concerned with reproduction and family; and that dealing with interpersonal sexual relations. Throughout the following discussion, we attempt to keep these three aspects of 'sex education' separate, as the manner in which HIV/AIDS education is positioned with respect to each is of crucial importance to our argument. In general, we use the term 'sexual and reproductive health' education to refer to the first two – HIV/AIDS education is more often than not framed within sexual and reproductive health. We use the term 'sex' education to refer to education that focuses on interpersonal sexual relations and sexual practice.

AIMS

In relation to school-based HIV/AIDS education this project had five aims:

Firstly, to make recommendations about the feasibility of monitoring HIV/AIDS and sexual and reproductive health education within the Asia and Pacific region (especially South and South East Asia).

Secondly, to document existing policies with a particular focus upon sexual health *information* and *skills*, interpersonal relationships and HIV/AIDS, and the provision of training for teachers and administrators.

Thirdly, to review existing curriculum guidelines and/or teaching materials around sex education and HIV/AIDS education.

Fourthly, to assess the quality of existing sex and HIV/AIDS education in the following terms:

- Models and approaches used
- Frameworks within which education takes place
- The responsiveness of education to the needs of young people
- The training of teachers

And finally, to describe the existing coverage of HIV/AIDS education in schools within each country.

METHOD

The development of a questionnaire

Following initial discussion with key personnel within UNAIDS and its co-sponsoring organisations, a questionnaire was developed and modified as the project progressed[6]. The questionnaire sought to elicit information on school-based HIV/AIDS sexual health in the following areas:

- Overall policy context
- Location within discipline/subject areas
- Ages and class levels of the students to whom it was delivered
- Content of sexual and reproductive health curricula
- Training of teachers
- Perceived barriers to undertaking this kind of education.

Who was contacted

The people contacted were drawn from multiple sites:

- Government officials, especially those within ministries of curriculum development and teacher training
- In country non governmental organisations such as national AIDS councils (Malaysia, the Philippines and Papua New Guinea)
- International organisations (UNICEF, UNAIDS, UNESCO, UNDP, HAPP, Margaret Sanger International)

Numerous initial contacts were made with IOs and NGOs who worked in close collaboration with departments of education. Senior staff within UNICEF and UNAIDS were key to establishing initial contacts with local Country Program Advisers and Program Officers in different countries.

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[6] See Appendix for a copy of the final questionnaire.

Making contact

Copies of the questionnaire were distributed to participants through e-mail, mail, and fax in each of the participating countries. Face-to-face and telephone interviews were also conducted and most of these were taped (with the consent of the respondents). Initial contacts were supplied by UNAIDS and in the majority of cases these contacts were members of UNAIDS Country Theme Groups or were personnel working for one of the UNAIDS co-sponsors. From the initial contacts, a 'snowball' effect developed to include people working in other IOs, NGOs and ministries of education. In several instances, people were contacted via media reports, conferences and the like.

Respondents were invited to return completed questionnaires to the Australian National Centre in HIV Social Research in Sydney, where the study was hosted. E-mail and telephone follow-up occurred at regular intervals following the initial distribution. Members of the project team attended the 5th International Conference on Asia and the Pacific (ICAAP). Meetings were arranged with a number of relevant key individuals prior to attending the conference and proved to be an effective way of eliciting detailed information and establishing strong links within a number of countries.

Respondents were also asked to forward documents relating to school based HIV/AIDS or sexual health policy, curriculum or training.

Following initial rounds of data collection, a draft summary outline of HIV/AIDS and sexual health education was compiled for each country. In mid 2000, these draft outlines (which appear as Country Profiles in this report and are available on the NCHSR website – http://www.unsw.edu.au/nchsr/) were sent to respondents for comment. In most countries further responses were elicited and most of those responses have been incorporated into the final Profiles. Due to time constraints some responses have not been included, although all reported criticisms and inaccuracies have been incorporated or acknowledged.

SECTION 2: THE FEASIBILITY OF MONITORING

One of the major aims of this work was has been to explore the feasibility of ongoing monitoring of HIV/AIDS and sex education in selected countries in the Asia and Pacific region. The monitoring undertaken by the project was largely descriptive and qualitative. Country Profiles describe aspects of school-based HIV/AIDS and sexual health education and can serve as the base upon which further evaluation can proceed. The existing descriptions are partial, however, and require further development and fuller description. Section 3 of this report can be read as an initial qualitative evaluation based upon the Country Profiles.

Modes of communication are central to any monitoring process. For the most part, the project was conducted from a desk with communication being established and maintained via email, mail, telephone and fax. Other less frequent forms of contact included face-to-face meetings and liaison with colleagues and others who visited participating countries and gathered information on behalf of the project.

While self-completed questionnaires provided a useful starting point, they often lacked the detail required. To a large extent, face-to-face contact overcame this problem by allowing researchers to clarify and expand upon the questions being asked. Face-to-face interviews and telephone interviews were recorded. All these tools were vital to gathering information.

Our investigation indicates that monitoring is feasible and below we suggest a possible way forward.

STRUCTURES AND PROCESSES

To structure and facilitate a continued process of information retrieval, we would recommend the adoption of a number of strategies for establishing and maintaining a monitoring process:

- Information should be gathered, especially in the formative stages, through close in-country liaison with participating countries. Site visits to each selected country would:
  - Enable a better understanding of the complexities of delivering sex and HIV/AIDS education in schools.
  - Facilitate greater interaction between the monitoring team and local partners thereby increasing the likelihood of cooperation and a better understanding of the possibilities and limitations of gathering information
  - Enable the monitoring team to do more of the legwork in tracking down documents and expertise and enable input from a broader range of people, especially with respect to classroom practices.
  - Permit field observations to be made, thereby better understand the cultural context within which education takes place (Many respondents suggested that it would be useful to visit their countries and some expressed surprise that such a project could be conducted without doing so). For example, school sites could be visited to allow curricula data to be better contextualised.
- Establish contact with those directly involved in the relevant areas, that is, with key people or personnel in each area of interest (e.g. students, teachers, curriculum planners, teacher trainers and advocates). The entire field of school-based HIV/AIDS and sexual and reproductive health education includes the areas of policy, curriculum, teacher training, teaching, learning, and advocacy. Understanding each of the parts and their interrelationships is necessary to understand the whole. [7]
- Give greater emphasis to interviews and to the retrieval of documents (including drafts). Interviews clarify the context of educational practice (cultural, administrative, political etc) and may be conducted as structured and semi-structured interviews.
- Create a formal system of data collection through agreements with relevant organisations. Ideally, this would include a network of communication between the monitors and a range of related parties. The monitoring team would thereby serve as a base that reached out to a range of government and non-government organisations. As required, key personnel within UNAIDS and UNICEF (or other key agencies) could facilitate communication between the monitoring team and existing personnel within the countries being monitored (i.e. authorise monitoring activities and encourage participation on the ground). The gathering of good quality information is more likely to ensue when top-level support and recognition is given to participating organisations and governments (that is, participants are more likely to respond when what they are doing is recognised within their organisation as work).
- Establish a network of communication between those working within the field and encourage their active participation in project activities. Regional HIV/AIDS, population and reproductive health congresses and conferences are ideal sites for conducting such activities. Representatives from various countries should be encouraged to participate in workshops with the aim of sharing information and program successes and difficulties. Such events would also function as a regular mechanism to monitor the progress of school-based sexual and reproductive health education in schools.

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[7] In terms of international cohesion, international organisations play a crucial role.

ESTABLISHING A BASE FOR MONITORING

Responsibility for monitoring should be based ideally within a single organisation and that organisation should take primary responsibility for gathering, compiling and evaluating information on school-based sex education. Access to the database of information collected should be made available to other interested parties.

A project management and research position would need to be created to carry out monitoring. The manager would be responsible for literature review, data collection, data collation, data analysis, and report writing.

Numerous relevant documents exist in the native languages of the countries and therefore required translation into English. Selected documents from some countries were translated as part of this pilot work (Indonesian, Thai, Filipino, and Chinese). Budget considerations, however, meant these translations were not as extensive as they might have been. Importantly, the process of translation also facilitated communication between countries.

Additionally, and as discussed above, there are inherent difficulties in conducting an international project from a desk. To some extent email, facsimile, phone, and the World Wide Web bridged the gap between the researchers and the country participants. These modes of communication, however, should be supplemented with short-term, intensive in-country visits.

RESEARCH METHODS

Qualitative research (e.g. in-depth interviews, participant observation, field-note taking) holds the potential to facilitate a deep understanding of the cultural context within which school-based sexual and reproductive health education is delivered. Given the lack of an overall understanding of the field of school-based HIV/AIDS and sexual and reproductive health education, we advocate a more qualitative and thematic approach to monitoring. This would entail *mapping* what education is planned or already exists, and then analysing (evaluating) that map in terms of HIV/AIDS and sexual health, for example, by exploring economic and cultural barriers to delivering programs.

Thematic concerns/content areas helpful in offering an account of national HIV/AIDS and sexual and reproductive health education systems include:

- Content of policy documents
- Curriculum development and content (e.g. HIV/STD knowledge, HIV/STD prevention, sexual practice, safe sex, disease prevention, contraception, skills development, gender inequality, sexual orientation, and relationship formation)
- Subject placement (e.g. health education, biology, science, civics, moral education, etc)
- Methods of delivery (e.g. skills-based or lecture-based)
- Extra-curricular activities
- Training of teachers
- Provision of resources for teachers
- Inclusion of people other than students in HIV/AIDS education, such as teachers, administrators, principals, cleaners, etc.
- Program reach (e.g. the percentage of all youth reached and the percentage of all students reached broken down by region and school type)

Ideally, these and related core concerns should be analysed as a web of interrelated elements and also in relation to the broader context within which school based HIV/AIDS and sexual and reproductive health education occurs including:[8]

- School education structures
- Enrolment ratios at school (including differences between males and females; urban and rural; and between different school grades)
- HIV prevalence rates (national and provincial)
- Presence of and access to other forms of HIV/AIDS and sex education (e.g. out-of-school peer education; general population campaigns)
- Rates of pregnancy, HIV and STD among youth
- Dominant cultural understandings and constructions of sexuality

[8] Data collection on some of these themes/content areas already exist, for example, in UNAIDS Country Profiles (available on the UNAIDS website), UNESCO education statistics, and in a range of journals and books. Of interest is WHO's current development of reproductive health indicators for global monitoring.

SECTION 3: MAJOR FINDINGS

In this section, we will move beyond a discussion of the feasibility of monitoring to look at some of the findings which emerged in the context of the pilot work. First, we will discuss two of the many factors that indirectly effect school based HIV/AIDS and sexual and reproductive health education. In different countries these factors are HIV prevalence and the proportion of all school-aged students who attend school. Subsequently, we will provide an overview of the main features of school-based HIV/AIDS and sexual health education in the areas of policy, curricula, teacher training and approaches to teaching. Finally, we draw a series of general conclusions concerning the manner in which the subject matter of HIV and AIDS-related and sexual health education is positioned and framed within particular subject areas. We will also examine some of the factors acting as constraints on the development of policy and practice with respect to sex education and HIV- and AIDS-related education in schools.

CONTEXT

Prevalence of HIV/AIDS by country[9]

As of 2000, the countries with the highest estimated rates of infection among the adult population[10] were Cambodia (4.04), Thailand (2.15) and Myanmar (1.99). The next highest infection rate was reported in Malaysia with under half of one-percent (0.42). Countries with the lowest rates (less than 0.1 percent) included China, Indonesia, Laos and the Philippines (see Table 1). The accuracy of the prevalence rates depends upon the accuracy of the monitoring processes that exist in each country, the reliability of which varies.[11]

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[9] All figures taken from the Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Diseases, last updated in 2000. Available on the UNAIDS website: http://www.unaids.org/hivaidsinfo/statistics/june98/fact_sheets/index.html

[10] The adult population rate is based upon those aged between 15 and 49.

[11] Schwartlander B., Stapecki K., Brown T., Way P., Monasch R., Chin J., Tarantola D. (1999) Country-specific estimates and models of HIV and AIDS: methods and limitations. *AIDS*, 13, 2445-2458.

Heterosexual transmission is reported as being the dominant or a significant mode of transmission in all countries except China, Malaysia, and Mongolia. Although in these countries the primary transmission mode is via injecting drug use, it is important to note that such transmission is often accompanied by sexual transmission and that to focus only on injecting drug use is likely to lead to an ineffective country response. As noted earlier, the focus of this report is the sexual transmission of HIV.

Table 1 : HIV Prevalence Rates

Country	Adult population with HIV (%)*	Primary mode of transmission
Brunei	0.20	Heterosexual
Cambodia	4.04	Heterosexual
China	0.07	IDU
Indonesia	0.05	IDU; Heterosexual
Malaysia	0.42	IDU
Mongolia	<0.01	No significant epidemic
Myanmar	1.99	IDU; Heterosexual
Philippines	0.07	Heterosexual
PNG	0.22	Heterosexual
Thailand	2.15	Heterosexual
Vietnam	0.24	IDU; Heterosexual

These figures are based upon the epidemiological fact sheets on HIV/AIDS and sexually transmitted disease. Fact sheets are available at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/index.html

The context of education

School-based HIV/AIDS and sex education can only reach those who attend school. Countries differ with reference to policies about compulsory education and the ways in which school education is structured. All countries distinguish primary from secondary schooling, and most distinguish junior from senior secondary. Schooling is compulsory for children aged between six or seven years and fifteen years in the majority of countries included in this study. Exceptions to this rule are Myanmar, the Philippines, Cambodia, Vietnam and PNG where schooling is mandatory for a smaller number of years. In general, primary schooling is compulsory in all countries, while junior secondary education is compulsory in most (see Table 2).[12]

[12] The table is drawn from the `99 UNESCO Statistical Yearbook.

Table 2 : School Structures by Country - Primary, Junior and Senior Secondary

Country	Compulsory education		Entrance age and duration of primary and secondary general education[1]													
	Age limit	Period	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Brunei	5-16	12		x	x	x	x	x	x	o	o	o	o	o	#	#
Cambodia	...	...		x	x	x	x	x	x	o	o	o		#	#	
China	7-15	9			x	x	x	x	x	o	o	o	#	#		
Indonesia	7-15	9			x	x	x	x	x	x	o	o	o	#	#	#
Malaysia	-	-		x	x	x	x	x	x	o	o	o	#	#	#	#
Mongolia	8-16	8				x	x	x	x	o	o	o	o	#	#	
Myanmar	5-10	5	x	x	x	x	x	o	o	o	o	#	#			
Philippines	6-12	6			x	x	x	x	x	x	+	+	+	+		
PNG[13]	-	-			x	x	x	x	x	x	x	x	o	o	#	#
Thailand	7-15	6		x	x	x	x	x	x	o	o	o	#	#	#	
Vietnam	6-11	5		x	x	x	x	x	o	o	o	o	#	#	#	

Symbols:
x – elementary school,
o – junior secondary school)
– senior secondary school
+ – secondary school

Countries also differ in the number of students attending – particularly at the secondary school level. Cambodia, Myanmar and PNG have noticeably smaller reported student attendance at the secondary level (see Table 3). Gross enrolment ratios give an indication of the *potential* reach of sex education programs in schools among the school-aged population. The ratios indicate that primary school has by far the greatest reach.

For those countries where male and female high school student ratios are available, males are very much over-represented in Cambodia, and somewhat over-represented in China, and PNG. On the other hand, female students are very much over-represented in Mongolia and somewhat so in Brunei and Malaysia. In general, it was in the poorest countries that women were under-represented in school attendance. Male/female ratios at school have implications for targeting HIV/AIDS education programs within and outside of school. The same logic applies to ethnic, regional and other differentials within school populations.

[13] PNG has recently reformed its educational structures to increase the number of years regarded as primary (including elementary) from 6-8 years.

Table 3 : Gross Enrolment Ratios by Level of Education, by Country[14]

Country	Year	Gross school enrolment ratios (%)[15]		
		Primary	Secondary	M/F ratios
Brunei	1996	106	77	72/82
Cambodia	1996	110	29	31/17
China	1997	123	70	74/66
Indonesia	1996	113	56	–
Malaysia	1997	101	64	59/69
Mongolia	1996	88	56	48/65
Myanmar	1994	120	30	29/30
Philippines	1997	117	78	77/78
PNG	1995	80	14	18/12
Thailand	1996	87	56	–
Vietnam	1997	113	57	–

CURRENT PRACTICE

Policy on HIV/AIDS education

It should not be assumed that not having a policy means a lack of commitment to HIV/AIDS or sexual health education in schools. Indeed, it may sometimes be better than to have a bad one. Having said that, a good policy provides persuasive leverage to introduce or improve existing HIV/AIDS education.

Most of the policy documents gathered were authored by government HIV/AIDS committees and/or government ministries (especially ministries of education and health). In many countries, those policies were published in association with IOs such as UN agencies.

As of 2000, Mongolia, Indonesia, Papua New Guinea, the Philippines and Thailand had developed the most comprehensive policies. Cambodia and Vietnam reported and made available

[14] Statistics taken from the UNESCO 1999 Statistical Yearbook.

[15] Some of the figures sum to more than 100%. This is because Gross Enrolment Ratios are measured by taking the total enrolment of students in primary school, regardless of age, expressed as a percentage of the population corresponding to the school years.

draft versions of policies relating to HIV/AIDS and sexual and reproductive health education. The draft policies of both countries were relatively detailed. Brunei, Malaysia and Myanmar reported having no specific policies on HIV/AIDS and sexual health in schools (see Table 4). In China, a policy was reported to being available but was not examined.

Direct comparison between countries is made difficult by the different degrees of completeness of our data. The generalisations that follow should be read in this light. The policies we obtained provide a country specific framework for the development of educational practice. In general they:

- Identify the reach of education and include reference to all types of school (formal and non-formal, public and private). Most refer to both secondary and elementary schools, although the major focus by far is the senior years in high school.
- Describe how HIV and AIDS should be incorporated into the curriculum.
- Urge school-based programs and activities to go beyond HIV/AIDS and reproductive *knowledge* to focus upon sexual health in social context. This meant references were made to *values clarification, assertiveness development, understanding gender roles,* and other *skills-based* concepts.
- Recognise the importance of cultural differences, especially in terms of regions or localities.
- Recognise the need for teacher training.
- Seek to promote an inter-sectoral response involving government and non-government agencies, including parents, community members and religious leaders.
- Make little or no reference to specific risk practices, such as penetrative sex, but recommend such things as promoting 'healthy lifestyles' and 'appropriate values', or informing students about modes of HIV transmission.
- Do not provide details of specific HIV risk reduction strategies beyond abstinence and fidelity.

Table 4 : Existence of Policies by Country as of 2000

Country	Yes	No	Being Developed	Comments*
Brunei		x		The Malay Islamic Monarchy was said to govern how HIV/AIDS and sex-related education is delivered in schools
Cambodia	x		x	Some references are made to schools in National AIDS Authority policies. The Ministry of Education Youth and Sport and other ministries have drafted a strategic plan for the years 2000-2005
China	x			Policies on sex-related education have been in place since 1988 and HIV/AIDS related polices since 1993
Indonesia	x			The Ministry of Education and Culture have had school- based HIV/AIDS policies since 1997
Malaysia		x		Malaysia has no existing or intended HIV/AIDS policies although the Malaysian AIDS Council refers to schools in the *Malaysian AIDS Charter* (which does not bind the government)
Mongolia	x			An HIV/AIDS policy emerged in 1990 in the *Medium Term Plan 1*. Increasing emphasis has been given in policy since 1994
Myanmar		x		Myanmar has no existing or intended policy though it has implemented HIV/AIDS and sexual and reproductive health education programs in a few schools (refer to Country Profile)
PNG	x			School-based HIV/AIDS policies have been in place since 1997 (contained in the *National AIDS Council Act*). Population education policies have also been in existence since 1997
Philippines	x			As early as 1995, the Department of Education Culture and Sport circulated Memoranda to schools to encourage HIV/AIDS education in schools. In 1998, school-based eduction was mandated in the *Philippine AIDS Prevention and Control Act of 1998*. The implementation rules and regulations followed in the same year
Thailand	x			School-based policies have been in place since 1991 and were developed by the National AIDS Committee. The Ministry of Education has subsequently developed its own policies
Vietnam			x	There are currently no formal policies in place in Vietnam. However, the Ministry of Health has a draft policy for reproductive health education, which includes school-based education.

Note: * Refer to the Country Profiles for greater detail

A number of aspects of country policies are worthy of note. All recognise the importance of informing school students about HIV transmission and its attendant risks. Knowledge of HIV and ways of avoiding infection is considered important. The responsibility for imparting this knowledge is generally located across a number of subject areas and HIV/AIDS education is typically integrated into existing subjects such as biology, science, and health. It is also the case that HIV and AIDS education is often positioned within a broad moral and ideological framework. In official policy documents there is frequent talk of 'desirable health values', and 'healthy and responsible behaviour' and 'family values'. While most governments seem keen to place emphasis

on health and morality in the policy frameworks they offer for school-based education, details of risk reduction and harm minimisation are typically absent.

Curricula

Curriculum documents outlining the content sexual and reproductive health were obtained from all countries, except China. In China, curriculum development has been devolved to the provincial level (although guidelines are formulated at the national level). Lesson plans and/or teacher guides were available from Cambodia, the Philippines, Thailand, and Papua New Guinea. For the remaining countries, lesson plans were not obtained.

All countries deliver some form of sexual and reproductive health education to students at some stage in their history of schooling, although the education that is provided differs greatly between countries in terms of content, depth and reach. Here we will focus on some of the similarities.

The education most students receive in most countries is focused upon the biology of sexual reproduction and not upon sexual *practice* in social context. Where sex is discussed in social terms, the family usually frames it. These emphases are reflected in the titles given to HIV/AIDS and sexual and reproductive health education programs. For example, in Malaysia such work takes place within the context of Family Health Education; in Thailand in Life and Family Education; in Vietnam in Population Education, and in Indonesia and Mongolia in Adolescent Reproductive Health. That 'sex' is not used in curricula titles points to the sensitivity of the subject matter. 'Sex education', therefore, clearly does **not** describe what most countries do. With respect to the transmission of HIV – most curricula refer to HIV as the AIDS virus and some fail to typically differentiate between HIV and AIDS. When discussing the modes of transmission countries mention the following:

- Mother to child (vertical)
- Blood products
- IDU
- Sex

The *relative* risk of different sexual practices is not, however, mentioned in any curricula (as far as we have been able to determine). Sex is positioned as risky and sex is equated with vaginal intercourse. There is no mention of anal or oral intercourse or other forms of sexual kissing and touching. The danger is that *any* sexual activity may be taken to be risky for HIV transmission or

that *only* vaginal intercourse will be considered risky. This is because the whole field of 'sex' is implied to be vaginal intercourse, or is not defined.

Sexual activity is typically framed as something that should occur between husband and wife and where sex is positioned outside of marriage and reproduction it is nearly always discussed as a 'problem'. For example, in lesson plans from Thailand and the Philippines sex between unmarried young people and sex with sex workers is actively discouraged. In Thailand, numerous lesson plans in one curriculum mentioned young men engaging in sex with sex workers but curiously mentioned condoms only once.

Homosexuality is only mentioned explicitly in the curricula of two countries. The first is the Philippines where it is mentioned in population education (revised in 1997) as an 'emergent sexual behaviour'. Homosexuality is also mentioned in the Philippines HIV/AIDS education modules and positions gay men (binabae) as a 'risk group'. The second example occurs in Mongolia where homosexuality appears in the newly created (1997) Adolescent Reproductive Health Program under the topic of sexual behaviour and orientation.

Curricula documents from most countries make reference to the prevention of pregnancy and sexually transmissible diseases. It is unclear whether condoms are specifically discussed (this is because we generally have curriculum outlines but few lesson plans or teacher guides). Where condoms (or contraception or disease prevention) are discussed, this is typically so in relation to biology or family planning.

All countries except Brunei have developed skills-based curricula that include HIV/AIDS education. All of the existing pilot projects incorporate some form of skills-based program. All countries that have such a curriculum emphasise sexual abstinence as the primary strategy to prevent HIV transmission. The 'skill' that is most often taught is how to say no to, or avoid, sex, although some countries (Mongolia, Thailand, Cambodia, and Papua New Guinea) also tell students to use condoms if they do engage in sex, (often via the ABC of sex: *A*bstain, *B*e faithful or use *C*ondoms).

We do not know the extent of the coverage of HIV/AIDS and sexual and reproductive health education. Although we are aware of several innovative pilot projects currently underway (e.g. in Papua New Guinea, Mongolia, Myanmar, Cambodia and Indonesia, China, Vietnam) it cannot be said with confidence that any country comprehensively delivers HIV/AIDS and sexual and reproductive health education to most young people who attend school. This is especially true of

primary schools but is also true of high schools. The existence of an official curriculum does not ensure that it is taught in schools. In Indonesia, for example, reproductive health is incorporated into health education, which is a compulsory subject. Despite being compulsory, however, it was reported that reproductive health might not be taught because the curricula for health education was already crowded and the subject was not examined. Given that most countries do not examine HIV/AIDS education (or if they do, not in detail), the tendency is to focus upon those subjects that are linked to formal qualifications.

At the primary school level, HIV and AIDS appear not discussed in detail, if at all. Similarly, interpersonal sexual relations, especially in relation to explicit discussion of sexual practice, are not mentioned in any curricula. All sex-related topics focus instead on reproduction, differences in male and female anatomy, and the physical changes at puberty. Education in these areas often begins soon after the child enters school (see Table 5).

In general, the prevailing teaching method at the primary level is didactic, and this remains true in relation to sex-related education, although it is in this area that life-skills models are being introduced. In primary schools sex-related education is typically positioned or framed as 'science' although there is also a 'moral' positioning. Given this, it follows that the major teaching method is often the lecture or formal talk, that is, sex-related information is taught in the didactic mode with the student having little control or influence over the process. In the main, the 'knowledge' that has to be acquired concerns reproduction.

According to our data, condoms are not discussed in detail in primary schools except in Papua New Guinea and perhaps occasionally in Cambodia. In both cases such discussion occurs as part of pilot projects. Most countries consider explicit sexual talk to primary school students to be inappropriate. In general, senior secondary school is regarded as the age appropriate time to begin to discuss sex in some detail. Whether or not one agrees with this, the fact remains that in many countries few students progress to junior secondary school (see table 3 above), and fewer to senior secondary school. As such, school based reproductive health education is only a part of the solution and needs to be supplemented with out-of-school programs.

In contrast to practice within primary schools, in some countries there has been a move towards including HIV/AIDS in the school curriculum at the secondary level. There has also been a move to broadening sex-related material beyond a focus on sexual reproduction and anatomy. However, this trend is by no means universal.

As in the primary school setting, HIV/AIDS and sex-related education in secondary schools is generally integrated into a broad range of subjects. Most commonly these subjects include Physical Health, Biology, Science, Civics and Home Economics. Thailand has a non-compulsory and non-core health education package that teachers can deliver on 'special' occasions and many countries admit visiting speakers to talk with students about sex and HIV/AIDS related subject matter.

Curricula rarely seem to address issues such as how to cope with sex for the first time or how to maintain an active yet safe sexual life, both of which are important aspects of interpersonal sexual relations. Most countries, however, do talk about contraceptive methods, but typically that discussion was abstracted from the lives of students and, if put in context, framed by marriage and family planning (as noted above).

According to our data, China, Vietnam, Cambodia and PNG are the only countries that explicitly mention condoms within secondary school curriculum. In the Philippines, although there appears to be a reluctance to address the issue of condoms explicitly, there is implicit acknowledgement. In the core area of family planning, for example, it is stated that: "every family planning method whether natural or artificial has some advantages and disadvantages for the user" and, in the area of family size: "can be planned using natural or artificial means".

However, 'safe sex' is rarely mentioned within curricula. The 'ABC of sex' (Abstinence, Be faithful or use Condoms) was mentioned in the curricula of Mongolia, Thailand, Cambodia, and Papua New Guinea. Indonesian respondents noted that the 'ABC of sex' had some currency, through NGO health groups visiting schools and delivering one-off presentations, but was not incorporated into curricula.

Teacher training

For appropriate and effective HIV/AIDS and sex education to be delivered, teachers need adequate pre-service and in-service training and professional development. On the whole, data could be elicited from only a few respondents involved in teacher education and training. Myanmar and Mongolia are exceptions where respondents were involved in multiple levels of project development and implementation.

Teacher training was, however, identified in the great majority of countries as a fundamental barrier to the delivery of good quality HIV/AIDS and sexual and reproductive health education in

schools. Some countries, such as Cambodia, noted that there was a lack of teacher training in general – not just in relation to sexual and reproductive health. Wages are so low that teachers need to supplement their incomes with second jobs, such as private tutoring (especially in secondary school education). Moreover, many teachers, especially in remote areas and poorer countries, lack formal training. These existing conditions do not bode well for specialist training in sexual and reproductive health. In addition, most countries highlighted the existence of cultural barriers to discussing sex, and emphasised that many teachers are reluctant to deliver such education due to a lack of personal understanding of the material to be delivered.

To our knowledge, reproductive and sexual health *pre-service* training is provided in only three countries – Thailand, Papua New Guinea and Vietnam – but we are uncertain of the proportion of teachers trained (See table 5). No information for the Philippines, Malaysia and Cambodia has been obtained. Countries that do not provide pre-service training include Brunei, China, Indonesia, Mongolia, and Myanmar.

By contrast, all countries except Brunei provide some form of short-term in-service teacher training. The model of training, as far as we know, is always skill-based and at least partly funded by IOs (we are uncertain of funding in Malaysia, Thailand and the Philippines).

Table 5 : HIV/AIDS or sex-related teacher training

Country	Pre-service	In-service
Brunei	No	No
Cambodia	?	Yes*
China	No	Yes*
Indonesia	No	Yes*
Malaysia	?	Yes
Mongolia	No	Yes*
Myanmar	No	Yes*
PNG	Yes	Yes*
Philippines	?	Yes
Thailand	Yes	Yes
Vietnam	Yes*	Yes*

* Known to be a part of pilot projects

The general model of in-service training follows the cascade model and involves training a core group of master trainers, who in turn train other trainers, who in turn train teachers. The

method is a means of maximising the number of trainers with limited human and financial resources.[16]

Mode of delivery: knowledge-based and life-skills

Most, perhaps all sexual and reproductive health education before AIDS, whether integrated into existing subjects or created as a new subject, used traditional didactic teaching methods. Our data indicate that the didactic approach remains the predominant form of sex-related education, and in many countries HIV/AIDS education has been incorporated into existing curricula. However, the urgency of the AIDS epidemic has provided an impetus for governments to consider new approaches to sex-related education and, with the arrival of AIDS, skills-based education is being progressively introduced.

WHO has defined life-skills education as dealing with human "abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". It aims to promote the "healthy psychosocial development of the child". It has also been positioned as a model for imparting a balance of values, information, attitudes and skills. The model was initially developed to prevent young people from using recreational drugs but has been broadened to include a range of other social concerns. WHO, for example, has applied the model to the area of mental health and UNICEF has been involved in promoting life-skills in sex-related education, including gender equity. Within the Asia and Pacific region, life-skills programs within schools have typically been developed through partnerships between governments, UN agencies and other international organisations.

What can be said, on the strength of existing data, is that the mode of delivery changes in accord with how subject matter is discussed and positioned. Although reproduction, HIV/AIDS and STD knowledge typically fall within didactic and life-skills teaching modes, the biological aspects of sex are far more likely to be the primary focus of didactic teaching and are typically taught in science-related subjects. As such, the social aspects of sexual practice are often not discussed. To illustrate, condoms are most likely to be incorporated into science–based curricula,

[16] For a detailed description of the cascade training model refer to the Country Profile of Myanmar (under 'Training: teachers and other education related staff).

using the didactic mode of teaching. Typically, condoms do not form part of discussions of interpersonal sexual relations, while interpersonal sexual relations, if discussed at all, always fall within the skills-based mode of education. When life-skills constitute the mode of teaching about condoms, it is typically as a fall back position when abstinence or fidelity have 'failed' (the ABC of sex as discussed earlier). Life-skills has the potential to deal with interpersonal sexual relations, but it should be recognised that moral frameworks constrain the ways in which sex can be explicitly discussed (at least in terms of curricula development).

As stated earlier, our analysis is heavily reliant upon what is contained within curriculum outlines rather than on lesson plans (as we have very few of these) and it is possible that although curriculum outlines do not specifically mention condoms, the lesson plans may. Given that life-skills is grounded in interactive education techniques, it is likely that this mode of education is more conducive to the discussion of a range of issues that are not incorporated within official curricula.

Schools are an important site of value development and reinforcement, and are often concerned with clarifying the dominant values of the given society to which school-aged children belong. That said, they rarely aim to help children clarify their own values, being concerned to promote those of the dominant society or culture. In one sense, life-skills or interactive modes of teaching bring that function into the open. In another way, however, life-skills may make the imparting of values a more complex and difficult task for teachers.

There are two main advantages of the life-skills model over the didactic approach. First, life-skills emphasise interactive learning through role playing, games, debates, small group work and brainstorming. They also open up a dialogue between students and teachers, and between students and other students. The relative fluidity of these learning practices creates a space for sensitive issues to be raised that might otherwise not be.

Some respondents commented that the implementation of skills-based learning was honoured in name rather than in actual practice. They suggested that students are often told what to think rather than learn to think for themselves. Our reading of curricula documents supports this observation. Most of the curricula (even-skills based curricula) promoted specific values. For instance, the family and sexual reproduction were universally positioned as central to understanding the *value* of sexuality; and fidelity within marriage and sexual abstinence outside of marriage were positioned as key harm reduction imperatives.

Comments from a Thai Ministry of Education official are enlightening with respect to skills-based education.[17] He claimed that life-skills might be an appropriate form of education in many areas of education, but was not appropriate in the area of 'sex education'. This was because, he claimed, we do not want children to learn the 'skills' of sexual practice until an appropriate age. Although this statement offers something of a misinterpretation of the life-skills approach, it rightly grounds skills-based education in the day-to-day lives of those being taught.

Where rigidity in the classroom context does not lend itself to an exploration of controversial subject matter, peer education may be a more appropriate avenue. It is a technique that has been adopted to a greater and lesser extent in many countries (Malaysia, Indonesia, China and Thailand; PNG is about to develop such programs), and is typically skills-based. Nonetheless it is important to recognise that the adoption of life-skills and interactive learning within classrooms creates a space for the innovation and allows difference to be expressed.

DISCUSSION

Dealing with difference

Some caveats concerning the accuracy of our data need to be re-emphasised at this point. Most of the individuals who gave us information were directly or closely related to policy or curriculum development and implementation. The information however, should not be read transparently.

As noted in Section 1, the phrases 'sexual and reproductive health education' and 'sex education' mean radically different things to different people and organisations – both within and between countries. Moreover, the data for this study were collected over one to two years and will be in need of updating. Although ongoing contact has been maintained with respondents in all countries, policies and curricula continue to change as countries respond to the threat of HIV. Within these constraints, we offer the following summary observations and comments.

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[17] The comments were those of Deputy Director-General Sarote Wattanasarote and were reported in the Bangkok Post (2/4/00 p.2).

There are multiple factors that determine what HIV/AIDS and sexual health education students are taught. These include:

- Policy development at the national and ministerial level
- Curriculum development
- Position or framing of the curriculum content within subjects
- Development of teaching resources (e.g. lesson plans, teachers guides and textbooks
- Teacher training
- The mode of delivery of education to students

Most of our information reported here relates to the development of national and ministerial policies and written statements of the curriculum. No matter how good they are, policy and curriculum do not automatically translate into good teaching practice. There is little information about HIV/AIDS and sexual and reproductive health as it is delivered in schools. While we have been able to collect some limited teaching resources (Thailand, Papua New Guinea, the Philippines and Cambodia) and some information relating to teacher training in most countries, we have virtually no information on classroom practice beyond the frequent assertion that despite the absence of condoms in curricula, condoms are nevertheless discussed (usually because students themselves raise the concern).

There is continuing debate about the *content* of HIV and AIDS-related education programs and how and in what manner they are delivered to school students. It is generally agreed that HIV/AIDS education should include information on: the nature of the virus, its modes of transmission, the consequence of infection, and the steps that can be taken to protect against infection – even if these are very general.

Many factors influence whether or not and to what extent HIV/AIDS and sexual health education are delivered in schools. Our data do not permit an in-depth analysis of all factors but points to a deep concern among many people about discussing sex with young people. The fundamental tension facing those who address school-based sexual health is not so much over whether HIV/AIDS and sexual health education should be delivered, but what its content should be.

A pragmatic need underpins talk about sex. In the 1970s and 1980s throughout much of the world that need was one of containing population to enable economic development. As a consequence of this need, many countries integrated population education into their school-based curricula, especially those with a perceived need to reduce their population (e.g. the Philippines,

China and Vietnam). Population control necessarily relates to reproduction and as such, to discuss population control one also needs to discuss sex. However, as far as our data indicate, school-based reproductive talk remains linked to the mechanics of reproduction (i.e. the biology of sexual reproduction) or family planning (e.g. spacing of births, limiting the number of births and understanding the contraceptive means by which this is achieved), leaves little room for a discussion of STI/HIV risk reduction.

Framing contraception within the family also removes the concern about extra-marital and premarital sex. A deep and internationally shared disquiet exists among many authorities (governmental, religious, parental) about any discussion of sexual pleasure, especially in the context of what is regarded as 'illicit' or 'immoral' sexual behaviour.

Reluctance to talk about sex was challenged in the 1990s with the emergence of the HIV/AIDS epidemic in the Asia and Pacific region. As with overpopulation, the HIV epidemic threatened economic development, particularly in so far as it is men and women in their most productive years who are disproportionately infected with HIV. However, the difference between population based education and HIV/AIDS education is that whilst the former can readily be grounded within the family, the latter cannot, at least not in a way that positions the family as a haven safe from HIV. HIV transmission, as other sexually transmissible diseases, implies sex outside of marriage and sex for pleasure. The reality of serial monogamy, premarital sex and extramarital sex mean that sex within marriage is also an important pathway of HIV transmission, and therefore, is an important area for HIV prevention efforts.

Many young people engage in sex before marriage, and once married, many engage in extra-marital sex (and/or their partners). A tension is thus established between a moral sexual ideal and a lived sexual reality. All of the countries included in this study are confronted with the same dilemma. Should *sex education* be given to those who fail to live up to the ideal? The Bruneian respondents were categorical in their promotion of the moral ideal at the same moment delivered contraceptive and disease preventive education, but only on the condition that it was framed by science.

As might be expected, where HIV is more prevalent, such as in Thailand and Cambodia, HIV/AIDS education was introduced earlier and tends to be more detailed and explicit. The introduction of HIV/AIDS education may also relate to the ease with which different cultures can discuss sex. Every country involved in this study promoted sexual abstinence in the first instance. Some countries (Thailand, Cambodia, Mongolia and Papua New Guinea) subsequently promoted

condoms for those who fail to abstain. To our knowledge these are the only countries that included detailed descriptions and information in lesson plans on how to properly use condoms when engaging in sexual intercourse (Mongolia may also do so in its new pilot project).

Modernisation (some say Westernisation) of countries in the region has made a complex situation even more complex. Globalisation has meant that 'traditional' values are more difficult to uphold[18]. Modern values are perceived by some as a threat to the moral integrity of their societies. Others see them as an opportunity for freedom and an enhanced sense of personal liberty.

In most countries, the solution to the complex dilemma, at least in terms of curriculum development, has been to promote sexual abstinence and faithfulness within marriage. Only some countries have incorporated condoms into their curricula. However, as cautioned earlier, this information needs to be critically scrutinized, especially in terms of what is actually delivered to students in classrooms. Where condoms have been introduced into curricula as a means of preventing HIV transmission, their inclusion is most extensive in the pilot projects (i.e. national coverage is not necessarily extensive at this point in time).

Location or framing of curriculum content

Hegemonic Discourses

Particular modes of framing or positioning HIV/AIDS education within the curriculum may make it easier to confront or to avoid contentious issues. These include detailed risk reduction strategies and the discussion of interpersonal sexual relations and drug use (although the latter is not the subject of this report). As we have seen, much HIV-related education continues to take place within subjects such as Science, Biology, and Health Education, or is addressed within the context of Citizenship and Political Studies, Religious or Moral Education. To the extent that HIV and AIDS is contained within a subject area such as science and biology, the links between it and broader social concerns are likely to be left unexplored. Indeed where HIV/AIDS is positioned as a 'question' for science, any useful discussion of interpersonal sexual relations and drug use may be systematically downplayed. On the other hand, where HIV-prevention is addressed as an important aspect of political studies or family health, interpersonal and social concerns are likely

[18] Many countries have been subject to centuries old colonisation. Talk of traditional values needs to be seen within this broader time frame.

come to the fore, but they may be discussed in often idealistic ways that do not challenge traditional, and often conservative, moral values.

Integrating HIV/AIDS education into existing curricula rather than making it a separate subject may facilitate the avoidance of more detailed (and necessary) discussions of sex. If HIV/AIDS-related education is spread across a number of subject areas, and in the absence of concerted efforts to achieve integration and 'linkage', it is likely that young people will receive fragmented sexual health information – some bits about anatomy, other bits about HIV transmission, and still other bits about family values.

The current often somewhat unhelpful positioning of HIV/AIDS-related education as part science, part morality but rarely a personal choice helps most countries deal ideologically with the potential clash between cultural traditions and values, on the one hand, and HIV/AIDS and sexual health education, on the other. The issues faced by many governments – particularly those that seek to promote strong and often conservative religious and moral commitments be these Hindu, Muslim or Christian – are many and varied. So while there is widespread acknowledgement that HIV and AIDS is a problem, and there is a commitment to address the issue at the school level, there is also concern about maintaining cultural traditions and values.

Similar issues have of course arisen in relation to the implementation of action following the International Conference on Population and Development held in Cairo in 1994. While the rights of individuals to control their own fertility were acknowledged, plans of action to achieve such rights were interpreted with reference to cultural contexts and the moral values of the countries concerned.

Subordinate Discourses

To the extent that it is true that for education to be successful it must acknowledge and build on the understandings and beliefs of those it seeks to educate, then it is also true that education must engage with subordinate as well as dominant discourses. Not only are the morals and cultural values of the dominant adult male world important, equally important are the morals and cultural values of women, the young and those marginalised in other ways. The values of the latter groups may differ from the dominant or hegemonic.

While, this study has attempted to outline national school education structures and how sexual and reproductive health is incorporated within them, the international scale of the project has obscured fundamental differences *within* countries such as:

- Urban, rural, remote and differences between provinces
- Degrees of stability: political, economic and social
- Private and public schools; formal and informal, secular and religious
- Gender difference (male and female)
- Class structures
- Ethnic difference
- Sexuality (heterosexual, homosexual, bisexual)

If we take just one of these – gender difference – and illustrate by reference to Cambodia[19]. Here, and for women, premarital virginity is required. Its loss leads to the kinds of social rejection that can on occasion end in prostitution. Societal norms for men are in almost all aspects contrary to those for women. Men are accorded the right to follow their sexual drive. Now while it is true such societal norms governing male and female sexual behaviour must be taken into account in prevention programs for HIV, it is also true that educators need to acknowledge the different societal expectations for men and women. Double standards and contradictions must be dealt with. Moreover it is important to recognise that social values are not static and fixed. Economic liberalisation and the revolution in information technology, for example, have brought many changes.

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[19] Hor B. (1998) Cambodia. In T. Brown, R. Chan, D. Mugrditchian, B. Mulhall, D. Plummer, R. Sarda & W. Sittitrai (Eds.), *Sexually Transmitted Diseases in Asia and the Pacific.* Armidale, NSW, Australia: Venereology Publishing Inc, 62-70.

Tarr and Aggleton[20] on the basis of their work in Cambodia set out some useful principles with reference to young people and the development of sexual health education. They include:

- Beginning with an analysis of the dominant discourses and understandings about sex and sexuality in the society or community. Recognising them as discourses which may or may not have a direct relationship to present day sexual realities
- Moving beyond such recognitions to inquire into contemporary sexual meanings, beliefs, etc. and developing prevention messages that speak to a sexual life as it is *lived*, not how it is imagined or hoped to be.

With reference to such principles, how does the ABC of HIV/AIDS education fare?

First, promotion of abstinence might work in a country where the young do not have sex ... at least until marriage. Existing behavioural evidence suggests, however, that the age of sexual initiation is decreasing while the age of marriage is increasing, for example in Malaysia[21] and the Philippines[22].

The 'abstinence only' sexual health education movement has been propelled by the persistent belief that comprehensive sexual health education leads the young to have sex, but there is no reliable evidence to support such a view. The casualties therefore are young people themselves, denied information about how to prevent HIV and STDs in the likely event that a proportion of them have sexual intercourse before they are married.

There has been a great deal of debate about sex and HIV-related education in schools as noted in Section 1. Research conducted for WHO/UNAIDS (Grunseit, Kippax et al.)[23] has clearly demonstrated that sex education does not lead to promiscuity or to earlier initiation of sex in the developed world. The conclusions of that work were that: "It is important that policy makers, program managers, and teachers are aware that the evidence indicates that young people's sexual behaviour can be modified through education." In the context of an expanding epidemic "Failing

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[20] Tarr, C.M. and Aggleton, P. (1999) Young people and HIV in Cambodia: meanings, contexts and sexual cultures, *AIDS Care*. 11(3): 375-384.

[21] Huang, M. (1999) Case Study on Adolescent Reproductive and Sexual health – Malaysia, UNESCO.

[22] Gacad, E. (1998) Philippines in T. Brown, R. Chan, D. Mugrditchian, B. Mulhall, D. Plummer, R. Sarda & W. Sittitrai (Eds.) *Sexually Transmitted Diseases in Asia and the Pacific*. Armidale, NSW, Australia: Venereology Publishing Inc, 256-279.

[23] Grunseit, A., Kippax, S. Aggleton, P., Baldo, M. and Slutkin, G. (1997) Sexuality education and young people's sexual behaviour: a review of studies, *Journal of Adolescent Research*. 12(4): 421-453.

to provide appropriate and timely information and services for fear of condoning and encouraging sexual activity cannot be supported". Further enquiry is needed in the developing world to confirm or otherwise these findings.

Secondly, fidelity may be a useful strategy but care must be taken that such a strategy is feasible. Data from China, for example, indicates that attitudes are changing with respect to both extra-marital as well as pre-marital sex[24]. It is moreover vitally important to acknowledge that serial monogamy does not protect against HIV infection. Furthermore, monogamy itself does not protect against HIV transmission unless both partners are HIV negative and neither partner has sex outside the relationship.

The very high HIV-prevalence among married women who have had sex with no one but their husbands indicates that fidelity is not the answer in many countries[25, 26].

Finally, condom promotion has been successful in many countries. As well as in rich-resource countries such as Switzerland, they have been effective programmes in Thailand, Brazil, Côte d'Ivoire, Senegal and Uganda. If condom use is positioned as a harm reduction/harm minimisation strategy and not simply as a way to space a family, then they seem to be an extremely effective way of preventing HIV transmission.

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[24] Liao, S. (1998) HIV in China: epidemiology and risk factors, *AIDS.* 12 (suppl B): S19-S25.

[25] Piot, P. (1999) *Action on AIDS in the new millennium: a critical time for Asia and the Pacific.* Plenary address at 5th International AIDS in Asia and the Pacific Conference: The Next Millennium: Taking Stock and Moving Forward, Kuala Lumpur.

[26] Kippax, S. Crawford, J. and Waldby, C. (1994) Heterosexuality, masculinity and HIV: barriers to safe heterosexual practice, *AIDS.* 8 (suppl 1): S315-S323.

APPENDIX A

THE QUESTIONNAIRE: HIV/AIDS AND SEXUALITY EDUCATION [IN YOUR COUNTRY]

The questionnaire is divided into four sections: policy, curricula, training, and a general section. Keep in mind, however, that the questionnaire is meant as a *guide* to your response. It is understood that you may not be familiar with some of the areas or that certain important areas may not be covered.

This questionnaire relates to sexuality education and to HIV/AIDS education in *primary* and *secondary* schools. If you are unable to answer or provide documentation for any questions it would be appreciated if you could tell us of someone who could.

If there are gaps in or problems within the questionnaire, please feel free to make additional comments.

POLICY ON HIV/AIDS AND SEXUALITY EDUCATION

1 Is there a school-based sexuality or HIV/AIDS education policy in [your country]?

2 Are the policies written, spoken, unspoken?

3 If no policies exist, are they being developed, and if so, at what stage of development are they at?

4 If a written policy exists, may we have a copy or do you know how we can get a copy?

5 At what level has HIV/AIDS and sexuality education policy been developed: Government/Ministerial, Departmental, schools, etc.

6 Do the policies cover all schools in [your country]? For example, are private and public schools subject to the same policies; is responsibility for them devolved to provinces, states, etc; and are policies applicable to both formal and informal schooling systems?

7 Is sexuality education and HIV/AIDS education compulsory in all schools?

8 How are the interests of different groups reflected in the policies? For example, the interests of public health officials, politicians, religious leaders, parents, or students.

9 What is included in the HIV/AIDS and sexuality education school policy? For example, does it make reference to, health, safety, discrimination, training, teaching content, resources, time-lines, priorities, etc.

THE CONTENT OF HIV/AIDS AND SEXUALITY EDUCATION (This set of questions is about what is contained within the sexuality education curriculum.)

10 Between what ages does primary (elementary) education take place?

11 In primary school, what ages get HIV/AIDS and sexuality education?

12 Between what ages does secondary education take place?

13 In secondary school, what ages get HIV/AIDS and sexuality education?

14 Is there a HIV/AIDS and sexuality education curriculum? If so, can you provide us with a copy, or do you know where we might get a copy?

15 What HIV/AIDS or sexuality education resources are provided to teachers (e.g. text books, class outlines, etc)

16 What is the primary focus of HIV/AIDS and sexuality education in the different school grades, from primary to secondary school?

17 In what way can sexual practice be discussed in sexuality education? For example: biological and physiological explanations, the use of condoms or contraceptives; different sexual acts; the formation of sexual relationships; and sexual practice within or outside of marriage.

18 In what way are sexually transmissible infections discussed in sexuality education? For example, are different infections discussed in terms of, how they are transmitted, their symptoms, and ways of preventing them?

19 What strategies for avoiding HIV infection are students taught? For example, in what way, if at all, are the following discussed as HIV avoidance strategies - monogamy, abstinence, 'Safe sex', the use of condoms, and sexual negotiation?

20 If sexuality education is linked to subject areas, how are they linked? For example, reproduction may be incorporated into Biology and Population Studies, or sexual relationships might be incorporated into Civics.

HIV/AIDS AND SEXUALITY EDUCATION TRAINING

21 Who gets HIV/AIDS or sexuality education training: existing teachers, trainee teachers, school administrators, peers, or school counsellors?

22 Who trains them?

23 What models are used? For example, life-skills, biological science, or harm minimisation.

24 Who teaches HIV/AIDS or sexuality education: Some teachers, all teachers, teachers within particular subject areas?

25 Are school counsellors, students, or health professionals involved in HIV/AIDS and sexuality education in schools? If so, in what capacity?

26 Is anyone from outside of the school structure involved in HIV/AIDS or sexuality education within schools? If so, in what capacity.

GENERAL

27 Please list three constraints that affect the provision of school-based HIV/AIDS and sexuality education in [your country]?

28 What are some of the strengths of implementing or teaching HIV/AIDS or sexuality education in schools in [your country]?

29 Are HIV positive students restricted in their access to schools or to particular activities in schools?

30 If an HIV/AIDS or sexuality education curriculum has been implemented in schools, when did this happen?

31 What discretionary powers do teachers have when teaching HIV/AIDS and sexuality education (at both official and unofficial levels)? For example, can they raise issues or answer student questions not asked in the curricula?

32 Who are primary advocates for HIV/AIDS and sexuality education? That is, which organisations are promoting the need for HIV/AIDS and sexuality education in schools? For example, specific NGOs, government departments, schools, international organisations and so on.