
Sexuality education in Asia: Are we delivering?

An assessment from a rights-based perspective



October 2010





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Clarke D. (2010). *Sexuality education in Asia: Are we delivering? An assessment from a rights-based perspective*. Bangkok, Plan.

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Editorial and Production Support: Dena Allen and Warisara Sornpet
Designed by: Work in Bangkok Co., Ltd
Printed by: Plus Press Co., Ltd.

First published by Plan in 2010.
Text, illustrations, design © Plan 2010.
British Library Cataloguing in Public Data. A catalogue record for this book is available from the British Library. ISBN 978-1-906273-11-8
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Publisher: Plan Limited, Chobham House, Christchurch Way, Woking, Surrey GU21 4PP, United Kingdom. Plan Limited is a wholly owned subsidiary of Plan International, Inc. (a not-for-profit company registered in New York State, USA). A Limited Company registered in England. Registered number 03001663.

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An assessment from a rights-based perspective
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"Boys and girls also talk about [sex] among ourselves. But we can only talk to each other because we usually cannot talk with adults, neither those in our families, schools, nor anywhere. I think teachers are just like parents. They are afraid that talking about sex, especially about how to prevent unwanted consequences will prompt us to have sex. In my country, people think [sex education] means 'showing the squirrel how to get in the hole'. Actually, all squirrels already know the hole, and so young people already know about sex, but we need to make sure they have the correct knowledge."

Sukrit, a Thai student who participated in a satellite session on 6 August 2008 at the 17th International AIDS Conference, Mexico City



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Acronyms

4 AEP	Adolescent Education Programme (India)	SHN	school health and nutrition
AIDS	acquired immune deficiency syndrome	SIDA	Swedish International Development Cooperation Agency
CEDAW	Convention to Eliminate Discrimination Against Women	SIECUS	Sexuality Information and Education Council of the United States
CESCR	Covenant on Economic, Social and Cultural Rights	SRA	situation and response assessment
CRC	Convention on the Rights of the Child	SRH	sexual and reproductive health
DFID	Department for International Development	STD	sexually-transmitted disease
EDC	Education Development Centre (USA)	STI	sexually-transmitted infection
EFA	Education for All	TWG	Technical Working Group (ICHA)
GCE	Global Campaign for Education	UDHR	Universal Declaration of Human Rights
GIPA	the greater involvement of people living with or affected by HIV and AIDS	UNAIDS	Joint United Nations Programme on HIV/AIDS
GSO	General Statistics Office	UNDP	United Nations Development Programme
HIV	human immunodeficiency virus	UNESCO	United Nations Educational, Scientific and Cultural Organization
IATT	Inter-Agency Task Team	UNFPA	United Nations Population Fund
IAWG	Inter-Agency Working Group	UNGASS	United Nations General Assembly Special Session
ICAAP	International Congress on AIDS in Asia and the Pacific	UNHCHR	United Nations High Commissioner for Human Rights
ICHA	Inter-Departmental Committee for HIV and AIDS	UNICEF	United Nations Children's Fund
ICPD	International Conference on Population and Development	WHO	World Health Organization
ICRW	International Center for Research on Women	WPF	World Population Foundation
ICT	information and communication technology		
IDU	injecting-drug user		
ILO	International Labour Organization		
IWHC	International Women's Health Coalition		
M&E	monitoring and evaluation		
MARA	most-at-risk adolescent		
MARP	most-at-risk population		
MOEYS	Ministry of Education, Youth and Sport (Cambodia)		
MOH	Ministry of Health		
MSM	males who have sex with males		
NACO	National AIDS Control Organisation (India)		
NCPI	National Composite Policy Index (UNGASS)		
NER	net enrolment ratio		
NGO	non-governmental organisation		
PATH	Program for Appropriate Technology in Health		
PLHIV	people living with HIV		

Acknowledgements

Plan Asia Regional Office commissioned the assessment on sexuality education in the region along with this report highlighting the results. David Clarke, an independent consultant, conducted the assessment and authored the report. Ravipa Vannakit, Regional HIV/AIDS Adviser led the project, with support from Mattias Bryneson, Anne-Marie Davies, Rasa Sekulovic, Dena Allen, Warisara Sornpet and Emma Miall. Plan Asia Country Health and HIV Advisers provided additional assistance: Irfan Ahmed (Pakistan), Selina Amin (Bangladesh), Matana Bunnag (Thailand), Yun Cheng (China), Vinayakan Ellath (India), Wahdini Hakim (Indonesia), Kalana Peiris (Sri Lanka), Sherbahadur Rana (Nepal), Malou Sevilla (Philippines), Tran Van Thong (Vietnam) and Chea Thy (Cambodia).

Plan Asia would like to express our gratitude to all who reviewed the report, including those who participated in the electronic consultation process. We appreciate the help of Subidita Chatterjee who managed that process and assisted with internet searches for the initial research. Plan thanks the following for their valuable comments and suggestions on the draft report: Ahmed Afzal (UNESCO Jakarta), Simon Baker (independent consultant), Rapeepun Jommaroeng (UNESCO Bangkok), Michael J. Kelly (formerly University of Zambia), Seung Lee (Save the Children), Michael Morrissey (AusAID), Pat Pridmore (Institute of Education, University of London), Scott Pulizzi (Education Development Centre), Inon Schenker (University of Jerusalem), Lisa Sherbourne (Save the Children) and Eric Woods (independent consultant).

Plan extends special thanks to Pawana Wienrawee and Waranuch Chinvarasopak (PATH) for their passionate commitment to sexuality education development and their support for this project.

We also want to acknowledge the significant contributions of the partners who worked with us in organising the special session on Enhancing HIV Prevention for Adolescents through Effective Health and Sexuality Education in the 9th ICAAP in Bali, which was the impetus for this report: Pawana Wienrawee (PATH), Nadia van der Linde (UNFPA), Margaret Sheehan (UNICEF), Jan W. de Lind van Wijngaarden (UNESCO) and Scott McGill (Save the Children).



Foreword

Yes, this report is talking about sexuality education. Yes, we know it's a sensitive issue. But we are talking about the policies and strategies in place regarding sexuality education in the 13 Asian countries where Plan operates. We have tried to look at how we, governments and civil society are delivering on what we see as adolescents' right to learn about the sexuality-related issues that will protect their health and wellbeing and will enable them to help protect others.

As all states agreed when they ratified the Convention on the Rights of the Child, children have the right to information, to an education and to good health. We see the right to sexuality education inherent in those agreed-upon rights. Yet, young people often have limited means to receive accurate information, particularly on sensitive issues such as sexual and reproductive health.

From our years of community experience – and Plan has worked more than 60 years in Asia with some 400,000 families – we see how immediately needed sexuality education is in contemporary society.

In our programmes, we partner with children, their families and communities to ensure they can access information and education and are empowered to demand that their rights be delivered. Our work emphasises interventions to protect girls and boys through peer education and peer-support interventions, life skills-based education, comprehensive school-based sexuality education, youth empowerment (economic and other), community sensitisation, children/youth participation and advocacy for policy support.

Adolescents and communities, along with Plan, see the urgency of helping young people become informed about sexuality at an appropriately early age so that they can protect themselves from coercion, abuse and exploitation, unintended teenage pregnancy and sexually transmitted infections, including HIV. These are unfortunate realities in Asia as much as elsewhere in the world. If we do not prepare adolescents to contend with them, then we are failing as duty bearers and as caregivers.

We hope this report will inspire all of us development partners to increase our engagement on realising the sexual and reproductive health rights of the young generation. Also with this report, we want to promote a rights-based approach to development in general and sexuality education policies and practices in particular. This will help to promote norms and standards and, most importantly, hold ourselves more accountable.

Myrna Evora
Regional Director
Plan Asia

Introduction

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In 2009, Plan's Asia Regional Office, in collaboration with PATH, UNESCO, UNICEF and the United Nations Population Fund, organised a special forum during the 9th International Congress on AIDS in Asia and the Pacific (ICAAP) in Bali to promote more supportive policies and comprehensive programming for sexuality education. For the forum, Plan commissioned a study on policies and strategies in sexuality education, focusing on the Asian countries where it has country programmes. These are Bangladesh, Cambodia, China, India, Indonesia, Lao People's Democratic Republic, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Timor-Leste and Vietnam. A report was published on this special session.¹ This report reflects the findings of the study.

Purpose of the study

The study involves taking a rights-based approach to sexuality education. The objectives are to

- i) contribute to furthering a rights-based approach in the education sector in general, and sexuality education in particular
- ii) use the rights-based approach to generate insights and support analysis of policies, strategies and programmes
- iii) assess the status of sexuality education.

There is very little independent research available currently in the field of sexuality education in Asia. The last comprehensive study on policy on HIV and sexual and reproductive health education in the Asia-Pacific region was published in 2000.²

Structure of the report

This report is organised into four chapters. The first provides the background to sexuality education issues in Asia. The second describes the findings from the policy and plan mapping. The third presents the findings of the rights-based assessment and the fourth includes the conclusions and recommendations.

Methodology

A mapping of the policies and strategies relating to HIV and sexual health education in Asia was first conducted. (See the annexes for the full list of the documents obtained.) An internet search was the primary channel for the research, involving a number of steps on a country-by-country basis. This entailed a general searching on adolescent health and specific searching on HIV education policy. Key words used (typically in combination): adolescent, law, policy, plan, HIV and AIDS, STI, sexual and reproductive health, rights, rights-based approach, education, sexuality, stigma and discrimination, gender, strategy, action/strategic plan, UNGASS, EFA, Fast Track Initiative, life skills, peer, curriculum, extra/co-curriculum, teacher, training, work place, school, health, services, young people, children, monitoring, evaluation, community, parents, NGO, civil society, risk behaviour, UNESCO, UNFPA and UNICEF.

1 Plan et al. (2009). Report on the special session on enhancing HIV prevention for adolescents through effective health and sexuality education at the 9th ICAAP: Empowering people and strengthening networks. Bangkok, Plan

2 Smith, G. et al. (2000). HIV and sexual health education in primary and secondary schools. Findings from selected Asia-Pacific countries. Monograph 10/2000 Sydney, University of New South Wales

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The UNESCO databases on HIV education and education plans within the International Bureau of Education and the International Institute for Educational Planning, respectively, were particularly useful. Policy is set out by governments in a range of documents, sometimes called *policies* but may also be conveyed through law, decree, regulation and strategic plan, depending on the way a government works.

Based on a literature search on the rights-based approach to development, a model was developed for making the assessment of the policies and plans obtained. After completion of the research, an online consultation took place with various members of civil society organisations. The data were updated and the analysis reviewed during the 9th ICAAP Special Session on Enhancing HIV Prevention for Adolescents through Effective Health and Sexuality Education on 9 August 2009.

Limitations of the study

Policies and strategies on education are not always easy to locate. Nor are they always accessible to civil society. Generally, many key documents are available in translation due to development partner engagement and governments' reporting on international commitments.

It was not possible with the analysis to provide any conclusions on the quality or outcomes of the sexuality education being delivered in schools.

Caveat

The findings of this study should be considered indicative. They are based on the analysis of available documentation on HIV and sexual and reproductive health education. While great endeavour was made to trace and track down policy statements and strategic plans, it is probable that some key documents were not accessible or overlooked; there may be omissions, especially of micro-level policies (such as education ministry internal directives). Currently, there seems to be little emphasis in most countries on ensuring that policy and planning documents are made accessible to civil society. The field is fast moving, however, and fresh documents may become available before this report is published.

Executive summary

10 This report presents the first investigation of school-based sexuality education in Asia through a human rights perspective. The study reflected in this report looked to provide new insights that could help strengthen programming by assessing how States are delivering on their responsibility to provide sexuality education in schools. The main focus is on the laws, policies and strategic plans through which governments provide the enabling environment for sexuality education.

The target audience for this report are education policy makers and planners, HIV planners, United Nations agencies, international development agencies and civil society organisations concerned with education and human rights.

Having policies and strategies in place is no guarantee of effective implementation. Policies need to be disseminated, put into action and regularly reviewed. It was beyond the scope of this study, however, to investigate the quality of the sexuality education that is provided in schools. Nonetheless, some important conclusions can be drawn from the data obtained.

Currently, the main driver of sexuality education is HIV and sexual and reproductive health (SRH) education. It is in this field that policy documentation is most comprehensive and accessible. This study aimed to build on the findings of the last comprehensive assessment of HIV and sexual health education in primary and secondary schools in 11 countries in Asia and the Pacific published a decade ago.³

The geographical scope of the study was limited to the 13 Asian countries where Plan has programmes.⁴ It involved a mapping of policies and strategies relating to HIV and SRH education and the development of a rights-based framework to analyse them to obtain insights on the status of sexuality education.

The study is underpinned by the proposition that school-based sexuality education is a right and also much needed. In addition, it is considered important to prepare children, and adolescents in particular, for a responsible and fulfilling adult life as well as to empower them to prevent HIV infection and safeguard their sexual and reproductive health. Such education should be available before the onset of sexual activity, when it may be too late to prevent high-risk behaviours. Plan agrees with the Commission on AIDS in Asia that sexuality education should be integrated into the education mainstream.⁵ It should be valued as an important contribution from the education sector towards strengthening a nation's human capital.

The main findings of the study are indicative. They show that the right of adolescents to sexuality education is being delivered, although in varying degrees.

Progress is being made across Asia in almost all the countries in this study in putting in place policies, strategies and activities to support the implementation of some form of sexuality education in secondary and, in some cases, primary education. There is considerable diversity in approach, though there are significant commonalities, which reflects different policy priorities, social contexts, levels of resources and forms of governance. The key issues are empowerment of both duty bearers and adolescents and protection of adolescents.

However, there is still a long way to go. School-based sexuality education is not as comprehensive as it could be in schools. The coverage of sexuality education programmes is generally limited according to the United Nations General Assembly Special Session (UNGASS) and UNGASS country reporting; in most countries that provide data, less than half of the schools are implementing programmes. More effort is required to scale up interventions to ensure that all those in school are able to benefit from them. As well, too many adolescents do not participate in secondary education and are not able to realise their right to education, let alone their right to sexuality education.

Generally, basic enabling environments for sexuality education are in place across the 13 countries, largely through national laws and policies on HIV and national strategic plans on HIV. However, detailed and comprehensive policies and strategies have been prepared by very few education ministries. Cambodia has comprehensive policies specific to the education sector for HIV, SRH and school health together with a costed sector-wide strategic plan and an annual operational plan for implementation. Vietnam also has a detailed policy and an action plan on reproductive health and HIV for secondary education. Indonesia has integrated school health and HIV education into its national Education Sector Plan.

The main enabling vehicle for sexuality education appears to be the national strategic plan on HIV and AIDS. All 13 countries have prepared such a multisector plan and all include activities for the education sector. However, there is a lack of alignment; the strategies are generally not included in mainstream education sector plans, and progress reporting is taking place through national HIV processes (such as UNGASS country reports) rather than through the Education for All (EFA) process.

The consequence of the reliance on a multisector policy and plan is that detailed specifications on HIV and SRH issues often appear to be lacking or hard to find. They may be embedded in education ministry directives or internal documents and not readily accessible to civil society. It is likely that national policies and strategies are also not effectively disseminated, with the result that responsibilities and entitlements relating to sexuality education are not generally known by either duty bearers or rights holders.

The rights-based framework used in this study investigated the following issues as they relate to the policies and strategies that were found in the mapping process: i) assessment, ii) linkage to rights, iii) non-discrimination, iv) empowerment, v) participation, vi) protection and vii) accountability.

The main findings are as follows.

i) Assessment

Policy makers and planners have a wealth of information at their disposal. There are many forms of situation assessments undertaken that are relevant to understanding the different contexts of adolescence, including sexuality. However, few of these assessments can be considered to be rights-based in approach. A stronger focus on adolescence is required. Relatively few studies meaningfully involve adolescents. Gender analysis needs to be strengthened in these assessments in general and in areas such as gender-based violence in particular, and made more integral to sexuality education.

The UNGASS country reporting on HIV and AIDS is a useful assessment process, stronger than the EFA reporting regarding sexuality education. The situation assessments on the education sector's response to HIV, recently undertaken in six countries, provide a great deal of useful information; the practice should be continued and improved in terms of the quality of process and product.

ii) Linkage to rights

There is generally a lack of overt links to rights in policies and strategies.

iii) Non-discrimination

Issues of stigma and discrimination do not appear to be receiving sufficient attention in the policies or plans, and concern for gender equality is under-represented.

3 Smith, G. et al. (2000). HIV and sexual health education in primary and secondary schools. Findings from selected Asia-Pacific countries. Monograph 10/2000. Sydney, University of New South Wales

4 Bangladesh, Cambodia, China, India, Indonesia, Lao PDR, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Timor-Leste and Vietnam

5 Commission on AIDS in Asia (2008). Redefining AIDS in Asia: Crafting an effective response. New Delhi, Oxford University Press

12 **iv) Empowerment**

The empowerment of duty bearers is taking place but appears not to be sufficiently systematic in approach. Most countries are investing in teacher education in pre- and in-service training. A stronger emphasis is needed on empowering teachers in the classroom and in the school through supporting content mastery, pedagogical skills building and ongoing professional supervision. Few countries appear to be investing in education ministry capacity building at the central and decentralised levels and in school management training.

The progressive empowerment of adolescents is taking place in all countries through life skills education, integration of sexuality education in the curriculum, through co-curricular activities, including peer education and, increasingly, through access to health services. These are likely to increase adolescents' access to information about sexuality and health and potentially provide them with skills to protect themselves and others.

Constraints on empowerment include the quality of teaching and learning in sexuality education; lack of comprehensive information (high-risk behaviours are often omitted, as are social issues such as gender relations); lack of learner involvement in programme design; and lack of a regular assessment of learning outcomes.

v) Participation

Sexuality education is not yet sufficiently participatory in school or in the wider community. A whole-school approach is needed. More attention is required with regard to parental involvement. NGO participation and the inclusion of networks of people living with HIV should be addressed in both policy and strategy. Perhaps most importantly, there needs to be a much stronger emphasis on adolescent participation in policy, strategy and programme design, including learner-led and effective peer education activities.

vi) Protection

Protection is under-represented in concepts of sexuality education. Schools need to be safe, healthy and protective for staff and students. Policies and standards (such as on child-friendly schools) need to be put in place and observed. Schools need to tackle gender-based violence. Students need to be equipped with the skills that will enable them to protect their own health and wellbeing.

vii) Accountability

Accountability needs to be enhanced through greater investment in monitoring and evaluation (M&E) and research. Policies and strategies need to be robustly monitored, reviewed and, if necessary, revised.

Very few evaluation studies of the sexuality education programmes have been conducted. The findings are not always published so that they can be accessed by and communicated with civil society. There is a lack of international guidelines for monitoring and evaluation in sexuality education.

Recommendations

The rights-based framework developed for this assessment has proven meaningful and shown a utility beyond this study. It provides a comprehensive template for evaluating policies and plans. Combined, the seven elements provide a means of investigating whether rights are being addressed in policy and strategy.

The report concludes with recommendations for duty bearers and adolescents to advocate for a broader and more comprehensive approach to sexuality education that includes attention to rights, gender equality and high-risk behaviours and to advocate for compulsory sexuality education. Specific recommendations to duty bearers are enumerated that relate to each of the seven elements of the rights-based framework.



Chapter 1

Towards a rights-based
approach to sexuality education



Plan's perspective

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Plan recognises that there is an urgent need to better understand adolescent sexual behaviour and reproductive health and provide adolescents (aged 10–19 according to the World Health Organization definition) with appropriate education through schools and in the community.⁶ Plan's strategy focuses on two critical trends: the first is the widening gap between sexual maturity and the age at marriage, which has resulted in increased premarital sexual activity among adolescents in many countries in the region. The second trend is adolescents' low use of contraceptives.

Key issues regarding adolescent wellbeing include the lack of access to youth-friendly health services and information, peer pressure, the erosion of the role of the family, economic constraints and discrimination against young women. All of these place immense psychological pressure on adolescents, the overwhelming majority of whom are currently not being adequately prepared for the responsibilities and challenges of adult sexuality.

Because Plan takes a rights-based approach to development, this study applied a similar framework to the analysis of sexuality education as it is currently being delivered in its programme countries. The United Nations Office of the High Commissioner on Human Rights defines the human rights-based approach to development as

"...a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights."⁷

Plan also attaches a high priority to addressing gender inequality. This is reflected in the global campaign Because I Am a Girl, which focuses on fulfilling girls' human rights and improving their life opportunities. Thus the study also investigated issues of gender in sexuality education as a critical issue for policy and practice.

The study focused on HIV and sexual and reproductive health education as the entry point for assessing the current status of sexuality education in Asia. This is the main vehicle for any sexuality education that is taking place in most education systems at this time, largely because international funding and technical assistance have been more readily available for those issues. The development of HIV education has contributed significantly to the evolution of sexuality education in schools, but it has not encompassed all issues relevant to adolescent sexuality.

6 Plan Asia Regional Office (2005). Growing up in Asia: Plan's strategic framework for fighting child poverty in Asia 2005-2015. Bangkok, Plan
7 United Nations High Commissioner for Human Rights (2006). Frequently asked questions on a human rights-based approach to development cooperation. New York, UNHCHR

Sexuality and development

Too few young people begin their sexual lives with anything approaching adequate preparation.⁸ This can have harmful consequences. A lack of appropriate sexuality education leaves many people vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV.⁹ Young people may also suffer from reproductive tract infections, which are not sexually transmitted; some of them are asymptomatic and can cause problems with fertility later in life.

The need for sexuality education holds as true for Asia as for any region in the world. Asian adolescents are becoming sexually aware at a younger age. Puberty among girls is taking place earlier due to improved nutrition and living conditions. Marriage is taking place later, although teenage marriage is still prevalent, especially in South Asia. In some countries, adolescents are becoming sexually active earlier. The factors that are bringing about change in adolescent sexuality include urbanisation and rural transformation, which provide more opportunities for social mixing and sexual activity.¹⁰ The role of the family may be diminishing as the importance of peers and the media in individual development grows.

Gender inequality has profound influences on life chances for adolescents.¹¹ Girls face particular risks from unprotected and coercive sex. The prevalence of gender-based violence increases as they enter adolescence.¹² In several countries, early marriage presents health risks for girls as well as limiting their developmental opportunities. Teenage pregnancy carries higher risks of premature labour, spontaneous abortion and stillbirth. Young mothers are also at risk from anaemia because their own increased needs for iron due to their growth and menstruation are often not met. Teenage pregnancy can have severe social consequences; young mothers are often forced to drop out of school, limiting their economic opportunities. Social stigmatisation related to unmarried teenage pregnancies often leads girls to seek unsafe abortions, including self-induced. These pose significant health risks. Termination often takes place at a late stage because girls don't know what to recognise as signs of a pregnancy, which also delays a decision to seek help.

Masculinity has recently become recognised as an important dimension of gender analysis and an area for intervention in the pursuit of gender equality.¹³ Male sexual behaviours are at the core of sexual HIV transmission and much gender-based violence.¹⁴ The construction of male gender roles and sexuality are subject to many influences, including the family, the school, the media and, perhaps most powerfully, the peer group. Locally specific, qualitative research is needed to explore the context and meaning of male sexuality and reproduction, the physical as well as

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8 United Nations Educational, Scientific and Cultural Organization (2007). Review of sex, relationships and HIV education in schools. Paris, UNESCO
9 United Nations Educational, Scientific and Cultural Organization (2009). International guidelines on sexuality education: An evidence informed approach to effective sex, relationships and HIV/STI education. Paris, UNESCO
10 Dehne, K. (2005). Sexually transmitted infections among adolescents: The need for adequate health services. Geneva, WHO and GTZ
11 The concept of life chances was introduced by the sociologist Max Weber. They refer to the opportunities each individual has to improve the quality of his or her life.
12 International Center for Research on Women and United Nations Population Fund. Violence against women in India. Review of patterns and responses. New Delhi, ICRW and UNFPA
13 Cleaver, F. (ed.) (2002). Masculinities matter! Men, gender and development. London, Zed Press
14 Swedish International Development Agency (2007). AIDS and gender relations. Men matter! AIDS, gender and masculinities. Stockholm, SIDA



Defining sexuality education

Sexuality education can be defined as a lifelong process of acquiring information and forming attitudes and beliefs about important topics such as identity, relationships and intimacy.²⁴ *Sexuality education* is preferred to *sex education* because it is a more encompassing term. UNESCO defines the primary goal of sexuality education as children and young people becoming equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV.²⁵

emotional transition of boys to men, and men's problems and concerns in managing their sexual and reproductive health.¹⁵ The importance of working with young males to address harmful masculine attitudes and behaviours while they are in the process of forming their identity needs to be recognised.¹⁶

STI rates among young people have risen significantly in recent years as a result of an increase in unprotected sexual activity. Prevention is important because the long-term effects of gonorrhoea, chlamydia and syphilis are substantial. Where they are common, STIs are major causes of infertility, ectopic pregnancy and congenital infections. In addition, several STIs facilitate the spread of HIV epidemics.¹⁷ They are sensitive markers of high-risk sexual activity that can indicate where HIV may be spreading.

Preventing HIV infection remains a major challenge for countries in Asia and the Pacific, with the main mode of transmission still sexual activity. In South Asia and East Asia and the Pacific, an estimated 690,000 and 580,000, respectively, young people (aged 15–24) were living with HIV in 2007.¹⁸ In both regions, the number of males outnumbered females (300,000 and 210,000 females, respectively, in contrast to 390,000 and 360,000 males, respectively). With the

exception of Thailand,¹⁹ every country in Asia where Plan has a programme has an adult HIV prevalence rate of less than 1 per cent, which means that infections are concentrated among those who engage in the most-at-risk behaviours. However, owing to the region's large population, Asia's comparatively low HIV prevalence can translate into a substantial HIV burden.²⁰

HIV infection in the Asia and Pacific region is concentrated in higher-risk populations in which transmission is largely through unsafe, paid sex work, injecting-drug use and sex between males.²¹ Commencement of these risk behaviours may occur in adolescence. Unequal gender roles and relationships are major drivers of poor sexual health.²² In the field of HIV programming, there is increased attention on assessing the situation of the most-at-risk adolescents and young people in Asia. However, they constitute a small proportion of the age cohort (1–5 per cent) and are mostly out of school. A focus on this fraction of the population (aged 15–24) has possibly contributed to neglect of the broader needs and rights of younger adolescents. For instance, the research that has probed the sexual and reproductive knowledge, attitudes and practices of younger adolescents (usually aged 12–14) reveals a widespread lack of information, skills and cognitive preparedness for sexual intercourse compared with similar assessments of older adolescents.²³

Schools provide an important setting for reaching large numbers of young people with sexuality education before they become sexually active. The formal curriculum is a good delivery vehicle. This also involves linking with teacher education, supervision and support as well as assessment procedures concerned with measuring learning outcomes. A whole-school approach is required, involving school management practices and codes of conduct to ensure that schools provide a supportive, safe and healthy learning and working environment for students and staff.

Co-curricular activities have an important role to play in providing opportunities for participatory learning and complement the formal curriculum. Community and parental involvement are also important as well as school links to health care and other services.

The term *sexuality education* is seldom used by education ministries, presumably on account of local cultural sensitivities and because courses often cover a broader agenda on health and wellbeing. With the exception of a few countries in Northern Europe (such as Sweden, where sexuality education has been compulsory in schools since

1955), sexuality (or sex) education often is controversial among duty bearers in terms of ideas, values and beliefs that young people should be exposed to in school²⁶ and what should be discussed in the family. In Asia, Thailand appears to be the only country to have openly embraced the concept of sexuality education.

Achieving consensus on what is permissible among different stakeholder groups, including religious leaders and faith-based organisations, appears crucial to make any progress. Also, there is a need for advocacy to build a strong constituency for sexuality education in civil society.

It is the sexuality education curriculum, however, that has been the prime focus for education specialists. It is widely acknowledged that the curriculum needs to be appropriate in terms of learners' age and culture. It must also address the reality of their lives, including their sexual beliefs and behaviours. Education about sex is already part of many national curricula in subjects such as biology and religious education, though this has been usually limited to topics such as reproduction and morality.

15 Maina-Ahlberg, B. et al. (1999). Men, sexuality and reproductive health. Stockholm, SIDA
 16 Swedish International Development Agency (2007). AIDS and gender relations. Men matter! AIDS, gender and masculinities. Stockholm, SIDA
 17 World Health Organization. Sexually transmitted infections in South-East Asia. New Delhi, SEARO
 18 United Nations Children's Fund (2008). Children and AIDS. Third stock-taking report. New York, UNICEF
 19 Thailand is just above, at 1.4 per cent.
 20 Joint United Nations Programme on HIV/AIDS (2009). AIDS epidemic update. Geneva, UNAIDS
 21 Commission on AIDS in Asia (2008). Redefining AIDS in Asia: Crafting an effective response. New Delhi, Oxford University Press
 22 Aggleton, P. et al. (eds.) (2006). Sex drugs and young people: International perspectives. London, Routledge
 23 International Women's Health Coalition (2007). Overlooked and uninformed: Young adolescents' sexual and reproductive health rights. New York, IWHC

24 Sexuality Information and Education Council of the United States (2004). Guidelines for comprehensive sexuality education: Kindergarten through 12th grade. Third edition. New York, Fulton Press
 25 United Nations Educational, Scientific and Cultural Organization (2009). International technical guidance on sexuality education. Volume I. The rationale for sexuality education. Paris, UNESCO
 26 Luker, K. (2006). When sex goes to school. New York, Norton

What is new about the current approach to sexuality education is the emphasis on the social dimensions. For example, the SIECUS²⁷ Guidelines for Comprehensive Sexuality Education, organises the curriculum content in terms of six concepts (human development, relationships, personal skills, sexual behaviour, sexual health and society and culture).²⁸ UNESCO provides a modified list of concepts in its guidance for topics and learning objectives:²⁹ relationships; values, attitudes and skills; culture, society and human rights; human development; sexual behaviour; and sexual and reproductive health.

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The two guidelines have a great deal in common. They cover topics in human biology, health education, social science and civic education. A critically important issue, however, is how such a wide range of topics can be coordinated within a school curriculum framework. Can they all be organised in a single subject or is integration across a

number of subjects the best approach? There is no simple answer at present. Plus, there is also the need for links to gender mainstreaming in the curriculum.

Beyond these guidelines, there is less help on how the curriculum should be delivered, including how best to prepare and support teachers. Teachers are often parents themselves and have as little knowledge about sexuality issues as the majority of parents. They may also have built-in prejudices about sexuality education. There is thus a need to address student and serving teachers' mastery of the subject content through a combination of pre- and in-service training. Teaching methods also appear to be critically important. Research by Kirby et al.³⁰ indicates that teaching should be through participatory methods that actively involve students and help them internalise and integrate information. Multiple activities are needed that are educationally sound. This is clearly a major implementation challenge for education systems that rely on didactic teaching and textbooks for learning.



Adolescents' right to sexuality education

The right to sexuality education comes at the intersection 21 of the rights to education, health, participation and protection. A fundamental prerequisite is that children are able to exercise their right to education, which is key to the full and effective exercise of other rights. This right is provided for in the Universal Declaration of Human Rights (UDHR), the Covenant on Economic, Social and Cultural Rights (CESCR, Article 13) and the Convention on the Rights of the Child (CRC, Articles 28 and 29). Delivering on this right remains a major challenge in Asia and the Pacific, particularly in terms of secondary education.

The right to good health ("the highest attainable standard") and health care is established in the UDHR, Article 12 of the CESCR and Article 24 of the CRC.

The CRC in particular emphasises that children should have access to information and materials aimed at the promotion of their wellbeing (Article 17). Article 14 of the CRC provides for the right to freedom of expression, including the freedom to seek, receive and impart information of all kinds. The Committee on the Rights of the Child has concluded that adolescents' right to information about HIV and AIDS is part of the right to information (General Comment 3, Paragraph 4). The Committee emphasises that education should empower children to protect themselves from HIV infection and that effective HIV prevention requires that states not censor, withhold or intentionally misrepresent health information, including sexual education. Thus, it can be argued that schools that deny young people information about HIV and sexuality are actually violating their rights.³¹

General Comment 4 on the CRC covers the right to good health in view of sexual and reproductive maturation. States have an obligation to take legislative, administrative and other measures to enable adolescents to exercise those rights. The CRC also recognises the obligations of parents in the survival, upbringing and development of their children as well as providing direction and guidance in the exercise of their rights.

The International Conference on Population and Development (ICPD) Programme of Action recommended in 1994 that information and services be made available to adolescents to help them understand their sexuality and to protect them from unwanted pregnancies, sexually transmitted diseases and the subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.³² ICPD also recognises participation as an important principle and that youth should

27 Sexuality Information and Education Council of the United States

28 *ibid.*

29 United Nations Educational, Scientific and Cultural Organization (2009). International technical guidance on sexuality education. Volume II. Topics and learning objectives. Paris, UNESCO

30 *ibid.*

31 Open Society Institute and Equitas (2007). HIV/AIDS and human rights: A resource guide. New York, Open Society Institute and Equitas

32 International Conference on Population and Development. paragraph 7.4. ICPD



The importance of policy

When there is agreement within a government to provide sexuality education, a policy is needed to show that it is a priority to be institutionalised. Guidelines are then needed for implementing that policy at all levels of the education system, in particular within the school.

be actively involved in the planning, implementation and evaluation of development activities, such as sexuality education, that have a direct impact on their lives.³³ Five years later, all participating governments agreed in the ICPD +5 meeting that schoolchildren should receive education about population and health issues, including reproductive health.³⁴

Various human rights committees expressly recommend that sexual and reproductive health education be made a mandatory and robust component of all students' learning.³⁵ The Convention to Eliminate Discrimination Against Women (CEDAW) includes reference on access to specific educational information to ensure the health and wellbeing of families. The Committee on the Elimination of Discrimination Against Women urges States to make sexuality education compulsory and to provide it systematically in schools.³⁶ The Committee on the Rights of the Child has recommended that sexuality education be made part of the official curricula for primary and secondary education.³⁷ UNAIDS has concluded that the most effective approaches to sexuality education begin before the onset of sexual activity.³⁸

Participants in the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS agreed in 2001 on an international framework for tackling HIV. The UNGASS participants set a target in the Declaration of Commitment³⁹ that by 2005 States should ensure that at least 90 per cent and by 2010 at least 95 per cent of young men and women aged 15–24 have access to the information, education (including peer education and youth-specific HIV education) and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.

Achievement of the Millennium Development Goals, particularly those concerned with HIV and other communicable diseases, gender equality and child and maternal health, are dependent on progress in sexual and reproductive health.⁴⁰

Policy should clarify the following issues

- the curriculum for sexuality education and its delivery
- teacher training (pre- and in-service)
- school management of issues such as stigma and discrimination, gender-based violence and confidentiality
- parental and community involvement
- school health and safety
- access to health care and other services.⁴¹

Effective policy making establishes clear priorities for action and investment, defines rights and entitlements, clarifies roles and responsibilities in implementation and supports resource mobilisation.⁴² Policies can have legal force when they are linked to laws. Policies can be classified as distributive (the allocation of new resources), redistributive (changing the distribution of existing resources) or regulatory (control, regulation or standards setting).⁴³ In practice, a policy may combine all three forms.

There is general acknowledgement that a policy on HIV and SRH will be effective only if it is owned by the relevant stakeholders who are responsible for its operation.⁴⁴ This implies a participatory approach to policy formulation with stakeholder groups rather than with a narrow expert-driven technical approach that has minimal participation. The process should include the involvement of people living with HIV and representatives of the targeted age group and duty bearers. Civil society involvement should be maximised, including relevant NGO participation. Policy should also provide guidance on how it will be made accessible, communicated and generally disseminated. This is to enhance participation and

accountability. A policy should also provide arrangements for monitoring and review.

The increasing commitment to offer sexuality education in schools has actually been driven by two prominent public policy issues.⁴⁵ The first relates to concern for controlling excessive population growth. In the 1990s, international population policy shifted focus from the provision of stand-alone family planning programmes to the promotion of sexual and reproductive health care through integrated primary health care services. The second is the international response to controlling the spread of HIV. It is this public policy momentum that provided the funding and impetus for sexuality education in the form of HIV-related education.

There has been a great deal of international research into the effectiveness of school-based HIV education as well as sexuality education programmes. The research on the outcomes of such programmes in developing countries showed no harmful effects. This type of education did not increase sexual activity or result in the earlier initiation of it. The various assessments did indicate that adolescents increased their knowledge of important wellbeing issues and, in some cases, actually delayed sexual initiation, reduced sexual-risk behaviour and increased the use of condoms.⁴⁶ Originally, 17 characteristics of effective programmes were identified;⁴⁷ these have subsequently been increased to 18 in UNESCO's guidance on sexuality education,⁴⁸ which provides a valuable evidence-based guide to programme development and implementation.

33 International Conference on Population and Development, paragraph 6.15. ICPD

34 Warwick, I. and Aggelton, P. (2002). The role of education in promoting young people's sexual and reproductive health. London, University of London

35 Centre for Reproductive Rights (2008). "An international human right: Sexuality education for adolescents in schools." Factsheet. Available from www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_fs_sex-ed_2008_0.pdf

36 CEDAW/C/LTU/CO/4 (2008)

37 CRC/C/15 (2004) and CRC/C/TTO/CO (2006)

38 Joint United Nations Programme on HIV/AIDS (1997). Impact of HIV and sexual health education on the sexual behaviour of young people: A review update. Geneva, UNAIDS

39 United Nations (2001). Declaration of Commitment on HIV/AIDS. New York, United Nations

40 Department for International Development (2004). Sexual and reproductive health and rights. London, DFID

41 United Nations Educational, Scientific and Cultural Organization (2009). International technical guidance on sexuality education. Volume I.

42 The rationale for sexuality education. Paris, UNESCO

42 Clarke, D. et al. (2008). Step by step: A guide to HIV and AIDS policy development for the education sector. Boston, Education Development Center

43 Lowi, T. (1970). Cited in Parsons, W. (1995). Public policy. Cheltenham, England, Edward Elgar

44 United Nations Educational, Scientific and Cultural Organization and World Bank (2008). Strengthening the education sector response to HIV/AIDS in the Caribbean. Washington DC, World Bank

45 Decosas, J. (2009). Adolescent sexual health in West Africa. Rights, realities, responses. Dakar, Senegal, Plan West Africa

46 Kirby, D. et al. (2006). The effectiveness of sex education and HIV education interventions in schools in developing countries. In Ross, D. et al. (eds.) (2006). Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva, World Health Organization

47 United Nations Educational, Scientific and Cultural Organization (2009). International technical guidance on sexuality education. Volume I.

48 The rationale for sexuality education. Paris, UNESCO

48 ibid.

The importance of a national strategy

24

Ideally, a medium-term (three to five years), cost-analysed strategy or action plan is required to set directions and identify activities for implementing policy goals and objectives. This strategy should then be translated into an annual operational plan. All activities and development-partner contributions should be *on plan*. A strategy and operational plan are important vehicles for translating a rights-based framework into action.

Education-sector strategic plans have assumed prominent importance in development, similar to the AIDS strategy plans in the national multisector response. These plans have become the primary instruments for mobilising international development assistance. For instance, the main focus of local donors in the EFA Fast Track Initiative has been the appraisal of the primary education component of the education sector plan. In both education and AIDS strategy plans, policy documentation seems increasingly to play a subordinate role to preparing a plan. It can even be argued that the plan has replaced policy in some contexts and may be the only statement of government policy in some programme areas. Moreover, plans may make scant or no reference to policy documents. The proper alignment of policy and plans is arguably a significant issue for good governance.

As with policy making, strategic planning should include representatives of stakeholders to ensure ownership and appropriateness. In practice, they may be developed by planners with very limited participation of beneficiaries or important stakeholders. Strategies should be detailed, transparent and costed. As with policies, they should be widely communicated and disseminated, though they are much more unwieldy as communication documents. This suggests the importance of a communication strategy and tailored products for civil society stakeholders to support dissemination.

UNAIDS has provided clear guidelines on the approach to national strategic planning for the national response to HIV and methods to use.⁴⁹ The situation and response assessments (SRAs) are now a standard process that informs and underpins

strategic development. As a result, there is a considerable degree of conformity in national HIV planning frameworks.

Unfortunately, such guidelines for strategic planning have not been prepared for the education sector; thus there is considerable diversity in approach. Current planning methods are arguably not adequate to address the full range of educational challenges in the twenty-first century. Unlike the HIV response, where there is one national plan mandated, education ministries often have multiple and overlapping plans for sector development. Countries may have an EFA action plan and a wider sector reform plan. Some may operate on the basis of a subsector programme framework, such as the Primary Education Development Programme in Bangladesh.

How HIV and SRH education is included in national strategic planning is a complex issue. It certainly should be built into the national multisector HIV strategic plan. But equally important, it needs to be part of the main education sector plan. It would clearly be suboptimal if it were in the former and not the latter. Furthermore, the two planning frameworks obviously need to be aligned.

Given the complexity of the education sector's response to HIV, which typically involves the activities of multiple departments, it makes practical sense for education ministries to develop their own specific, costed strategic plans and to include these within both the national HIV and the education sector plans. This appears to be necessary to ensure a sector-wide approach instead of a fragmented project-based response.

49 Joint United Nations Programme on HIV/AIDS (1999). Guide to the strategic planning process for a national response to HIV/AIDS. Geneva, UNAIDS

A rights-based framework for analysis

25

There is a discernable move these days towards a rights-based approach to development, though it has not been tested or evaluated. Rhetoric about a rights-based approach is perhaps most noticeable in the education sector and among international NGOs, the United Nations system and some bilateral development agencies. The Swedish International Development Cooperation Agency (SIDA), for example, developed a strategy for a rights-based approach to sexual and reproductive health in 1997.⁵⁰

Plan, ActionAid International and Save the Children all subscribe to a rights-based approach in the education sector.⁵¹ UNESCO has developed a manual for implementing a rights-based approach to development in the Asia and Pacific region,⁵² while UNICEF has published global guidance.⁵³

However, there is currently no single agreed approach in the education sector. Thus there are multiple rights-based interpretations and operational modalities in practice.⁵⁴ The Global Campaign for Education published the most elaborate rights-based approach to educational development in the form of a guide for practitioners and activists.⁵⁵ The guide identifies four components: availability, accessibility, acceptability and adaptability. However, the guide does not apply these components to HIV prevention or education specifically; nor does it provide a comprehensive framework for the right to sexuality education.

For the purpose of this study's analysis and other evaluation needs, a different model was conceived, based on broadly accepted human rights programming principles.

The following framework was used when analysing the policies and strategies on sexuality education in the 13 countries selected for this assessment. It is derived from a rights-based approach to HIV⁵⁶ and includes programming elements that are considered necessary, specific and unique to the rights-based approach.⁵⁷ The framework entails seven elements:

i) Assessment

The function of an assessment from a rights-based perspective is to identify the human rights claims of rights holders and the corresponding human rights obligations of duty bearers as well as the immediate, underlying and structural causes of the non-exercise of rights. For this study, the rights holders are adolescents in school; duty bearers include governments, parents, community leaders, school managers and teachers.

An assessment should also be made of the capacities of rights holders to claim their rights and of duty bearers to fulfil their obligations. Sexuality education requires several forms of assessment, including of the sexual and reproductive health of adolescents and young people and of the education sector's response to HIV and SRH issues.

50 Swedish International Development Agency (1997). Sexual and reproductive health and rights: A strategy for development cooperation. Stockholm, SIDA

51 Bainton, D. (2009). Realising children's right to education: Priorities, strategies, policies and trends in international NGOs. Bristol, England, Centre for Globalisation, Education & Societies, University of Bristol

52 Tomasevski, K. (2004). Manual on rights-based education: Global human rights requirements made simple. Bangkok, UNESCO ASPBAE

53 United Nations Children's Fund (2007). A human rights-based approach to education. New York, UNICEF

54 Bainton, D. (2009). Realising children's right to education: Priorities, strategies, policies and trends in international NGOs. Plan International. Bristol, England, University of Bristol

55 Global Campaign for Education (2007). Education rights: A guide for practitioners and activists. Johannesburg, GCE and ActionAid International

56 Open Society Institute and Equitas (2007). HIV/AIDS and human rights: A resource guide. New York, Open Society Institute and Equitas

57 United Nations Educational, Scientific and Cultural Organization (2008). Undertaking a human rights-based approach: A guide for basic programming. Bangkok, UNESCO

ii) Linkage to rights

Sexuality education needs to be linked to the health-related rights, the right to information, the right to self-expression and other relevant rights. Does a policy or strategic plan define its objectives in terms of legally enforceable rights? Are rights embedded in the policy and programmes? Is programming informed by the recommendations of international rights bodies and mechanisms? Are stakeholders aware of their rights and responsibilities?

iii) Non-discrimination

The provisions for non-discrimination for children are found in Articles 2.1 and 2.2 of the CRC. Article 2.1 says States are obliged to

“...respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”

This means that States need to conduct a situation analysis in order to put in place needed measures, such as legislation, policies, structures and mechanisms, resource allocation and awareness raising to change attitudes and behaviours that discriminate against children. Article 2.2 implies that affirmative action may be necessary to combat discrimination, but any differential treatment should be temporary and end as soon as the objectives are met.

Equity is at the heart of a rights-based approach, which focuses on addressing inequality and discrimination and reaching out to marginalised and disadvantaged groups. Thus, a rights-based approach arguably has two dimensions in sexuality education. First, programmes should be non-discriminatory in their provision; they should be accessible by all. Second, they should promote in their learning content and processes non-discriminatory attitudes and behaviours towards marginalised and stigmatised populations, such as people living with HIV, homosexuals and the opposite sex in general.

iv) Empowerment

Empowerment is perhaps the most difficult characteristic to define. It has different meanings in different socio-cultural and political contexts and does not translate easily into all languages.

Discussions of empowerment in HIV and SRH education for adolescents and, more commonly, youth tend to centre on many factors

- a focus on action (not simply on information)
- interactive and engaging approaches to learning
- access to accurate, unbiased and comprehensive information
- life skills education that fosters critical thinking, problem solving and interpersonal communication skills and includes practice in skills development
- environments that encourage openness in communication about sexuality
- youth-led activities, including peer-to-peer activities.

Empowerment in sexuality education for adolescents will thus largely be a function of knowledge and skills acquisition as well as empowering participatory learning activities. Such education is not solely teacher-led.

The empowerment of duty bearers is another critical area to consider. This includes the empowerment of teachers through participatory pre- and in-service training on HIV and SRH education and the implementation of enabling policies at the school level to support their work. Is there a workplace policy on HIV? Is there a whole-school approach as embodied in child-friendly schools programming? Are there links to health services, parental education and participation in school management committees? Does a policy or strategy give participants and stakeholders the power, capability, capacity and access to make a change in their own lives? Does it place them at the centre of the development process?

v) Participation

Participation is key to empowerment. A primary principle of participation is that people are recognised as actors in their own development. Article 12 of the CRC says that:

“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”

Other participation rights are expressed in Article 13 (freedom of expression), Article 14 (freedom of thought, conscience and religion) and Article 15 (freedom of association and peaceful assembly).

In sexuality education, participation is a major principle in the learning process. Participatory learning activities and teaching methods are characteristic of effective sexuality education programmes.⁵⁸ Ideally, learners should participate not only in the learning process of a programme but also in the design and evaluation processes of that programme.

In the area of HIV policy and practice, the principle of enabling the participation of people living with HIV is widely accepted. This is the so-called GIPA principle – the greater involvement of people living with or affected by HIV and AIDS – in all stages of HIV programme development. GIPA is as relevant to the education sector as any other.

Policy formulation and programme design ideally should be informed by a situation assessment of the barriers to effective participation of both implementers (duty bearers) and learners (rights holders).

vi) Protection

Children have a right to protection from violence and sexual abuse. Do policies or strategies support the protection of learners from abuse, exploitation and violence in school? Are schools safe, healthy and friendly places for all children? Do schools teach adolescents what is acceptable adult behaviour in both social and intimate relationships? Do they equip adolescents with the skills to protect themselves? Does sexuality education work to address cycles of abuse and violence? Does policy protect the rights of the most vulnerable, including children infected with and/or affected by HIV or other marginalising conditions, such as a disability?

vii) Accountability

Duty bearers should be accountable. Monitoring and evaluation of processes and outcomes need to be guided by human rights standards and principles.

A challenge for governments and their development partners is to translate these principles into action and incorporate them into policy and strategy for the education sector. For development agencies, the onus is on them to support the design and implementation of programmes of assistance that positively contribute to adolescents being able to exercise their human rights.

⁵⁸ Kirby, D. et al. (2006). Impact of sex and HIV education programmes on sexual behaviours of youth in developing and developed countries; and (2006) The effectiveness of sex education and HIV education interventions in schools in developing countries. Geneva, WHO

Chapter 2

Mapping of policies and strategies





Policies and strategies relating to sexuality education

31

This assessment first involved a mapping of policies and strategies relating to sexuality education as well as relevant assessments. This was accomplished through an internet search for key government documents that would potentially include reference to any form of sexuality education (HIV, SRH, population growth and health education).

Tables 2.1 and 2.2 contain a brief summary of the laws, policies and strategies obtained. The annexes contain the full list of the documents obtained.

Policies or laws on HIV as well as on population were obtained for most of the countries in this study (table 2.1). Some countries have put in place laws or policies to protect children affected by or living with HIV. However, policy statements specific to the education sector on HIV or population were harder to find than multi sector documents. The education sector policies included in table 2.1 do not include curriculum documents or programme guidelines (micro policies).

An enabling environment for sexuality education, deriving from either law or policy for HIV, population or SRH, is in place in almost all countries. National laws and policies primarily address HIV or population and/or reproductive health. The education sector is just one of several sectors within the scope of the policy, and this in effect limits the details that can be included.

HIV prevention is generally the major issue driving the development of sexuality education, at least as evidenced in the national strategic plans (table 2.2), while population policy (table 2.1) has provided a measure of support for adolescent reproductive health education.

Table 2.1: Laws and policies on HIV

Country	National law on HIV	National HIV policy	Law/policy on HIV and children	Population/RH* policy/law	Education sector policy on HIV
Bangladesh		Yes		Yes	
Cambodia	Yes	Yes**	Yes	Yes	Yes
China	Yes		Yes	Yes	Yes
India		Yes	Yes	Yes	
Indonesia		Yes**			Yes
Lao PDR		Yes	Yes	Yes	
Nepal		Yes			
Pakistan		Yes		Yes	
Philippines	Yes			Yes	
Sri Lanka		Yes			
Thailand		Yes		Yes	Yes
Timor-Leste					
Vietnam	Yes	Yes**	Yes	Yes	Yes

*RH: reproductive health

** Multiple policies

A national HIV plan was found for all 13 countries (table 2.2), which confirms the robustness of the Three Ones approach⁵⁹ that includes the prescription of a single national action framework for HIV. All of the country plans include strategic direction for the education sector on HIV and SRH education, although in varying degrees of detail. That they (and the policies) are multisector documents limits the level of detail that is available within the planning framework for education; gaps are probably inevitable.

There is an increasing emphasis on meeting the needs of the most-at-risk adolescents and young people (such as those who are already out of school).⁶⁰ This may mean less space may be available in the future for school-based interventions, which indicates that the education sector must take more responsibility.

59 UNAIDS established the Three Ones principle in 2004; they are i) one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; ii) one national AIDS coordinating authority, with a broad-based multisector mandate; and iii) one agreed country-level monitoring and evaluation system.

60 Van Wijngaarden, J. (2007). Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-) effective policies and programmes. UNICEF, UNFPA and UNESCO

Table 2.2: Strategies on HIV and SRH education

Country	National HIV strategy/plan	Population/RH strategy	Education sector strategy/plan	Education sector strategy/plan on HIV/SRH	Strategy or programme on SHN
Bangladesh	Yes	Yes	Yes		Yes
Cambodia	Yes	Yes	Yes*	Yes	Yes**
China	Yes		Yes		Yes**
India	Yes	Yes	Yes	Yes	Yes
Indonesia	Yes		Yes*	Yes	Yes**
Lao PDR	Yes		Yes		Yes**
Nepal	Yes	Yes	Yes		Yes
Pakistan	Yes		Yes		Yes
Philippines	Yes		Yes		Yes
Sri Lanka	Yes		Yes		Yes
Thailand	Yes		Yes		Yes
Timor-Leste	Yes	Yes	Yes		
Vietnam	Yes	Yes	Yes	Yes	

* HIV education in education sector plan

** Policies on school health and nutrition (SHN) obtained

How governments formulate and use policy to support HIV and SRH education varies considerably across the region, reflecting different traditions and approaches to governance as well as commitment to addressing those issues. The availability of resources from international development partners may be an important factor because most HIV funding appears to be donor provided. A number of countries are *policy rich* in that they have multiple inter-related and interlocking policies (such as Cambodia, for which there is even a National HIV/AIDS Policy Inventory⁶¹). This presents issues of alignment and coordination of policies.

There are other national strategies that are relevant to HIV and SRH education, and these may also offer multiple sources of funding. For example, Bangladesh has a national Adolescent Reproductive Health Strategy that includes effective dissemination of knowledge and information through the curriculum in secondary and higher secondary schools. India also has a National Adolescent Reproductive and Sexual Health Strategy. Cambodia, Timor-Leste and Vietnam have national population growth or reproductive health strategies. However, these are generally more focused on the health sector and have minimal or no inclusion of education about SRH. It is, therefore, clearly of critical importance that HIV and SRH education be included in the education sector plan, which provides the main action framework and budget commitment for the sector.

61 Joint United Nations Programme on HIV/AIDS (2007). Summary of the national HIV/AIDS policy inventory. Phnom Penh, UNAIDS



Education sector plans were found for all 13 countries. However, these are generally either silent about HIV and SRH education or contain little in the way of detail. Reluctance to include this type of programming in the education sector plan has been a generic problem identified in other research on HIV and SRH interventions in education plans endorsed by the EFA Fast Track Initiative.⁶² EFA national action plans tend to include life skills education because it is reflected in the third EFA goal; but they do not always contain any reference to HIV and SRH education activities (which are life skills-based). Cambodia and Indonesia have included HIV and SRH education in their mainstream education sector planning documents but with limited space for details.

Only two countries had developed detailed medium-term education-sector strategies for HIV and SRH (Cambodia and Vietnam), and one of them was sector-wide and costed (Cambodia). Indonesia has mainstreamed HIV in its Education Sector Plan. The country has decentralised administration and at least two provinces (Bali and Papua) include HIV education in their provincial strategic plans. Various programmes are taking place at the provincial level in line with the national policy, depending on local needs and the availability of resources. In India, individual states have a strong voice in determining whether HIV education will be implemented and, if so, how. The implementation of the Adolescent Education Programme (AEP) in India involved states preparing their own annual implementation plans of action, using a national template for guidance. Detailed national guidelines for implementation have also been available.

The role of school health programmes is clearly fundamental across the 13 countries. Most are implementing some form of school health and nutrition (SHN) programme, typically including some HIV and/or SRH education. Some are longstanding, such as in Sri Lanka, which has more than 25 years of experience in this field and is currently implementing a School Health Promotion Programme. Some countries support the Health Promoting School concept (such as Thailand). There appears to be a lack of broad policy

documentation on school health and nutrition, which is readily available to all stakeholders, both in and outside the education system. For example, there may be school health guidelines (such as in Nepal⁶³), but there is often no policy statement to provide the overall picture of objectives, processes, responsibilities and entitlements to duty bearers and rights holders (table 2.2).

There are numerous SHN initiatives taking place that are relevant to sexuality education. Cambodia and Lao PDR⁶⁴ stand out for having a detailed policy statement on SHN, and Nepal does so for having a SHN strategy and guidelines. Indonesia has included its school health programme in its Education Sector Plan for 2010–2014. The Philippines has published SHN curriculum specifications.⁶⁵

62 Clarke, D. and Bundy, D. (2008). The EFA Fast Track Initiative: An assessment of the responsiveness of endorsed education sector plans to HIV and AIDS. Geneva, UNAIDS
63 Ministry of Education (2006). Implementation guidelines for school health and nutrition. Kathmandu, Ministry of Education, Government of Nepal
64 Bundy, D. et al. (eds.) (2009). School health, nutrition and HIV/AIDS programming: Promising practices in the Greater Mekong sub-region. World Bank
65 UNACOM and Human Sciences Committee (2009). The basic curriculum in Philippine basic education. Volumes 1 and 2. Manila, UNESCO

Chapter 3

Main findings



i) Assessment

38

There is a wide range of assessment data relevant to sexuality education available for policy makers and planners.

There is a wealth of information available on HIV and SRH. Various methods are currently being used to understand the situation of people in relation to HIV and sexual health in Asia (table 3.1). HIV surveillance increasingly includes a focus on vulnerability and risk behaviours. All 13 countries have some form of HIV-related behavioural assessment. There is a strong emphasis on assessing the situation of the most-at-risk population (sometimes referred to as MARP), with a view to informing the design and implementation of targeted interventions. A few countries have undertaken sexuality surveys, such as the Philippines' Young Adult Fertility and Sexuality Study 3 in 2002 and Thailand's National Sexual Behaviour Survey in 2006.

There is an increasing number of studies on young people and HIV and SRH, although very few, if any, include research on younger adolescents. The Thailand survey, for example, did not include any respondents younger than 18.⁶⁶ Sri Lanka's Behavioural Surveillance Survey⁶⁷ did not include any age stratification. In such contexts, the situation of adolescents is not assessed and, as a result, they risk being missed on the policy radar. There is an increasing interest in assessing the situation of the most-at-risk adolescents (sometimes referred to as MARAs), such as in Nepal.⁶⁸

A rights-based approach to assessment is rare.

Only two of the HIV and SRH assessments included a rights-based approach. They provide important insights. A recent study on SRH and the rights of young people in Pakistan (supported by the World Population Foundation and the European Union) applied an innovative tool for assessing SRH rights.⁶⁹ Interestingly, the study gave the lowest score on performance, with regard to the right to information and education on SRH, and recommended a higher priority for developing an enabling environment for sexuality education.

More assessments need to target adolescents.

Few governments appear to have targeted adolescents for research in order to obtain comprehensive strategic information about health, social issues and sexuality for that age group. Perhaps the best model is the Survey Assessment of Vietnamese Youth undertaken by Vietnam's Ministry of Health and General Statistics Office, with technical and financial support from WHO and UNICEF.⁷⁰ The survey enabled a broad assessment on the situation of youth, including family life, friendships, dating, sexual and reproductive health, pregnancy and abortion, and HIV as well as health-compromising and problem behaviours. Unfortunately, the survey provided no information on young people's perceptions of HIV and sexuality education.

There is a need to strengthen adolescent participation and consultation.

It appears that consultations on HIV and sexuality with young people are very rare. The consultation with adolescents on HIV and AIDS that was conducted in Thailand, with the support of UNICEF, is unique in the Asia region.⁷¹ The consultation's report revealed that the participating adolescents acknowledged having little opportunity to engage in policy making or programme design in their countries.

The Thailand consultation on HIV and AIDS revealed valuable insights. Although sexuality education is in the curriculum, the participating adolescents thought it did not provide them with sufficient knowledge. They also thought that teachers lacked in-depth knowledge of the subject as well as the participatory teaching skills necessary for effective delivery. They considered the content to be too academic and theoretical as well as incomplete, particularly regarding

66 Ministry of Public Health (2006). National sexual behaviour survey of Thailand. Bangkok, Government of Thailand
 67 National STD/AIDS Control Programme (2007). Sri Lanka behavioural surveillance survey: First round results 2006-2007. Colombo, Government of Sri Lanka
 68 United Nations Children's Fund (2008). The situation of adolescents and young people most at risk in Nepal. Kathmandu
 69 World Population Foundation (2010). A research study on status of sexual and reproductive health rights of young people in Pakistan. Pakistan, WPF.
 70 Ministry of Health and Government Statistics Office (2003). Survey assessment of Vietnamese youth. Hanoi, Government of Vietnam
 71 United Nations Children's Fund (2004). Consultations with young people on HIV/AIDS 2004. Thailand country report. Bangkok, UNICEF. The consultation included Pacific island countries.

Table 3.1: Assessments relevant to HIV and SRH education

Country	HIV	MARA	SRH/HIV Adolescents and/or young people	Gender-based violence	UNGASS country progress report	UNGASS shadow youth report	Children affected by HIV	EFA MDA** report	Education sector response to HIV
Bangladesh	Yes		Yes		Yes			Yes	
Cambodia	Yes		Yes	Yes	Yes		Yes	Yes	Yes
China	Yes				Yes		Yes	Yes	
India	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indonesia	Yes		Yes	Yes	Yes		Yes	Yes	Yes
Lao PDR	Yes				Yes		Yes	Yes	
Nepal	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
Pakistan	Yes		Yes*		Yes	Yes	Yes	Yes	
Philippines	Yes		Yes		Yes			Yes	
Sri Lanka	Yes		Yes		Yes			Yes	
Thailand	Yes		Yes*		Yes		Yes	Yes	Yes
Timor-Leste	Yes			Yes	Yes				
Vietnam	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes

*rights-based approach
 **mid-decade assessment

homosexuality. They said skills for HIV prevention are not being taught and that sexual health services are not easily available.

Gender analysis needs to be strengthened.

There appears to be a dearth of studies that focus on gender analysis, particularly regarding adolescents, as well as on gender mainstreaming in education. Individual agencies may undertake gender analysis to inform their programming, but comprehensive national assessments seem to be very uncommon. The links between gender and sexuality are not being made in mainstream education discourse.

Gender-based violence is an issue that has an increased profile as a result of HIV concerns. Reports on gender-based violence were obtained for six countries (Cambodia, India, Indonesia, Nepal, Timor-Leste and Vietnam). The assessments describe the prevalence of such violence, its impacts and the national responses (which centre on legal and health sector interventions). There appears to have been no studies specifically on gender-based violence within the education sector itself. Thailand has a study on violence against children in schools that includes some attention to gender-based violence.⁷²

72 Plan Thailand (2009). Violence against children in schools. The circle of interconnected problems in society. Bangkok, Plan

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UNGASS country progress reports provide a window on HIV-related policies and the national HIV strategy.

The UNGASS country progress reports include sections on policies and a national HIV strategy. The main policies are highlighted and gaps identified. However, although the health sector policy framework is often well described (such as in Bangladesh), none of the UNGASS country progress reports mentions any policies relating to education and HIV.

Most countries in Asia report through the UNGASS National Composite Policy Index (NCPI) process that they have a policy or strategy promoting HIV-related reproductive health and sexual health education for young people (table 3.2). Eleven countries in their individual 2008 UNGASS NCPI reports (UNAIDS, 2008) affirm that they include such education within the secondary curriculum. Four countries report that it is also included in primary education (Cambodia, Lao PDR, Thailand and Vietnam). This reflects the more serious HIV epidemics that these countries are confronting, and it is consistent with the evidence from effective HIV and sexuality education programmes on the importance of early introduction at school before risk-taking behaviours begin. However, NCPI reporting on education could be further strengthened.

UNGASS country progress reports on HIV provide coverage data on HIV-based, life skills-based education.

UNGASS country reports provide an opportunity for assessing the status of the education sector's response to HIV (table 3.2). While all countries submitted such reports, 8 of the 13 countries provided some assessment of progress on school-based HIV education (Bangladesh, Cambodia, China, India, Indonesia, Pakistan, Philippines and Thailand). The reports vary considerably in the details that they provide. The indicator for the education sector (indicator 11) concerns the coverage of life skills-based education (the proportion of schools that provided such education in the previous academic year). Eight countries (Bangladesh, Cambodia, India, Indonesia, Lao PDR, Nepal, Pakistan and Thailand) provided coverage data (expressed in percentages of schools implementing life skills-based HIV/AIDS education in the previous year) in the most recent UNGASS country reports. Apart from India and Lao PDR, all the other countries reported that less than 50 per cent of schools are implementing life skills-based HIV/AIDS education.

There are low levels of knowledge on HIV among young people, with significant gender disparities.

According to the UNGASS country progress reports (indicator 13), less than 50 per cent of young people surveyed (aged 15–24) in the seven countries that provided data (table 3.2) correctly identified ways of preventing the sexual transmission of HIV and major misconceptions about HIV transmission. (Those countries were Bangladesh, Cambodia, India, Nepal, Sri Lanka, Thailand and Vietnam.) The highest levels of knowledge were reported in Cambodia and Vietnam. With the exception of Cambodia, male levels of knowledge were higher in all countries that reported on this indicator, although India did not disaggregate its data by sex.

Table 3.2: Data from UNGASS country progress reports

Country	Indicator 11 Life skills education ⁷³	Indicator 13 Young people's knowledge of HIV ⁷⁴	Indicator 15 Sex before age 15 ⁷⁵	NCPI
Bangladesh	0.14%	All: 17.7% Male: 22.4% Female: 13.4%	All: 24.3% Male: 11.8% Female: 30.6%	In secondary education and teacher training
Cambodia	All: 25.6% Primary: 26.4% Secondary: 21.4%	All: 47.4% Male: 45.3% Female: 49.2%	All: 0.6%* Male: 0.8% Female: 0.4%	In primary and secondary education and teacher training
China	Not reported	Not reported	Not reported	In secondary education and teacher training
India	Secondary: 79%	All: 28%	All: 3%	In secondary education
Indonesia	All: 10%	Indicator "not relevant"	Indicator "not relevant"	In secondary education and teacher training
Lao PDR	All: 70.56%	Data missing	No data available	In primary and secondary education and teacher training
Nepal	All: 5.6% Primary: 8.4% Secondary: 4.6%	Male: 43.6% Female: 27.6%	Not reported	In secondary education and teacher training
Pakistan	All: 6%	Not reported	All: 0.67% Male: 0.92% Female: 0.42%	In secondary education and teacher training
Philippines	No data available	No data available	Female: 1%	
Sri Lanka	No data available	All: 7.9% (limited data)	All: 2.5% (data should be interpreted with caution)	In secondary education and teacher training
Thailand	40.5% of schools covered by 3 patterns of HIV-based life skills education	All: 37.42%	All: 4.82%	In primary and secondary education and teacher training
Timor-Leste	Not reported	Not reported	Not reported	
Vietnam	No data available	All: 46.2% Male: 50.3% Female: 42.3%	All: 0.4% Male: 0.5% Female: 0.3%	In primary and secondary education and teacher training

*Likely to be under-reported

⁷³ Percentage of schools that provided life skills-based HIV/AIDS education within the past academic year.

⁷⁴ Percentage of young women and men aged 15–24 who correctly identified ways of preventing the sexual transmission of HIV and major misconceptions about HIV transmission.

⁷⁵ Percentage of young women and men who have had sexual intercourse before the age of 15.

UNGASS shadow reports can be insightful.

Shadow reports are vehicles for civil society to provide their perspectives on country progress towards achieving UNGASS commitments on HIV and AIDS. A number of youth shadow reports have been prepared through the Global Coalition on Youth and AIDS, with support from UNFPA. Four countries submitted youth shadow reports (India, Nepal, Pakistan and Vietnam). The Pakistan report stated that there is no national policy promoting life skills education in schools.⁷⁶ India's shadow report urged that the Adolescent Education Programme be implemented country-wide. Nepal's shadow report stated there is an urgent need to incorporate life skills and peer education, starting in primary schools, and to properly train teachers.⁷⁷ Vietnam's shadow report did not discuss school-based HIV education.⁷⁸

Research is needed on early sexual debut.

Seven countries have attempted to report sex-disaggregated data on sexual debut before the age of 15 (Bangladesh, Cambodia, India, Pakistan, Sri Lanka, Thailand and Vietnam (table 3.2)). However, there are problems reported in data quality. Bangladesh has the highest reported rates of early sexual debut (24.3 per cent), followed by Thailand (4.8 per cent). Cambodia and Vietnam have the lowest reported rates. It is not clear how these findings are informing policy on child protection.

EFA progress reporting is neglecting HIV education.

The EFA Mid-Decade Assessment reports (table 3.3) provide an opportunity for education ministries to report on the progress towards EFA Goal 3. Countries in general have included some reference to life skills education, and about half make the connection with HIV education. The reporting on life skills education tends to be conflated with technical and vocational education (skills for work) and lifelong education. In general, there is little or no statistical data on progress in the various reports. There is very little mention of school health and nutrition programmes (only Sri Lanka and Thailand). Reporting on gender is concerned mainly with eliminating gender disparities in school enrolment and completion rates. There is no mention of gender-mainstreaming processes or outcomes. In general, there is very superficial reporting on the school curriculum and learning outcomes.

The EFA Global Monitoring Report, published annually by UNESCO, has yet to put in place any framework for assessing progress on life skills-based education at the country level. In fact, there is no framework for monitoring developments in terms of the curriculum or its implementation at the school level (in primary and secondary education), including learning outcomes.

Countries have conducted assessments on the impact of HIV on children and their families.

There have been assessments on the impact of HIV on children (in eight countries), usually with UNICEF support. These are important for child protection because they identify the additional vulnerability and risks for children that arise from HIV infection in the family in general, and with the parents in particular. Such children are frequently stigmatised and discriminated against. Children of sex workers and injecting-drug users are highly vulnerable also. India has undertaken a gendered analysis of the impact of HIV, which may be unique in the countries selected for this study.⁷⁹

76 Global Youth Coalition on HIV/AIDS (2006). Pakistan. National youth shadow report: Progress made on the UNGASS declaration of Commitment on HIV/AIDS. New York, United Nations Population Fund

77 Global Youth Coalition on HIV/AIDS (2008). Nepal. National youth shadow report: Progress made on the UNGASS declaration of Commitment on HIV/AIDS. New York, United Nations Population Fund

78 Global Youth Coalition on HIV/AIDS (2008). Viet Nam. National youth shadow report: Progress made on the UNGASS declaration of Commitment on HIV/AIDS. New York, United Nations Population Fund

79 National AIDS Control Organisation (India) (2006). Gender impact of HIV and AIDS in India. New Delhi, UNDP

Table 3.3: EFA Mid-Decade Assessment reporting

Country	Gender	Life skills and lifelong education	HIV education	School health
Bangladesh	Yes	Yes	Yes	
Cambodia		Yes	Yes	
China	Yes	Yes		
India	Yes	Yes	Yes	
Indonesia	Yes	Yes	Yes	
Lao PDR	Yes	Yes	Yes	
Nepal	Yes	Yes	Yes	
Pakistan	Yes			
Philippines	Yes			
Sri Lanka	Yes	Yes ⁸⁰	Yes	Yes
Thailand	Yes	Yes		Yes
Timor-Leste				
Vietnam	Yes			

Situation assessments of the education sector's response to HIV are becoming increasingly important for planning.

SRAs of varying scope on how the education sector addressed HIV issues have been conducted in Cambodia,⁸¹ India,⁸² Indonesia,⁸³ Nepal,⁸⁴ Thailand⁸⁵ and Vietnam,⁸⁶ with the various support of UNESCO, UNFPA, UNICEF, Partnership for Child Development and the United Kingdom's Department for International Development (DFID).

SRAs are an important means for mobilising the education sector and civil society on HIV, SRH and SHN. Such an assessment also provides an education ministry with strategic data for planning purposes. In Cambodia, the SRAs were used to inform the process of developing a medium-term strategic plan for HIV education in the education sector. Several countries have not yet conducted any national SRAs regarding the education sector and HIV to inform national strategic planning: Bangladesh, China, Lao PDR, Pakistan, Philippines, Sri Lanka and Timor-Leste.

As yet, there is no agreed methodology or standards for undertaking SRAs, including on using a rights-based approach. Only the India and Indonesia situation assessments included participatory qualitative research with adolescents. There is much work to be done to include the views of adolescents (and duty bearers) in SRAs for education. There is also a need for a regular review of the education sector's response to HIV. These situation assessments should not be regarded as one-off efforts and should be updated on a regular basis, in line with the planning cycle. There is scope for cross-country lesson learning and experience sharing.

80 Termed life competencies.

81 Clarke, D. (2007). Situation and response assessment of the education response to HIV. Phnom Penh, MOEYS

82 Clarke, D. (2008). Reducing vulnerability and risk: Formal education sector response to HIV in India. London, Partnership for Child Development

83 Atma Jaya Research Team (2010). Education sector response to HIV, drugs and sexuality in Indonesia. Jakarta, UNESCO

84 Ministry of Education, Government of Nepal (2009). Review on the education sector response to HIV and AIDS in Nepal. Kathmandu, UNICEF

85 Visser, M. (2008). Improving the education response to HIV and AIDS: Lessons of partner efforts in coordination, harmonization, alignment, information sharing and monitoring in Jamaica, Kenya, Thailand and Zambia. UNAIDS IATT on Education. Paris, UNESCO

86 Clarke, D. (2009). A mapping of the education sector response to HIV in Vietnam. Hanoi, UNESCO

ii) Linkage to rights

Laws relating to rights need to be highlighted in policies and strategies.

The education sector's response to HIV and SRH in Asia can be strengthened with regard to mentioning rights. Three of the 13 countries (Bangladesh, Cambodia and India) have overt reference to rights in their policy or strategic documents on education and HIV or SRH. Cambodia, China, Philippines and Vietnam have national laws on HIV and AIDS, which underpin their multisector programme development, including education. References to international rights bodies and mechanisms are rare. India's Policy Framework on Children and AIDS mentions the CRC.⁸⁷

44



87 Government of India (2007). Policy framework for children and AIDS. New Delhi, Government of India

iii) Non-discrimination

More effort is required for children and adolescents to exercise their right to education.

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By definition, children who drop out of school are not able to participate in formal education, and this denies them access to sexuality education or any other area of learning. This should be a major concern for governments, not only for human capital development and economic growth, but also for the healthiness, gender awareness and sense of responsibility among their future citizens. Education empowers and protects.

The net enrolment ratio (NER) in secondary education (enrolment of the official age group for secondary education, expressed as a percentage of the population of that age) shows that in all countries that provided data, there is a substantial proportion of adolescents who are not in secondary school.⁸⁸ The lowest NERs are reported in Bangladesh (41 per cent), Cambodia (34 per cent), Lao PDR (36 per cent), Nepal (42 per cent) and Pakistan (32 per cent). The picture from a gender perspective is mixed. In some countries, it is the boys who are under-represented in secondary school (Bangladesh, Philippines and Thailand). In others, it is the girls (Cambodia, Nepal and Pakistan). Indonesia is close to gender parity.

This means that much more effort is required from governments, civil society and development partners to help realise the right to education for all adolescents. This requires attention to the causes of dropping out and a stronger focus on the situation of disadvantaged children, including those who live in extreme poverty, who have disabilities, whose families are mobile or live in remote rural communities or are members of ethnic minority populations.

Coverage of life skills-based education needs to be increased.

Not all children in school are actually receiving sexuality education. Implementation is generally far from system-wide and universal. The UNGASS country progress reports provide data on indicator 11 (table 3.2). The highest coverage rate of life skills-based education was reported in India (almost 80 per cent of secondary schools); but that proportion will have been significantly reduced as a result of a backlash against the AEP programme, which subsequently was suspended in a number of states. Lao PDR also has a relatively high coverage rate (more than 70 per cent). Thailand and Cambodia have less than 45 per cent, but greater than 25 per cent of schools providing life skills programmes. Thailand reports that it has three modalities of such a programme. Only 10 per cent or fewer of schools are implementing life skills-based education programmes in Bangladesh, Indonesia, Nepal and Pakistan. According to its most recent UNGASS country progress report, China provides more than 4,000 schools with HIV education materials and has trained 10,000 teachers,⁸⁹ which is really only a small proportion of the overall total. The Philippines' UNGASS report states that school-based life skills education does not include specific HIV-related topics.⁹⁰

This means that coverage is generally quite low among the adolescent age group who are still in school. Some programmes are at the pilot stage, such as Bangladesh. Only Cambodia provides a coverage rate for primary education (26.4 per cent of schools).

88 United Nations Educational, Scientific and Cultural Organization (2010). Reaching the marginalised. EFA Global Monitoring Report. Paris, UNESCO

89 People's Republic of China (2008). UNGASS country progress report. Reporting period: January 2006–December 2007. Beijing, People's Republic of China

90 Philippine National AIDS Council (2008). UNGASS country progress report. January 2006–December 2007. Manila, PNAC

Tackling stigma and discrimination through education needs to be more systematic.

The negative human development consequences of HIV stigmatisation in Asia have been well researched.⁹¹ Education can play an important role in changing attitudes to people living with HIV (PLHIV) and other stigmatised groups in society.⁹² Research indicates that effectively designed and implemented HIV and sexuality education programmes can improve attitudes to PLHIV.⁹³

Despite the widely acknowledged importance of addressing discrimination against people living with or affected by HIV, there is surprisingly little mention of the issue in either the policy or strategy documentation. The lack of reference to stigma and discrimination appears to represent a serious gap or under-representation in the current approach to HIV and SRH education. Cambodia and Vietnam explicitly mention addressing stigma and discrimination in their education policies and plans. It may be that these issues are included in micro policies, such as curriculum and related guidelines, but this needs to be researched more fully. Cambodia, India and Vietnam explicitly mention the educational needs of children living with HIV. Other areas of sexuality-related discrimination such as homophobia could also be addressed.

A stronger emphasis is needed on promoting gender equality in sexuality education.

The need to promote gender equality and address gender issues, such as masculinity and gender-based violence, is under-represented in the available documentation. Only two countries explicitly mention gender in relation to HIV and SRH education: Bangladesh and Cambodia. The various SRAs also do not include much in the way of gender analysis. This needs to be strengthened in the next generation of assessments.

iv) Empowerment

Empowerment is critical to the effectiveness of sexuality education. This entails the empowerment of both duty bearers and adolescents. Duty bearers such as teachers need to have the appropriate technical capacity (knowledge, skills and motivation) to deliver the education effectively. Policies and strategies need to be formulated with professional empowerment as an objective. For adolescents, empowerment would include the acquisition of knowledge, attitudes, values and skills to enable them to make decisions about their lives in relation to sexuality. Empowerment is thus about learning processes and outcomes.

91 United Nations Development Programme (2007). HIV-related stigma and discrimination in Asia: A review of human development consequences. Colombo, UNDP

92 De Lind van Wijngaarden, J. and Shaeffer, S. (2008). UNESCO's response to the report of the commission on AIDS in Asia. How should education systems react to refocus in adolescents most at risk for HIV? Bangkok, UNESCO

93 Kirby, D. et al. (2006). The effectiveness of sex education interventions in schools in developing countries. In Ross, D. et al. (eds.). Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva, WHO Technical Report Series 938



Capacity building of duty bearers needs to be more systematic.

Teacher preparation, education or training is mentioned in the documentation from nine countries. This probably under-represents the extent of teacher training activity and conflicts with the UNGASS National Composite Policy Index reporting data (table 3.2). Some form of teacher training is taking place in all countries implementing HIV and SRH education. Whether ministries of education are taking a strategic approach, backed by policy, to develop sustainable teacher capacity on HIV and SRH education is unclear from this study.

The fact that most countries mention teacher training is important. Effective teacher preparation for HIV and SRH education is critical for successful implementation.⁹⁴ Teachers play a pivotal role and need ongoing support from the school and community to be effective in teaching culturally sensitive topics.⁹⁵

Very few countries mention the need to build education ministry capacity for the effective delivery of HIV and SRH education at central or decentralised levels of the system. In the available documentation, only two countries explicitly mention this (Cambodia and Vietnam) (table 3.4). In Cambodia, the Inter-Departmental Committee for HIV and AIDS is the mechanism for policy, planning and capacity building in relation to HIV and SRH education. It is based in the School Health Department (box 1) and is a promising model for supporting a mainstreaming process.

Box 1: Cambodia – Inter-Departmental Committee for HIV and AIDS (ICHA)

The Ministry of Education, Youth and Sports' (MOEYS) Inter-Departmental Committee for HIV and AIDS (ICHA) was established in 1999 to strengthen the education sector's response to HIV within the national programme. It has become responsible for

- developing the MOEYS response within the national HIV Strategic Plan
- educating in-school and out-of-school children and youth on HIV risks and how to protect themselves
- mainstreaming HIV within the Ministry.

ICHA was reorganised in 2005 with DFID support on the basis of a functional analysis to strengthen institutional arrangements to implement HIV programming in MOEYS. As a result, ICHA consists of

- The ICHA Policy Board, which is chaired by the Secretary of State for Education, Youth and Sports. Membership of the board includes two directors of directorates, the director of the ICHA secretariat and directors of 15 departments and institutes. There is a terms of reference for the board. Its function is to enable an integrated approach to policy and strategy development and programme management.
- The ICHA Technical Working Group (TWG), which is chaired by the deputy director general, General Directorate of General Education, with the director of School Health Department as vice-chair. It is the locus of technical and professional advice on HIV and leads the implementation of annual and quarterly action plans. The same 15 departments of the MOEYS are represented by HIV focal points on the TWG. There is a terms of reference for the TWG.

Capacity building is typically needed to mainstream HIV and SRH education into central and decentralised departments of an education ministry, in teacher training institutions and in schools. Few countries overtly recognise the importance of a whole-school approach or of strengthening school management to tackle HIV, SRH and SHN. This may be taking place at a pilot or project level. In Lao PDR, a guide on SHN was prepared for school principals. In Cambodia and Nepal, school health committees were established. Research is needed to provide evidence on how effective these are. India⁹⁶ and Indonesia⁹⁷ prepared detailed guidelines for implementing their HIV education programmes. The former was clearly important in scaling up programme coverage.

Table 3.4: Empowerment

Country	Life skills	Curriculum content	Co-curricular activities	Peer education	Education ministry capacity	Teacher training	School management
Bangladesh	Yes			Yes		Yes	Yes
Cambodia	Yes	Yes	Yes	Yes	Yes	Yes	
China	Yes						
India	Yes		Yes	Yes		Yes	
Indonesia	Yes	Yes	Yes	Yes			Yes
Lao PDR	Yes	Yes				Yes	Yes
Nepal	Yes			Yes		Yes	Yes
Pakistan	Yes	Yes	Yes			Yes	
Philippines	Yes	Yes					
Sri Lanka	Yes	Yes				Yes	
Thailand	Yes		Yes	Yes		Yes	
Timor-Leste	Yes						
Vietnam	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Curriculum integration is a common strategy.

Almost all countries mention that they are taking steps to develop a curriculum for HIV and SRH education. However, the full details of such curriculum development are typically lacking in the policy and strategy documents found. It is probable that such details are available in national curriculum frameworks that include details of content scope and sequence.

Only a few countries provide a clear statement that they will include an ABC strategy (abstain, be faithful and/or use a condom), such as Cambodia and Thailand, which suggests that HIV prevention content is not generally comprehensive. Education on condoms is not permitted in the Philippines. HIV education-programme development in Thailand seems to be particularly innovative, comprehensive and participatory (box 2).

A concern is raised in several SRAs about the lack of comprehensive information on HIV and SRH (India, Indonesia and Nepal). It seems likely that information about high-risk behaviours, such as sex work or males who have sex with males (MSMs) are not included in most school curricula. Some national HIV strategies refer to basic (limited in scope and probably mainly biological) information about HIV and AIDS rather than emphasising more comprehensive social information. Gender issues, including stereotyping, harmful masculinities and gender-based violence, may be underestimated or totally missing. More research is needed to investigate how comprehensive curricula are in their integration of sexuality issues as well as how faithfully a curriculum is delivered in the classroom.

94 Clarke, D. (2008). Heroes and villains: Teachers in the education response to HIV. Paris, UNESCO IIEP

95 Boler, T. (2003). The sound of silence: Difficulties in communicating on HIV/AIDS in schools. London, ActionAid

96 National AIDS Control Organization, Ministry of Human Resource Development, Government of India and UNICEF. (2005). Adolescence education:

National framework and state action plans (2005-2006). New Delhi

97 Ministry of National Education (2004). HIV prevention strategy through education. Jakarta

Box 2: Thailand – Teenpath⁹⁸

The Teenpath HIV prevention programme has been implemented in more than 6,000 schools in Thailand by PATH since 2003 and supported by the Ministry of Public Health, with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Plan has supported the implementation of Teenpath in 17 districts. It pursues the following objectives:

A. Supportive policy and community environment

The Deputy Minister of Education and the Permanent Secretary joined the Teenpath Project Advisory Board, giving the project legitimacy and high-level support. Activities to promote sexuality education have included

- Sexuality Education for Young People conferences, which involved teachers, students, civil society networks and high-level officials
- forums on sexuality, organised with young people, to improve their understanding of sexuality issues; the forums included a focus on gay, lesbian, bi-sexual and transgender youth
- Talk Openly, Love Safely campaign, which was implemented with the media to promote sexuality education and HIV prevention among the general public; a manual on parent-child communication was developed
- a website to provide access to information on SRH to young people (www.teenpath.net)
- youth-led activities for policy advocacy (youth polls, media contests, youth leader camps).

B. Capacity building to promote comprehensive sexuality education

Partnership building

Partner organisations were recruited to work as provincial coordinators and implementers. They are responsible for recruiting master trainers, recruiting schools to participate in the project, conducting teacher training and providing ongoing professional support to schools.

Curriculum development

The curriculum is based on three concepts

- sexuality, which encompasses biological, socio-cultural, psychological and spiritual elements
- positive youth development, which presumes adolescents can make good decisions for themselves if they are provided with sufficient information, skills development and opportunity to explore and assess their own attitudes and values
- facilitation of learning, which means a student-centred approach. Evaluations showed that the approach improved student-teacher relationships and opened up new channels of communication. The skills acquired by teachers resulted in improved teaching across the curriculum.

Training

It was recognised from the outset of the project that key to the success would be identification and development of effective teachers and school administrators. Activities have included

- master trainer training; a five-day training curriculum was developed
- teacher training, developed to emphasise three areas: i) exploring attitudes to sexuality, youth and learning; ii) increasing knowledge about sexuality and iii) developing skills in communicating about sexuality and facilitating a student-centred learning approach.

C. Adolescent development and participation

The important component was to recognise that adolescents' perspectives are integral to their adopting positive health behaviours. Youth capacity as leaders and advocates was developed. Activities have included

- ICTeen Camp, which offered instruction on ICT skills and sexuality and HIV issues
- drama camps, which connected HIV issues with the performing arts
- media advocacy camp.

D. Model of adolescent-friendly sexual health services

An objective was to develop a model for adolescent-friendly sexual health services and strengthen the links between participating schools and service providers.



98 Program for Appropriate Technology in Health (2008). Teenpath project. HIV/AIDS prevention programme for in- and out-of-school youth. End of project report. Bangkok, PATH

Education ministries have introduced or are introducing sexuality education through strategies to integrate HIV and SRH messages and information into existing curricular subjects. This is a standard response in a mainstreaming approach and is generally preferred to a stand-alone HIV education programme. A few countries emphasise the provision of information (including basic information) and messages (such as Indonesia), while others (Thailand and Vietnam) stress participation and skills building, which are likely to be more empowering.

Commonly selected subjects for HIV and SRH integration include biology or life sciences (Cambodia, Indonesia, India, Lao PDR and Vietnam) and social sciences (Cambodia, India and Vietnam). HIV is integrated into health education in nine countries (Cambodia, China, India, Lao PDR, Indonesia, Nepal, Philippines, Sri Lanka and Thailand). In Cambodia, health education is integrated across the curriculum.

Box 3: Some concerns with curriculum integration for learner empowerment

There are a number of concerns about the effectiveness of strategies for curriculum integration of HIV and SRH education.

- Integration into biology and science courses tends to result in a focus on bio-medical aspects of reproduction and SRH. This may also happen in health education.
- Social issues and sexual practices, including gender roles and norms, tend to be neglected.
- High-risk behaviours tend not to be included in mainstream curricula, especially issues relating to MSM and sex work (sex workers and clients).
- Mainstream curricula are typically taught in a didactic way, with little opportunity for active learner participation. The acquisition of knowledge is prioritised over skills development. It is unclear how a life-skills participatory approach is being delivered across the curriculum in subjects in which HIV and SRH are integrated.

Life skills-based education is being implemented in all countries.

The empowerment of learners in sexuality education (and also in other curriculum areas) appears to rely heavily on the effectiveness of life skills-based education. It is included in all of the countries' education responses to HIV and SRH. This is in part testimony to the work of UNICEF, UNFPA and some NGOs (such as WPF and World Education) in promoting this approach. The contribution of UNICEF in particular has been widespread and important, especially in South Asia.⁹⁹ Some of this work is still at a pilot stage and will need eventually to be taken to scale at the system level. Investment in life skills-based education involves a recognition that young people need to both gain information and develop psychosocial skills for healthy decision making.

Life skills-based education, however, is a promising approach and not a panacea. It needs to be carefully designed, informed by international and national evidence of effectiveness and implemented strategically, with due attention to capacity building, at the school level in particular.¹⁰⁰ The effectiveness of a life skills-approach in promoting empowerment of the learner depends on a complex range of factors, including the skills and motivation of the teacher, appropriate content matter, a whole-school approach to learner-centred participatory teaching and the regular assessment of learning outcomes. The specific content matter that is used in a life skills programme depends on the findings of a comprehensive needs assessment (such as that undertaken in Pakistan¹⁰¹), especially the risk and vulnerability factors in the local context.

99 United Nations Children's Fund (2007). Stocktaking of life skills-based education. Occasional paper. New York

100 Clarke, D. (2008). Life skills education for HIV prevention. Bangkok, UNICEF

101 National AIDS Control Programme and United Nations Children's Fund (undated). Situation assessment of adolescents in selected districts of Pakistan for life skills and HIV prevention. Islamabad, UNICEF

Co-curricular activities are complementary to curriculum integration.

A few countries have implemented both curricular integration and co-curricular life skills programmes in what might be considered as the education equivalent of combination therapy (Cambodia, India, Indonesia, Pakistan, Thailand and Vietnam). Co-curricular activities are explicitly mentioned by these countries. But this certainly under-represents the extent to which co-curricular activities are taking place at a local level, often with NGO involvement, such as the Junior Red Cross Circles in Nepali schools or the Girl Scouts in Philippine schools.¹⁰² Thailand has innovative co-curricular activities involving ICT and the performing arts (box 2). While these typically are a low priority in schools where the assessed curriculum drives teaching and learning, co-curricular activities provide opportunities for more innovative approaches, including participatory, peer-to-peer and youth-led activities.

Peer education is commonly mentioned as an approach in seven countries. It seeks to utilise the positive aspects of adolescent peer groups by helping them learn from each other.¹⁰³ If properly applied, peer education has strong potential to empower adolescents through mutual learning and support. But it is important to develop national standards for peer education. International guidance has been developed by UNFPA and partners.¹⁰⁴ There is no mention of developing national standards in any of the available documentation.

Adolescent access to health services is being promoted.

A major contribution that the health sector can make to the sexual health of adolescents and young people is increasing access to quality and youth-friendly health services for the prevention, care and treatment of HIV and STIs.

Access to health services is mentioned in documents in seven countries: Cambodia, Indonesia, Lao PDR, Nepal, Sri Lanka, Thailand and Vietnam. In several of these (Cambodia, Lao PDR, Indonesia, Nepal and Thailand), the education and health ministries operate through a joint memorandum of understanding.



102 Philippine National AIDS Council (2008). UNGASS country progress report. January 2006–December 2007. Manila, PNAC

103 United Nations Educational, Scientific and Cultural Organization (2003). Peer approach in adolescent reproductive health education: Some lessons learned. Bangkok, UNESCO

104 United Nations Population Fund (2005). Standards for peer education programmes. Youth-peer education toolkit. New York, UNFPA

v) Participation

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Participation should be more strongly emphasised in policies and strategies.

Participation is under-represented as a concept in the various policies and strategies. It is perhaps subsumed in reference to life skills and peer education, which can be considered a proxy for participatory education. The documents obtained almost certainly severely underestimate the extent to which participation is taking place at the project level. It appears that these practices have, in general, yet to make their way into system-wide documentation, which is essential for scaling up and sustainability.

A stronger emphasis on civil society participation is needed.

While minimum standards for civil society participation have been proposed for HIV and the universal access initiative,¹⁰⁵ they do not seem to be applied in the education sector. It is clear when reviewing the whole range of reporting on the education sector's response to HIV as well as in the area of SHN, that NGO participation is often a critical factor in programme development. This is not yet sufficiently well recognised or defined in education sector policy or strategy.

Adolescent participation needs to be promoted.

Participation of adolescents is mentioned in some of the documentation in reference to decision making (such as Thailand) and participation in the design of HIV activities (Vietnam). Vietnam's Ministry of Education and Training Action Programme on reproductive health and HIV education contains a range of activities to promote learner participation. Cambodia's School Health Policy (issued by the MOEYS) emphasises the participation of stakeholders in government, civil society and development activities.

Education ministries are entering into partnerships with health ministries.

A number of countries have memoranda of understanding between their education and health ministries, particularly to promote joint activities in the areas of school health and nutrition. This may be enshrined in policy, such as in Indonesia,¹⁰⁶ which also includes its Ministries of Religious Affairs and Internal Affairs. These partnerships are likely to be critical to the effectiveness of sexuality education and should assist in facilitating access to health services through schools. There is currently little evidence on how effective these partnership arrangements are, and independent research is needed to identify success factors and impacts.

Box 4: Children as active citizens

Plan participated as a member of the Inter-Agency Working Group in Children's Participation in the development of a policy and programming guide on children as active citizens with rights and responsibilities.¹⁰⁷ This guidance is relevant to increasing participation in the education sector and in HIV, SRH and SHN education. The guide includes an indicator checklist for measuring children's citizenship and civil rights.



Participation needs to be inclusive.

The following are under-represented in the documentation in terms of participation

- the whole school
- parents and community
- civil society organisations (including NGOs); NGOs have played an important role in many contexts in supporting the efforts of education ministries in a range of areas at the central, decentralised and community levels¹⁰⁸
- people living with HIV in any education sector activity (the so-called GIPA principle); only Cambodia's MOEYS mentions it
- adolescent participation in school health committees and school management committees.

105 The 7 Sisters. (2007). Minimum standards for civil society participation in the universal access initiative. Bangkok 106 Joint Ministerial Decision on School Health Units
107 Inter-Agency Working Group (2008). Children as active citizens: A policy and programme guide. Bangkok, IAWG

108 Pulizzi, S. et al. (2008). Ensuring quality: Ministry of Education and NGOs responding to the AIDS pandemic. Boston, Education Development Center

vi) Protection

Schools need to be safe, healthy and protective workplaces.

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The recognition that the school is a workplace where duty bearers have important responsibilities to safeguard employees' and students' health, safety and security – as well as their rights – is an important step for the education system. Protection needs to include linkage to rights and non-discrimination. Standards need to be set and monitored.

The international response to HIV has highlighted the importance of workplace policies and programmes. The ILO has provided technical guidance,¹⁰⁹ which has been adapted with inputs from UNESCO for the education system in sub-Saharan Africa and the Caribbean. No such work has taken place to develop workplace policies for the education sector in Asia. Thus, it is hardly surprising that a specific workplace policy and programme is mentioned by only one country – Cambodia, which is the only country for which a specific policy document for the education sector was obtained. Vietnam's workplace policy for education is integrated into its National Law on HIV and AIDS.

Protection needs to be recognised as a component of sexuality education.

There is very limited reference to the need for child protection in schools in the available documentation, including gender-based violence. This may be a function of the narrow focus of the policies and plans, but there seems to be little attention being paid to ensuring that schools are fully protective of all children in relation to what is discussed in the sexuality education curricula. The development of counselling services in schools to include sexuality-related issues would be an important adjunct. Both the curriculum and co-curricular activities should include an emphasis on developing life skills that are necessary for adolescents to protect themselves from abuse, exploitation, unintended pregnancy and HIV/STI infection as well as learn what acceptable behaviours they can follow as they mature.

Countries are in the process of piloting or scaling up initiatives to establish child-friendly schools with UNICEF support. This is an important process and, if implemented effectively, these schools are likely to confer a substantial measure of protection for all children.

Two examples of policy or planning that recognise the importance of child protection are

- Cambodia's Child-Friendly School Policy and Master Plan 2007–2011
- Cambodia's HIV Workplace Policy, which includes protective measures for children living with and affected by HIV.

The general lack of detailed policies means that responsibilities for child protection are not clearly spelled out in relation to HIV and SRH. They may be detailed in other policies and guidelines, however.

109 International Labour Organization (2001). An ILO code of practice on HIV/AIDS and the world of work. Geneva, ILO

vii) Accountability

Accountability needs to be enhanced.

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There needs to be more openness on the part of all duty bearers regarding sexuality education as well as education generally. Policy, strategy and evaluation documents need to be easily accessible and communicated to all stakeholders. They should be available online and on each education ministry's website.

There needs to be more investment in M&E.

Only two countries give significant priority to M&E or programme review in the available documentation. These countries are planning to strengthen their M&E arrangements (Cambodia and Vietnam). These also are the countries that have developed detailed policy documents and medium-term strategies, which can only enhance accountability.

²⁷ Sexuality Information and Education Council of the United States

The Three Ones principle promotes one national M&E framework for HIV. Of necessity, it is a multisector framework. UNGASS participants recommended core indicators,¹¹⁰ and countries are, by and large, using them (table 3.2). Some of these apply to the education sector, such as life skills education in schools (indicator 11). However, the UNGASS country reporting indicators are not fully adequate to track programming on HIV and SRH education and a more comprehensive approach is required to supplement the core indicators with additional indicators for the education sector.

Programme evaluations need to be published.

Much of the accountability arrangements are at the programme level and thus largely invisible to policy makers and civil society. These include evaluation studies. Evaluations were obtained on life skills and HIV education programmes for Cambodia (two studies), Pakistan, Thailand and Vietnam.

There may be more under the radar. Only one evaluation was obtained that had been published in the past five years (Impact Assessment Report by the World Population Foundation, Pakistan on its life skills programme). If programme evaluations are not published, accountability is diminished, as are opportunities to learn lessons and share experience. None of the evaluations, however, was undertaken from a rights-based perspective.

More research is needed and the findings disseminated.

Few countries indicate the need for research in the available documentation. There has been very little research on education policy and strategy on sexuality education in Asia. It is a decade since a comprehensive review was carried out of HIV and sexual health education in primary and secondary schools in selected Asia-Pacific schools.¹¹¹

Guidelines are needed for M&E of sexuality education.

Guidelines are needed for education ministries to support the implementation of sexuality education and improve accountability. UNESCO's recently published sexuality education guidance¹¹² lacks attention to developing M&E arrangements, including relevant indicators. This is a significant gap.

110 Joint United Nations Programme on HIV/AIDS (2009). Guidelines on construction of core indicators: 2010 reporting. Geneva, UNAIDS

111 Smith, G. et al. (2003). HIV/AIDS school-based education in selected Asia-Pacific countries. Monograph. Sydney, New South Wales

112 *ibid.*

Chapter 4

Conclusions and recommendations



Conclusions and recommendations

The rights-based framework developed for this assessment proved meaningful and indicates utility beyond this study. It provides a comprehensive template for evaluating policies and plans. The seven components together provide a means of investigating whether rights are being addressed.

The findings of this assessment are indicative. More detailed research is required at the country level. Nevertheless, there are grounds for optimism. It does seem that the rights of adolescents to sexuality education are being delivered, albeit in varying degrees. Progress is being made across Asia in almost all the countries in this study in putting in place policies, strategies and activities to support the integration of sexuality education into secondary and, in some cases, primary education. There are significant commonalities as well as considerable diversity in approach, which reflects different policy priorities, social contexts, levels of resources and forms of governance.

A major impetus has been the efforts to provide age-appropriate education about HIV and SRH as a contribution to the national multisector response. The national HIV strategic plan is the key document in all countries, though there may also be supportive laws and policies. Very few education sector plans have included sexuality education, even though it is being implemented (as HIV and SRH education). There is some catching up to do. Cambodia and Vietnam have developed detailed plans for mainstreaming HIV education, the former having a costed plan. Greater effort is needed to disseminate policies and communicate the main content of strategies with civil society.

In terms of the rights-based framework, the following conclusions are made.

i) Assessment

Policy makers and planners have a wealth of information at their disposal. There are many forms of situation assessment being undertaken that are relevant to understanding the different contexts of adolescence, including sexuality. However, few of these assessments can be considered to be rights-based in approach. A stronger focus on adolescence is required. Relatively few studies meaningfully involve adolescents. Gender analysis needs to be strengthened in these assessments in general and in areas such as gender-based violence in particular, and made more integral to sexuality education. The UNGASS country reporting on HIV and AIDS is a useful assessment process, stronger than the EFA reporting regarding sexuality education. The situation assessments on the education sector's response to HIV, recently conducted in six countries, provide a great deal of useful information; the practice should be continued and improved in terms of the quality of process and product.

ii) Linkage to rights

There is generally a lack of overt linkage in policies and strategies to rights. Development practice is a long way from being rights-based.

iii) Non-discrimination

Too many adolescents do not participate in secondary education and thus are not able to realise their right to education, let alone the right to sexuality education. The coverage of sexuality education programmes is also limited, according to UNGASS country reporting. More effort is required to scale up programmes to ensure that all those in school are able to benefit from them. Issues of stigma and discrimination do not appear to be receiving sufficient attention in policy or plans and gender equality is under-represented also.

iv) Empowerment

The empowerment of duty bearers is taking place but appears not to be sufficiently systematic in approach. Most countries are investing in teacher education in pre- and in-service training. A stronger emphasis is needed on empowering the teacher in the classroom and in school through content mastery, pedagogical skills building and ongoing professional support. Few countries appear to be investing in education ministry capacity building at the central and decentralised levels and in school management training.

The progressive empowerment of adolescents is taking place in all countries through life skills education, integration of sexuality education in the curriculum, co-curricular activities, including peer education, and increasingly through access to health services. These are likely to increase adolescents' access to information about sexuality and health and potentially provide them with skills to protect themselves and others.

Constraints on empowerment include the quality of teaching and learning in sexuality education; lack of comprehensive information (high-risk behaviours are often omitted as are social issues such as gender relations); lack of learner involvement in programme design; and lack of a regular assessment of learning outcomes.

v) Participation

Sexuality education appears to be insufficiently participatory in school or in the wider community. A whole-school approach is needed. More attention is required regarding parental involvement. NGO participation and the inclusion of networks of people living with HIV should be addressed in both policy and strategy. Perhaps, most importantly, there needs to be a much stronger emphasis on adolescent participation in policy, strategy and programme design, including learner-led and effective peer-education activities.

vi) Protection

Protection is under-represented in concepts of sexuality education. Schools need to be safe, healthy and protective for staff and students. Policies and standards (such as on child-friendly schools) need to be put in place and observed. Schools also need to tackle gender-based violence and educate adolescents on what is appropriate adult and teen behaviour in social and intimate relationships.

vii) Accountability

Accountability needs to be enhanced through greater investment in M&E and research. Policies and strategies need to be robustly monitored, reviewed and, if necessary, revised. More evaluation studies need to be undertaken, and the findings published so that they can be accessed by and communicated with civil society. International guidelines for M&E in sexuality education are urgently needed.

Recommendations

Duty bearers and rights holders

- Advocate for a broader and more comprehensive approach to sexuality education that includes attention to rights, gender equality and high-risk behaviours.
- Advocate for compulsory sexuality education.

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Duty bearers

Policy

- Education ministries should have clear policy statements on sexuality education that are easily accessible and disseminated to stakeholders.
- Policies should be formulated in participatory processes involving representatives of stakeholder groups. Both duty bearers and adolescents should be represented and be able to participate meaningfully.
- Policies should be informed by the data available from various situation assessments concerning adolescents.
- Policies should promote non-discrimination and gender equality.
- Policies should be accountable. They should be regularly monitored, reviewed and revised as necessary.
- Policies should be embedded with links to human rights.

Strategic plans

- SRAs should be undertaken to support strategic plan development.
- Strategic plans should be prepared in participatory processes involving representatives of stakeholder groups. Both duty bearers and adolescents should be represented and be able to participate meaningfully.
- Strategic plans on sexuality education should be detailed and costed.
- Strategies should be regularly monitored, reviewed and revised as necessary, with the participation of both duty bearers and adolescents.
- Strategic plans should link to policies and rights.

Situation assessment

- Consider using a rights-based approach in situation assessments.
- Promote the participation of adolescents in situation assessments.
- Focus more specifically on the adolescent age group and ensure that gender analysis is robust.
- Develop standards and guidance for carrying out SRAs for the education sector (on SHN and sexuality education).

Non-discrimination

- Ensure there is clear policy for the education sector on stigma and discrimination.
- Strengthen efforts to tackle stigma and discrimination systematically through education in general and sexuality education in particular.
- Ensure that no children are excluded from school-based sexuality education as a result of social disadvantage, such as disability, ethnicity, gender, remoteness, etc.

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Empowerment

- Prioritise the empowerment of duty bearers and adolescents (rights holders).
- Develop a strategy to develop institutional capacity that will empower teachers in sexuality education and the education ministry at the central and decentralised levels to manage programmes.
- Focus on empowering the learner. Ensure that learners have access to comprehensive information on sexuality, including high-risk behaviours, through participatory learning activities.
- Scale up life skills education, and monitor its quality in the classroom.
- Assess the learning outcomes resulting from curriculum integration of sexuality education.
- Promote participatory co-curricular activities that adolescents enjoy to complement curriculum-based teaching and learning.
- Ensure that gender issues such as gender-based violence are more effectively addressed.
- Promote access to adolescent-friendly health services through schools.

Participation

- Develop strategies to increase the participation and inclusion of all stakeholders, such as parents, community members and learners.
- Strengthen partnerships with health ministries, including through memoranda of understanding that specify roles and responsibilities. Include a regular participatory review process.
- Develop policies and strategies for enhancing participation within the education sector and with partners, such as NGOs and other line ministries.

Protection

- Ensure that protection is a priority in schools and embedded in school policies.
- Ensure that all schools are safe, healthy and protective through actions such as training school management and putting in place clear standards that can be monitored.
- Strengthen efforts to tackle gender-based violence in the curriculum and co-curricular activities.

Accountability

- Monitor policy implementation.
- Ensure that an appropriate framework for M&E of sexuality education is in place and disseminated.
- Ensure that regular evaluations take place and are published.
- Commission research as required in areas such as stigma and discrimination.
- Develop evidence-based guidance for M&E for sexuality education.
- Build M&E capacity in the ministry of education.

Select bibliography
and annexes



Select bibliography

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Annexes

Annex 1 contains tables for i) national AIDS laws and policies, ii) national population and reproductive health policies and laws, and iii) national youth policies. These are tabulated together with their relevant education content.

Annex 2 contains tables for i) education sector policies on HIV, and ii) school health policies and strategies.

Annex 3 contains tables for i) national HIV and AIDS strategies with their relevant education content, ii) population and reproductive health strategies with their relevant education content, iii) education plans and HIV and iv) HIV strategies for the education sector.

Annex 4 provides a list of national assessments relevant to adolescence and sexuality education.

Annex 5 provides a tabulation of how countries are approaching HIV and SRH education in the curriculum.

Annex 1

1. National AIDS laws and policies

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Country	Policy	Education component
Bangladesh	National Policy on HIV/AIDS and STD-Related Issues (1996)	All educational institutions, formal and non-formal, to have HIV/AIDS/STD education in curriculum. To be included in school health curriculum in formal education, and teachers are to be well equipped.
Cambodia	Law on the Prevention and Control of HIV/AIDS (2002)	<p>Integrate the knowledge on HIV/AIDS in subjects taught in schools. This subject shall include the causes, modes of transmission, means of prevention, consequences of HIV and AIDS and facts about STDs, especially focusing on life skills, in accordance with promoting social value through the introduction into the curriculum of all educational establishments, including non-formal education systems.</p> <p>Organise workshops and the training of trainers on HIV prevention and AIDS control for teachers and other instructors who will be assigned to teach on the subject.</p> <p>Mobilise communities, associations and organisations for their involvement in the design and implementation of HIV/AIDS education and information dissemination programmes (Article 3).</p>
China	Regulation on AIDS Prevention and Control (2006)	Article 13: The education authority at county and upper levels shall guide, supervise and urge the higher education institutions, secondary vocational schools and ordinary middle schools to integrate HIV prevention, AIDS control and knowledge into relevant courses and conduct extracurricular educational activities. Higher education institutions, secondary vocational schools and ordinary middle schools shall organise students to study HIV/AIDS-related knowledge.
India	<p>National AIDS Prevention and Control Policy (2000)</p> <p>Policy Framework for Children and AIDS (2007)</p>	<p>In educational institutions, AIDS education should be imparted through curricular and extracurricular approaches.</p> <p>The programme of AIDS education in schools and Universities Talk AIDS programme should have universal applicability throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators for the rest of the community.</p> <p>Integrate life skills-based HIV prevention education into the school curriculum and teacher training (pre- and in-service). Include co-curricular activities to complement the curriculum-based HIV prevention education in the short and medium terms.</p> <p>Reinforce teacher training to build non-discriminatory attitudes and to cope with the issues of children living with HIV.</p> <p>Build and sustain a resource for HIV prevention life skills-based education in secondary and higher secondary schools. Build capacities of children to be peer educators, reduce stigma and discrimination in the community and ensure knowledge and skills to protect themselves from infection.</p> <p>Ensure all children affected by HIV are able to realise their right to education. No discrimination for admission and retention. Ensure non-discrimination.</p>

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Lao PDR	National Policy on HIV/AIDS/STIs (2001)	No explicit mention of the education sector.
Nepal	National AIDS Policy (1995)	<p>No explicit mention of the education sector.</p> <p>HIV/AIDS and STDs prevention activities will be conducted as a multisector programme. HIV and STDs prevention activities will be integrated with other programmes in both the government and non-government sectors.</p>
Philippines	Philippines AIDS Prevention and Control Act of 1998	The Department of Education, Culture and Sports (DECS), the Commission on Higher Education and the Technical Education and Skills Development Authority (TESDA), utilising official information provided by the Department of Health, to integrate instruction on the causes, modes of transmission and ways of preventing HIV and other sexually transmitted diseases in subjects taught in public and private schools at intermediate grades and at secondary and tertiary levels, including non-formal and indigenous learning systems: Provided, that if the integration of HIV/AIDS education is not appropriate or feasible, the DECS and TESDA shall design special modules on HIV/AIDS prevention and control: Provided, further, that it shall not be used as an excuse to propagate birth control or the sale or distribution of birth control devices: Provided, finally, that it does not utilise sexually explicit materials.
Sri Lanka	National AIDS Policy (2005)	<p>The government encourages all levels of educational institutes to have HIV/AIDS/STD education in their formal curricula and informal educational tools. It is the policy of the government to openly discuss issues related to sexuality and safety. Both the print and electronic media are encouraged to include sexuality issues in their publications and productions. There will be no editorial restrictions or censorship on the use of scientific terms used to describe sexuality and sexual organs or any other medical term as required for effective communication.</p> <p>Teachers may provide information to their students about the modes of transmission and prevention, using explicit language when necessary. Information on family life and sex education would be designed in an age-appropriate manner so that children in junior school will have access to such knowledge in relation to their bodies.</p> <p>Children in high schools will be supported to have open discussions on sex and sexuality.</p>
Vietnam	Law on HIV/AIDS Prevention and Control (2007)	<p>The Ministry of Education and Training shall assume the prime responsibility for:</p> <ul style="list-style-type: none"> • developing curricula and teaching content on HIV prevention and control • combining HIV prevention education with sexual and reproductive health education • directing education establishments within the national education system to provide HIV prevention education (Article 12). <p>HIV prevention and control in the workplace is the responsibility of the employer and includes non-discrimination clauses (Article 14).</p>

2. National population and reproductive health policies and laws

Country	Policy	Education sector component
Bangladesh	National Population Policy (2004)	Ministry of Primary and Mass Education and Ministry of Education, in keeping with the education policy, may ensure improved quality and completion of primary and secondary education levels. The existing programmes of encouraging gender equity in education may be continued and strengthened. In addition, the Ministries are urged to update their curricula on population, health sciences and life skills education through formal and informal schooling systems. Likewise, the universities may take the necessary steps to modify demographic/population and reproductive health courses.
Cambodia	National Population Policy (2003)	Encourage the provision of reproductive health education in school curricula and through out-of-school programmes targeting adolescents and less-educated women (6.1). Introduce gender awareness into school curricula (6.4).
China	The Law on Population and Family Planning of the People's Republic of China (2002)	Schools in a manner suited to the characteristics of the receivers and, in a planned way, conduct among pupils education in physiology and health, puberty or sexual health (Article 13).
India	National Population Policy (2000)	Policy recognises that adolescents constitute an under-served group with special sexual and reproductive health needs and advocates special programmatic attention to addressing this population. It recommends the need to ensure adolescents' access to sexual and reproductive health information, and counselling and services that are affordable and accessible. Increase the provision and outreach of primary and secondary education.
Lao PDR	Resolution of the Lao PDR Government on National Population and Development Policy (1999)	Provide adolescents with reproductive health and sexuality education.
Pakistan	Population Policy (2002)	Ensure population and family life education for school and college students (strategies). Build a mindset for responsible parenthood (youth and adolescents). Males will be sensitised that family planning is a need for their own health and family wellbeing.
Philippines	Reproductive Health Care Agenda Act (2001)	Sexual and reproductive health and rights education in schools: The Department of Education, the Commission on Higher Education and the Technical Education and Skill Development Authority, using information provided by the Department of Health, shall require the integration of instruction on sexual and reproductive health and rights into the curricula in public and private schools at intermediate grades, secondary and tertiary levels, including non-formal and indigenous learning systems.

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Thailand	National Reproductive Health Policy (1997)	Policy focuses on a wide range of issues, including family planning, maternal and child health, HIV/AIDS, reproductive tract infections and cancers, sex education, adolescent reproductive health, infertility and elderly health.
Vietnam	Vietnam Policies and Strategy on Population and Development (NCPFP, 1993)	In the 1996–2000 period, population education for primary schools was nationally introduced so as to create and improve knowledge about the relationship between population and development for generations in the twenty-first century.

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3. National youth policies

Country	Policy	Education sector component
India	National Youth Policy (2003)	Policy addresses the needs of those aged 13–35 but recognises adolescents (aged 13–19) as a special group requiring different strategies from those appropriate for young adults (aged 20–35). It recognises the vulnerability of youth in the sexual and reproductive health arena and recommends the provision of counselling, services and information to enhance safe behaviours and to encourage marriage at an older age.

Annex 2

1. Education sector policies on HIV

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Country	Policy	Content
Cambodia	Child-Friendly School Policy	<p>To develop teacher proficiencies so that teachers have theoretical and practical knowledge, with a specific focus on learning/teaching activities and materials that promote active, creative and child-centred approaches to learning in a joyful classroom environment. To nurture teachers' attitudes, behaviours and moral values that will lead to learning in a harmonious way.</p> <p>To ensure that all children participate in education, are cared for by all concerned people and institutions to keep them healthy and safe, and protect them from violence in the school, the family and in society.</p> <p>Use more specific policies, such as the life skills policy, the school health policy and the policy on children with disabilities, to support implementation of the child-friendly school policy.</p>
	Life Skills Education (2006)	<p>General life skills (content areas: health education, HIV, personal development, citizenship) to be integrated into core curricula in Khmer, mathematics, science and social science.</p> <p>Local life skills programmes organised on the basis of schools' open choice.</p>
	HIV and AIDS Workplace Policy (2008)	<p>The HIV and AIDS Workplace Policy aims at the prevention of HIV infection by ensuring safe school environments, workforce education for all and access to health services. It specifies that all students should have access to age-appropriate, gender-responsive HIV education. It should develop positive attitudes towards those living with HIV and address the concerns of the students and be sensitive to the psychosocial environment in which they live. Such education should stress the benefits of abstinence and safe sex, including condom use and faithfulness to one partner. Teachers should be well-prepared. There should be means for monitoring and evaluation.</p>
China	Guideline on HIV/AIDS Prevention Education in High Schools (2003)	<p>The guideline states that ten hours of HIV/AIDS prevention education in high schools should be arranged, two hours in each academic year. The goal is to raise students' awareness on HIV prevention, equip them with the knowledge and skills to prevent HIV transmission, help students develop a healthy lifestyle and encourage them to care for rather than discriminate against and stigmatise people infected with or affected by HIV or AIDS.</p>

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Indonesia	<p>The Decree of the Ministry of National Education and Culture 1997 No 9/U/1997 on HIV/AIDS Prevention</p> <p>Guidelines for HIV prevention are set out in the Letter of Decision of MONE No 303/1/1997</p>	<p>The Decree states that all rectors of universities, directors of institutions, coordinators of private universities and the MONE staff at the provincial level should do their utmost to increase the public's awareness of the dangers of HIV and AIDS and to improve their awareness of the importance of healthy and responsible life practices.</p> <p>The target population for HIV prevention education is students from elementary school through university level, non-formal education students and staff in both educational and administrative functions within educational institutions. HIV education would be delivered through</p> <ul style="list-style-type: none"> • curricular and extracurricular activities at elementary school • curricular activities, extracurricular activities, peer education, guidance and counselling at senior secondary schools • integration of HIV and AIDS knowledge into relevant topics; information should be reviewed before integration into the local curriculum. <p>The policy emphasises the role of school health services, student organisations (OSIS), Adolescent Red Cross, scout groups, Pencinta Ala Groups, BP3 and other committees that can collaborate with public health services.</p> <p>The responsibility for monitoring the HIV response lies with the Working Group on AIDS, led by the Head of the Department for Physical Quality and Development at MONE. At the school level, it is the school director. At the city and district levels, the respective heads are responsible.</p>
Vietnam	MOET Minister's Decree (10/GD-DT) of 1995	<p>This provides for the enhancement of HIV prevention education and has been used as the basis for scaling up HIV education in both formal and non-formal education.</p>

2. School health policies and strategies

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Country	Policy	Content
Cambodia	School Health Policy (2007)	<p>Four components of the MOEYS' School Health Policy</p> <ol style="list-style-type: none"> 1. Provide essential basic health care services to pupils, students and education staff. 2. Provide health education and a focus on communication that leads to a change in behaviours. 3. Improve learning environments and physical health-related facilities. 4. Enhance openness for the participation and involvement of ministries, institutions, development partners and civil society. <p>Strategies:</p> <ul style="list-style-type: none"> • Provide counselling services to students affected by physical abuse, HIV or domestic problems. • Integrate health topics into the formal and non-formal curricula, including sexual and reproductive health and HIV prevention into textbooks, at all grades. Prohibit discrimination against people living with HIV. Promote the rights of children through peer education. Promote awareness on sexual and reproductive health by using information billboards, leaflets, games, newsletters, physical education and sports. Strengthen training of teachers in all teacher-training colleges on health education and sexual and reproductive health. Improve the capacity of education officers at all levels. Monitor and evaluate the quality and effectiveness of health education. • Encourage the formation of School Health Committees. Encourage communities, specifically school-support committees and parent associations, to actively take part in the prevention of communicable diseases, especially HIV, and in protecting vulnerable children.
China	Principle of Health Education on STD/HIV/AIDS Prevention (1998)	The document directed that all schools (including primary schools) should incorporate STD/HIV/AIDS prevention education within the health education curricula and activities.
Indonesia	MOU between four ministries: MONE, MORA, MOIA and MOH in 1984	<p>School health programme (UKS) established through an MOU.</p> <p>Purpose of the UKS is to improve the quality of education and student learning achievement by</p> <ul style="list-style-type: none"> • increasing healthy life skills of students • creating a healthy school environment • improving knowledge and changing students' attitudes • maintaining good health by preventing and curing diseases. <p>There are three programme pillars</p> <ul style="list-style-type: none"> • health education • health services at school • healthy school environment. <p>Each headmaster and one or two UKS teachers appointed to oversee implementation. The MONE to provide guidelines and standards.</p>

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Lao PDR	<p>Law on Hygiene, Disease Prevention and Health Promotion (2001)</p> <p>National School Health Policy</p>	<p>Hygiene in relation to schools and educational institutions refers to maintaining clean, beautiful and orderly schools and educational institutions. Schools and educational institutions shall be established at locations safe from communicable diseases, accidents and hazards, and shall be equipped with sports grounds and resting places.</p> <p>The buildings of schools and educational institutions shall be provided with sufficient and appropriate space for the number of students and shall be equipped with sufficient light and air circulation and with tables and chairs adequate for students of that age.</p> <p>Teachers, students and the relevant organisations shall guarantee that schools and educational institutions are maintained in constant cleanliness and are supplied with drinking and clean water, with hygienic latrines and with other necessary facilities in accordance with the principles of hygiene. Health examinations shall be organised for students.</p> <p>Health education refers to the process of education through the provision of information and knowledge on health issues to all citizens in order to ensure the understanding and awareness of hygiene, disease prevention and health promotion that are likely to change the views, behaviours and lifestyle of persons, families and communities that ultimately strengthen their health.</p> <p>Organisations involved in health, education, culture and information, the mass media and other organisations in society, both public and private, are responsible for providing health education and knowledge to the population on a regular basis and in a diversified manner. Health education shall be included in the school curriculum.</p> <p>Attention shall be focused on educating youth and teenagers to understand the policies of spacing out childbirth and sexual safety, pregnancy and giving birth, and not marrying before reaching maturity.</p> <p>Objectives</p> <ul style="list-style-type: none"> • to increase children's knowledge on basic health issues • to empower and motivate children to adopt basic healthy practices in daily life • to strengthen collaboration between the Ministry of Education and Ministry of Health • to strengthen the capacity of school teachers in delivering health messages through a child-to-child approach using existing and new materials • to develop a package of school health materials • to strengthen the system of monitoring and evaluation of the school health programme.
Nepal	School Health and Nutrition Strategy (2006)	<p>The strategy stresses the need for a collaborative effort between the two key ministries, the MOE and the MOH, for the wellbeing and quality of education of school children. It has four strategies</p> <ol style="list-style-type: none"> i) emphasis on improved nutrition and health services ii) focus on creating healthy school living iii) reinforce life skills-based and behaviour-centred health education (including on HIV) iv) supportive community and policy environments.

Annex 3

1. National HIV and AIDS strategies

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Country	Strategy	Education sector component
Bangladesh	National Strategic Plan for HIV/AIDS 2004–2010	<p>Strategy 4: Integrate a human rights-based approach to HIV as a personal and a developmental issue into the curricula for education institutions.</p> <p>Implementing strategies</p> <ul style="list-style-type: none"> • to strengthen discussion forums and research on these issues • to ensure curriculum development and capacity building for teaching and research • to encourage young researchers to research on HIV.
Cambodia	Revised National Strategic Plan for a Comprehensive and Multisector Response to HIV/AIDS 2008–2010	Based on its HIV Strategic Plan 2008–2012, the MOEYS will continue school-based HIV prevention programmes but with a growing emphasis on integrating HIV into reproductive, sexual health, drug abuse and life skills education programmes and curricula. MOEYS will use a twin-track approach, integrating HIV education into the primary and secondary curricula as well as providing life skills-based HIV training as a co-curricular activity.
China	National Medium- and Long-Term Strategic Plan for HIV/AIDS Prevention and Control 1998–2010	<p>By the year 2002, the “health education prescription” should reach all the freshmen at universities, colleges and vocational training schools. HIV prevention and control knowledge should be incorporated into health education curriculum in junior high schools.</p> <p>All junior high schools at the level of municipalities, provincial capitals and cities with separate economic planning should have HIV/AIDS information in their curriculum. For schools at the county level and above, this should reach over 85 per cent. For schools at the township level and above, 70 per cent should have HIV/AIDS information as part of the curriculum.</p>
India	National AIDS Control Programme (NACP III)	NACP III will consolidate and scale up the ongoing Adolescence Education Programme (AEP) that is being implemented by the Ministry of Human Resource Development-Department of School Health Education (MHRD-DOSHE) through co-curricular coverage; curricular integration; in-service and pre-service teachers’ training curriculum; integration into alternative innovative education schemes and integration into the education policy of measures to prevent discrimination and ensure accurate content in the curriculum. This programme will then be phased out, over a period of two years, from the NACO programme and mainstreamed into the MHRD-DOSHE for its ongoing effort. Under NACP III, AEP peer educator clubs and Red Ribbon Clubs in high schools will be strengthened.
Indonesia	National Strategic Plan 2007–2010	<p>The education sector (formal and informal) has a crucial role to play in channelling messages to the general population. Prevention efforts in this regard will be directed at heightening awareness, concern and involvement regarding the HIV and AIDS response in people’s own environments.</p> <p>The life skills education programme, which includes information on how HIV can be avoided, is targeted at children from elementary school up to high school, including those attending both state and private schools. The programme is also aimed at teenager groups and children who have dropped out of school.</p>

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Lao PDR	National Strategic and Action Plan on HIV/AIDS/STI 2006–2010	<p>Disseminating and updating an age-appropriate life skills curriculum, including basic information about HIV/AIDS and sex education and drugs.</p> <p>Including basic information on HIV/AIDS, reproductive health and drug issues in the teachers’ pre-service and in-service training and strengthening the capacity of teachers to deliver this information in an effective way.</p> <p>Incorporating HIV, AIDS, STI and drug abuse issues into the curriculum of vocational schools and non-formal education.</p> <p>The National Strategic Action Plan 2006–2010 aims to reach 30 per cent of primary and secondary schools nationwide with RH/HIV/AIDS/STI education and drug-awareness activities.</p>
Nepal	National AIDS Action Plan 2008–2011	Implementation of life skills-based education in schools. Programme to be expanded into high-risk districts. Life skills education is integrated into teacher training, and peer education is planned for schools in selected high-risk districts.
Pakistan	National HIV and AIDS Strategic Framework 2007–2012	<p>Strategies for school-based initiatives</p> <ul style="list-style-type: none"> • Develop a graduated and culturally sensitive life skills curriculum for primary and secondary levels, designed to enhance young people’s confidence, communication skills and healthy decision making. • Develop a curriculum for teacher training institutes that corresponds with the life skills curriculum in order to enhance the capacity of new primary and secondary school teachers to provide effective life skills training for young people. • Provide in-service training on the new life skills curriculum to those primary and secondary teachers who are already in service in order to enhance their capacity to provide effective life skills training for young people. • Promote STI/HIV/AIDS education in extra-curricular activities for school-based youth, including such activities as debate clubs, theatre groups or peer-education initiatives.
Philippines	4th Medium-Term AIDS Plan 2005–2010	<p>The extent and quality of previous interventions will be assessed, the results of which will serve as the basis for developing an integrated approach in reaching young people, both in and out of school. Efforts to reach young people in schools will be doubled, and partnerships with community-based organisations involved in out-of-school youth programmes will be established.</p> <p>Key result area 2: Children and young people in school (formal, non-formal, alternative learning systems) are provided with appropriate STI/HIV/AIDS preventive information, life skills and services.</p>

Sri Lanka	National HIV/AIDS Strategic Plan 2007–2011	<p>Strategy 5. Prevention</p> <ul style="list-style-type: none"> • Increase the scale and coverage of HIV communication interventions for the general population and lesser-risk populations (youth, migrant workers, etc.). • MOE to mainstream skills-based reproductive health education, including HIV issues, into teacher training and student curriculum.
Thailand	National Strategic Plan for Integration of AIDS Prevention and Mitigation 2007–2011	<p>Develop continual learning processes on sexuality, sexual activity and AIDS issues in schools and other educational settings.</p> <p>Develop a referral service for youth to access health services for HIV and STI prevention.</p> <p>Build and promote a socially enabling environment to communicate messages on sex and AIDS for the family and the community.</p> <p>Develop and support young people's participation in decision making in the response to HIV prevention at all levels.</p> <p>Promote better collaboration among local organisations to further support AIDS awareness and HIV prevention in schools and tertiary education institutions.</p>
Timor-Leste	National HIV/AIDS/STI Strategic Plan 2006–2010	<p>The population group of young people covers a wide range of years. Subprogrammes need to be developed for primary school, junior secondary, senior secondary, university/post secondary and out-of-school young people.</p> <p>Education settings and youth centres will be primary sites for the delivery of life skills-based education.</p> <p>Popular culture should be utilised to promote broader HIV prevention messages.</p>
Vietnam	National Strategy on HIV/AIDS Prevention and Control in Vietnam till 2010, with a Vision to 2020 (2004)	<p>The MOET to assume the prime responsibility for and coordinate with other ministries, branches, central agencies and provincial/municipal People's Committees in organising the integration of the programme on education on HIV prevention and control, knowledge and skills into the training curricula of universities, colleges, intermediate professional schools, vocational training and general education schools, suitable to their students.</p> <p>MOET to develop a programme on education of life skills for preventing HIV transmission, to be used in schools of the educational and vocational training system.</p> <p>To offer more opportunities for young people to participate in, and contribute comments to, the development and designing of all young people's activities related to HIV/AIDS.</p>

2. Population and reproductive health strategies

Country	Strategy	Education component
Bangladesh	Adolescent Reproductive Health Strategy	<p>Effective dissemination of adolescent reproductive health knowledge and information through school curricula in secondary and higher secondary schools.</p> <p>Review and revise existing curricula, based on needs assessments.</p> <p>Training of teachers on revised curricula.</p> <p>Implementing monitoring and evaluation systems to ensure classroom teaching of the curricula.</p>
Cambodia	National Strategy for Reproductive and Sexual Health in Cambodia 2006–2010	No mention of the education sector.
India	National Adolescent Reproductive and Sexual Health Strategy 2005	<p>This strategy recognises the heterogeneity of young people, including young men and the unmarried.</p> <p>It calls on the health sector to provide friendly, confidential and non-judgemental services for youth, proposes detailed training of various providers to enhance their ability to serve youth needs, and advocates a wider range of services for youth than has been the case thus far.</p>
Nepal	National Adolescent Health and Development Strategy Nepal Ministry of Health, Family Health Division, 2000	The main objectives of the strategy are to increase the availability of and access to information on adolescent health; provide opportunities to build skills among adolescents, service providers and educators; and increase accessibility and utilisation of health and counselling services among adolescents. The strategy specifies some indicators for monitoring purposes, including decreased incidence of young age at marriage, use of family planning methods, utilisation of antenatal care services, knowledge of preventive behaviours of HIV transmission and school enrolment/literacy for the adolescent population aged 15–19.
Timor-Leste	National Reproductive Health Strategy 2004-2015	Substantially increase the level of knowledge in the general population on issues related to sexual and reproductive health.
Vietnam	Decision No. 147/2000 on Ratifying the Vietnam Population Strategy for 2001–2010	No clear specification for the MOET.

3. Education plans and HIV

Country	Education sector plan	Comment
Bangladesh	Education for All, National Plan of Action 2003–2105	No inclusion of HIV and SRH activities.
Cambodia	Education Strategic Plan 2006–2010 Education Sector Support Programme 2006–2010 EFA National Action Plan 2003–2015	HIV and SRH activities included.
China	EFA National Action Plan 2003–2015	No inclusion of HIV and SRH.
India	EFA National Plan of Action 2003–2015 Sarva Shiksha Abhiyan: A Programme for Universal Elementary Education	No inclusion of HIV and SRH activities.
Indonesia	MONE Strategic Plan 2005–2009 EFA National Action Plan 2003–2015	No inclusion of HIV and SRH activities.
Lao PDR	Education Sector Development Framework 2009–2015 EFA National Action Plan 2003–2015	No inclusion of HIV and SRH activities.
Nepal	School Sector Reform Plan 2009–2015 EFA National Action Plan 2003–2015	No inclusion of HIV and SRH activities.
Pakistan	Education Sector Reforms Action Plan 2001–2006 EFA National Action Plan	No inclusion of HIV and SRH activities.
Philippines	Philippine National Plan of Action to Achieve Education for All By Year 2015	No inclusion of HIV and SRH activities.
Sri Lanka	EFA National Action Plan	No inclusion of HIV and SRH activities.
Thailand	Implementation of the 15-Year Free Education with Quality Policy	No inclusion of HIV and SRH activities.
Timor-Leste	Strategic Plan for Universal Primary Completion by 2015	No inclusion of HIV and SRH activities.
Vietnam	National Education for All Action Plan 2003–2015 Vietnamese Education and Training Strategy to Year 2010 for the Course of Industrialisation and Modernisation of Vietnam	No inclusion of HIV and SRH activities.

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4. HIV strategies for the education sector

Country	Title	Strategic objectives	Priority activities
Cambodia	MOEYS Strategic Plan and Operational Plan for HIV 2008–2012 Goal: Reduce HIV-related vulnerability, stigma and risk behaviours through expanded coverage of effective education interventions	<ol style="list-style-type: none"> 1. Increased coverage and quality of HIV education in schools. 2. Increased coverage and quality of HIV education for children and youth who are especially vulnerable and at higher risk. 3. Strengthened institutional capacity to mainstream HIV across MOEYS departments and activities. 4. Increased coverage of evidence-based interventions to mitigate vulnerability and the impact of HIV on the education system. 	<ol style="list-style-type: none"> 1. Integrate HIV into the national curriculum. 2. Integrate life skills HIV education into the local life skills programme. 3. Strengthen pre-service teacher training. 4. Strengthen in-service teacher training. 5. Strengthen support at the school and community level. 6. Strengthen monitoring and evaluation. 7. Strengthen the enabling environment (disseminate/ implement workplace policy). 8. Strengthen MOEYS leadership for the HIV response. 9. Strengthen Interdepartmental Committee on HIV and AIDS functioning. 10. Strengthen capacity of apex teacher training institution. 11. Strengthen capacity of a decentralised response.

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Vietnam	<p>Action Programme on Reproductive Health and HIV/AIDS Prevention for Secondary School Students 2007–2010</p> <p>Goal: Contribute to the successful implementation of the National Strategy on HIV/AIDS Prevention and Control until 2010</p>	<ol style="list-style-type: none"> 1. Create an enabling policy and social environment favourable for the implementation of reproductive health and HIV prevention programmes in secondary schools. 2. Enhance the quality of teaching reproductive health and HIV prevention. 3. Improve the effectiveness of management, coordination, monitoring and evaluation of the reproductive health and HIV prevention education programme in secondary schools. 4. Increase participation of students and the effectiveness of peer education in reproductive health and HIV prevention education activities in lower and upper secondary education. 	<ol style="list-style-type: none"> 1. Formulate and promulgate policies and guidelines for the implementation of reproductive health, HIV prevention and life skills education. 2. Improve awareness of the importance of reproductive health, HIV prevention and life skills education among policy makers and education management staff. 3. Advocate for support from parents and public opinion. 4. Enhance teachers' capacity for teaching reproductive health and HIV education. 5. Develop and apply reproductive health and HIV prevention and HIV prevention training programme for students in secondary schools and teacher training programmes. 6. Strengthen the capacity of education management staff. 7. Develop a monitoring and evaluation system of reproductive health and HIV prevention education to be applied at all levels of education management. 8. Establish a peer-education network. 9. Establish health clubs and adolescent-friendly corners in secondary schools. 10. Organise communications and consultation activities.
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Annex 4

National assessments relevant to adolescents and sexuality education

Country	Assessments
Bangladesh	<p>UNGASS Country Progress Report. Reporting period: January 2008–December 2009 (2010)</p> <p>Adolescent and Youth Reproductive Health in Bangladesh. Status, Issues and Policies (Policy and USAID, 2003)</p> <p>Rapid Situation Assessment on Sexual Exploitation of Children and Adolescents (INCIDIN, 2005)</p> <p>Rapid Situation Assessment on Adolescent Drug Users (UNICEF, 2009)</p>
Cambodia	<p>UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)</p> <p>Situation and Response Assessment of the Education Response to HIV (MOEYS, 2007)</p> <p>Children and HIV/AIDS in Cambodia (2006)</p> <p>Behavioural Surveillance Survey (NCHAD, 2007)</p>
China	<p>UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)</p>
India	<p>National Family Health Survey III</p> <p>UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)</p> <p>Young People's Sexual and Reproductive Health in India: Policies, Programmes and Realities (Population Council, 2007)</p> <p>Study on Child Abuse (Ministry of Women and Child Development, 2007)</p> <p>Adolescents in India: A Profile (UN System in India, 2006)</p> <p>Barriers to Services for Children with HIV-Positive Parents (2007)</p> <p>National Youth Shadow Report (UNGASS, 2008)</p> <p>Rapid Situation and Response Assessment of Injecting-Drug Users (UNODC, 2008)</p> <p>Reducing Vulnerability and Risk: Formal Education Sector Response to HIV in India (PCD, 2008)</p>
Indonesia	<p>UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)</p> <p>Integrated Bio-Behavioural Surveillance (2007)</p> <p>Young Adult Reproductive Health Survey 2007 (Government of Indonesia and USAID, 2008)</p> <p>Education Sector Response to HIV, Drugs and Sexuality in Indonesia (UNESCO. 2010, draft report)</p>
Lao PDR	<p>Integrated Bio-Behavioural Surveillance (2008)</p> <p>UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)</p> <p>National Reproductive Health Survey (UNFPA, 2000)</p>

Nepal	Integrated Bio-Behavioural Surveillance (2004/5/6)
	Assessment of Youth Reproductive Health/HIV Programs (YouthNet and USAID, 2004)
	National Youth Shadow Report: Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS. (Global Coalition on Youth and AIDS, 2008)
	UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)
	The Situation of Adolescents and Young People Most At Risk in Nepal (Government of Nepal and UNICEF, 2008)
	Review on Education Sector Response to HIV and AIDS in Nepal (UNESCO, 2009)
Pakistan	A Research Study on Status: Sexual and Reproductive Health and Rights of Young People in Pakistan (World Population Foundation, 2010)
	Progress Report on the Declaration of Commitment on HIV/AIDS (UNGASS, 2007)
	National Youth Shadow Report: Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS (Global Youth Coalition on HIV/AIDS, 2006)
	Adolescents and Reproductive Health in Pakistan: A Literature Review (UNFPA and Population Council, 2000)
	Pakistan Reproductive and Family Planning Survey (2000–2001)
Philippines	UNGASS Country Report of the Philippines. Reporting period: January 2006–December 2007 (2008)
	Youth in the Philippines: A Review of the Youth Situation and National Policies and Programmes (UN ESCAP, 2000, Bangkok)
	Young Adult Fertility and Sexuality Study III (2002)
Sri Lanka	Sri Lanka Behavioural Surveillance Survey First-Round Results 2006-2007 (National STD/AIDS Control Programme, 2007)
	Country Report on the Follow-Up to the Commitment on HIV and AIDS (UNGASS). Reporting period: January 2006–December 2007 (2008)
Thailand	UNGASS Country Progress Report. Reporting period: January 2006–December 2007 (2008)
	Consultations with Young People on HIV/AIDS, 2004 (UNICEF)
	National Sexual Behaviour Survey of Thailand (Ministry of Public Health, 2006)
	A Review of Sexuality and Reproductive Health and Rights in Thailand (Ford Foundation, 2006)
	Improving the Education Response to HIV and AIDS: Thailand Case Study (UNAIDS IATT on Education, 2008)
Timor-Leste	UNGASS 2010 Country Progress Report. Reporting period: January 2008–December 2009 (2010)

Vietnam	Survey Assessment of Vietnamese Youth (SAVY, 2003)
	Integrated Bio-Behavioural Surveillance (2006)
	National Youth Shadow Report: Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS (Global Youth Coalition on HIV/AIDS, 2008)
	A Mapping of the Education Sector Response to HIV in Vietnam (UNESCO, 2009)
	The Third Country Report on Following Up the Implementation to the Declaration of Commitment on HIV and AIDS. Reporting period: January 2006–December 2007 (2008).

Annex 5

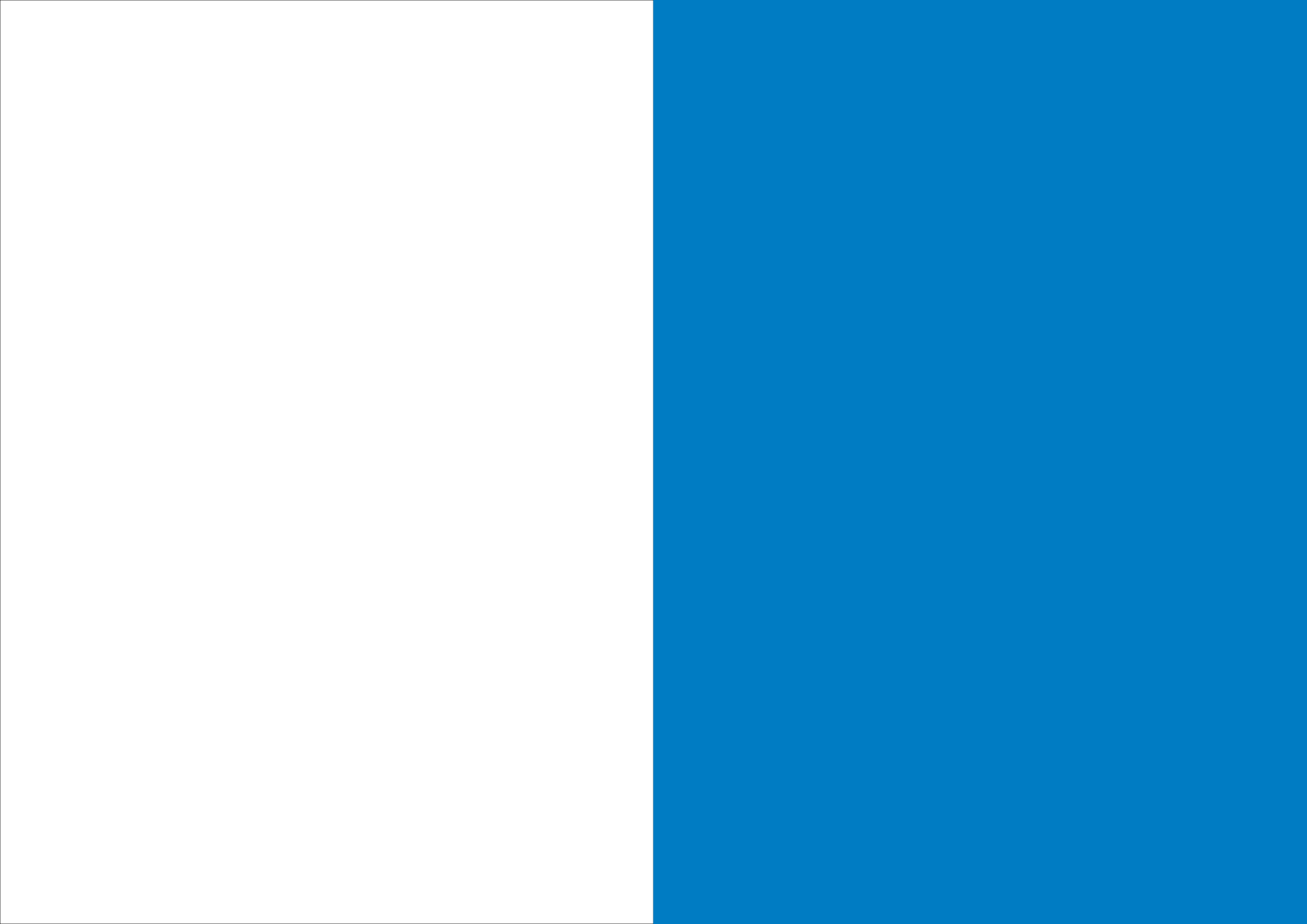
HIV and SRH education in the curriculum

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Country	Strategy	Subjects	Life skills education	Development partners
Bangladesh	Curriculum integration	In various subjects	Life skills education (piloted in secondary schools in 10 districts) Child-friendly schools	UNICEF UNFPA Save the Children GFATM
Cambodia	Curriculum integration and co-curricular approach	Local life skills Khmer Science Social science	Life skills for HIV/AIDS prevention (Prey Veng province) Child-friendly schools	UNICEF UNFPA
China	Health education	Health education	Life skills education Peer education	UNICEF UNFPA
India	Curriculum integration and co-curricular approach	Biology Social science Health and physical education	Adolescence Education Programme Child-friendly schools	UNICEF UNFPA
Indonesia	Curriculum integration and co-curricular approach	Biology and natural sciences (6 hours per week) and local content Physical and health education (PHE). PHE is a co-curricular subject and is taught from primary school through senior high school (ages 6–18). The subject is compulsory but is not examinable. For all school levels, 2 hours per week is dedicated to PHE.	HIV/AIDS Prevention and Care through life skills education and peer education among young people in Papua and West Papua provinces Child-friendly schools in Aceh province	UNICEF UNFPA WFF Plan
Lao PDR	Health education Curriculum integration	“The world around us” Biology Geography Civic education	Life skills education Child-friendly schools	UNICEF UNFPA

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Nepal	Curriculum integration	Health and physical education Population and environment Health, population and environment	Life skills education (scaling up) Child-friendly schools	UNICEF UNFPA Plan
Pakistan	Co-curricular approach	Life skills education	Life skills education (piloting in secondary and higher secondary schools in 6 districts) Child-friendly schools	UNICEF UNFPA WPF
Philippines	Curriculum integration	Science and health Health education	Life skills education Piloting child-friendly schools	UNICEF UNFPA
Sri Lanka	Curricular and co-curricular approach	Health and physical education	Life skills education Mainstreaming child-friendly schools	UNICEF
Thailand	Curricular and co-curricular approach	Health education Family life education Teenpath programme	Teenpath	UNFPA PATH Plan GFATM
Timor-Leste	Co-curricular approach	Healthy lifestyle and HIV/AIDS programme	Life skills education in 6 districts Child-friendly schools in 76 core schools	UNICEF UNFPA
Vietnam	Curriculum integration and co-curricular approach	Natural science Biology Civic education Social science	Adolescent development and participation project (110 lower secondary schools in 16 districts of 8 provinces) Child-friendly schools	UNICEF UNFPA Save the Children/ PEPFAR





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ISBN 978-1-906273-11-8

