



**UNESCO's strategy  
for HIV/AIDS  
preventive education**

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Front cover graphic: UNAIDS

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*This document is a UNESCO strategy paper which will guide its actions in the area of HIV/AIDS in the coming years. It is focused on preventive education in the broadest sense, including advocacy at all levels, customizing the message, changing risk behaviour, caring for the infected and the affected, coping with the institutional impact of the epidemic, as well as information sharing and capacity building to achieve these tasks.*

## Some facts

### **HIV/AIDS in Africa:** ***The enormous challenges of a long-lasting epidemic***

For the first time there are some signs that the incidence of HIV may be stabilizing in sub-Saharan Africa. New infections in 2000 totalled an estimated 3.8 million, compared with 4 million in 1999. However, this may change if rates go up in countries where they are still relatively low. The total number of Africans living with HIV or AIDS is now 25.3 million. In eight African countries, at least 15% of adults are infected. Here AIDS will claim the lives of around a third of today's 15-year-olds. During 2000, millions of Africans infected in earlier years began falling ill, and it is estimated that 2.4 million people died of HIV-related causes, compared with 2.3 million in 1999. In Botswana, 35.8% of adults are now infected with HIV, while in South Africa, 19.9% are infected, up from 12.9% just two years ago.

### **HIV/AIDS in Asia:** ***Held at bay – but for how long?***

An estimated 700,000 adults, 450,000 of them men, had become infected in South and South-East Asia in the year 2000. Countries in East Asia and the Pacific are on the whole still keeping HIV at bay, with some 130,000 new infections this year. Overall, as of end 2000, the two regions combined are estimated to have 6.4 million people living with HIV/AIDS. Compared to Africa, infection rates in the general population of Asia are still low. In both China and India the epidemic varies widely from region to region, but there are ominous signs of a rapid rise in the number infected in these and other countries in the region.

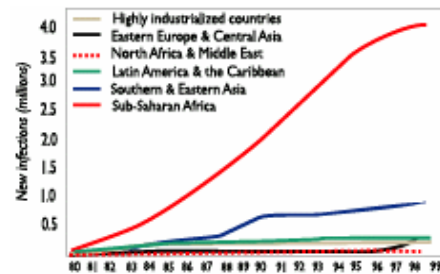
### **HIV/AIDS in Latin America and the Caribbean:** ***An epidemic with many faces***

An estimated 210,000 adults and children became infected during 2000. By the end of 2000, some 1.8 million adults and children were estimated to be living with HIV or AIDS, compared with 1.7 million at the end of 1999. Haiti is worst affected, whereas Saint Lucia and British Virgin Islands are at the other end of the spectrum.

### **HIV/AIDS in the Newly Independent States:** ***Drug injecting is still the main risk***

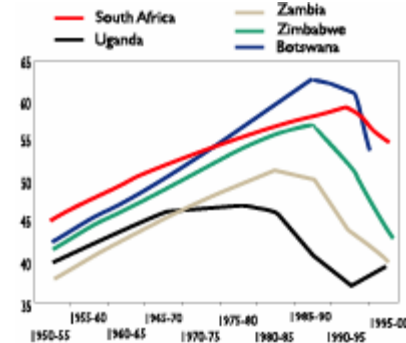
With a previously low prevalence, the region is now suffering an extremely steep increase in the number of

### ***Estimated annual number of new HIV infections by region, 1980 to 1999***



Source: UNAIDS, WHO

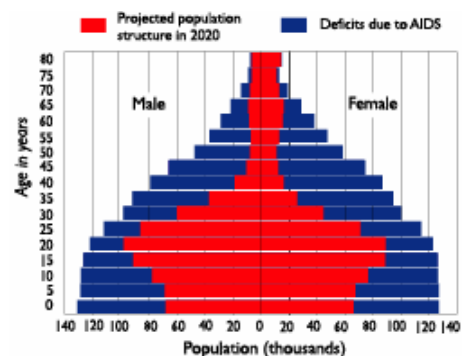
### ***AIDS reduces life expectancy***



Selected African countries with high HIV prevalence

Source: United Nations Population Division, 1998

### ***The devastating impact***



Projected population structure with and without the AIDS epidemic, Botswana, 2020

Source: US Census Bureau, World Population Profile, 2000

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people living with HIV/AIDS. The number of people living with HIV/AIDS was estimated at 170,000 at the end of 1997, but had climbed to 700,000 by end-2000. Most of the quarter of a million adults who became infected this year are men, and most of them are injecting drug users. The potential for further spread is enormous: the Russian Federation, for example, has an estimated 1.5-2.5 million injecting drug users - or 2% of the population - compared with 130,000 people infected by end 1999. Clearly, hundreds of thousands of drug users and their sex partners are at immediate risk of infection. The prevalence of sexually transmitted infections - with reported rates of syphilis of more than 200 per 100,000 - is yet another warning sign that transmission through sex may grow in importance.

*Source: UNAIDS.*

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## The situation

### **The deadly nexus**

*In less than two decades HIV/AIDS has been transformed from a medical curiosity to an international emergency. Yet it is not merely a health problem – it is already a development disaster and is becoming a security crisis with social impacts as devastating as any war. The epidemic is not threatening – it is here. The spread has not been curbed – on the contrary, for the next several years more will be infected than last year. Unlike other epidemics, it primarily affects young adults, particularly women. The epidemic is fuelled by inequalities due to lack of resources, gender and race. Yet, although it strikes the poor and disadvantaged*

### **The destruction of capacity**

Hence, the AIDS epidemic not only hampers development; it reverses it by destroying productive capacity and widens the gap between rich and poor.

The epidemic has an exceptional impact on the economy in two ways. Firstly, by loss of productivity from loss of the most productive. Secondly, by the burdens of caring for the sick and tending for orphans. AIDS is wiping out decades of investment in education and in human development. In sub-Saharan Africa, a region already poor, growth may be reduced by 25 per cent over the next 20 years. Even the rich countries would be hard put to manage the care and afford the treatments they now provide if infection rates were as those in that region.

The multiple consequences of a disease that knows no frontiers undermine all aspects of sustainable development – reducing poverty, advancing equity, accessing technology, improving health, guaranteeing human rights and securing education for all. It affects hundreds of millions more than those infected, their lives and their futures.

HIV/AIDS is a deadly nexus between all the items on the world development agenda – and it increases inequalities between the different regions of the world, and widens the gap between the rich and the poor.

### **Institutional damage**

AIDS attacks not only human bodies, but the body politic as well. Its effects vary greatly. But in many countries it already has an unprecedented institutional impact, not only on the organizations most needed for development but also on those most needed to prevent the spread of the epidemic itself. The high rate of disease and death among teachers, health workers and other trained professionals will make replacements increasingly hard to find – and there will be fewer to educate and care for them. It will erode access to education, and interfere with the capacity of key institutions to function. Governance itself may be threatened by decimation. The capacity to cope can be overwhelmed.

Children are at risk on an unparalleled scale. Millions are already infected – in some countries more than a third of the 15-year-olds will die of AIDS-related illnesses in coming years. Millions more are becoming orphans – more than 30 million in less than 10 years. Many youth will grow up deprived, de-socialized and disconnected. Children will lose teachers at school and parents who can support them at home. Classes will be dropped and schools will close, and many children and young will get a poorer education, while at the same time the industrialized world moves into the knowledge society.

## **Learning and acting**

*Much is still not known about the epidemic – and much is yet to be learned. But enough is known to act – and we know we must act immediately: to offer treatment, to provide care and maintain institutions in an environment that respects the human rights of all. No country is an island unto itself – the whole world is affected. Action is needed to stop the spread and make for longer, more productive and more dignified lives for the infected and affected. Action is needed to kindle hope and demonstrate compassion. In particular: prevention programmes that are country driven and rooted in communities do work and must be put to work. Preventive education and communication for change in behaviour must be intensified.*

# The urgency of renewed preventive education

*Two sets of facts about the HIV/AIDS epidemic are troubling. The first set pertains to the nature of the disease, the other to the extent of ignorance.*

## The nature of the disease

### **1. *There is no cure for HIV***

Of the millions that have been infected with HIV none have been able to get rid of it. There is at present no treatment that eradicates the virus from the body. The infection can be held at bay and the progression of AIDS slowed, but the virus cannot – and not in the foreseeable future – be eliminated.

### **2. *Vaccination is not yet in sight***

Vaccination has provided protection against many infectious diseases, from smallpox to polio. Due to intense research, effective vaccination is a hope, but is not likely to be available for the next few years. In the long run this will be the only permanent solution.

### **3. *Treatment is still too costly***

Over the past decade large resources have been invested in finding and providing treatment for HIV/AIDS. Treatments have prolonged and improved lives of the infected, also by ameliorating the secondary infections that accompany the disease. They have made it possible to prevent mother-to-child transmission. Treatment can keep parents raising their children and can keep workers in the labour force.

Treatment is least available where it is most desperately needed – in the poor countries with the largest number of infected – and the epidemic in turn increases poverty by destroying capacity. A quarter of the world's population lives on less than one dollar a day – less than about \$350 per year. Drugs available in the Western countries to alleviate the effects of the HIV virus and to postpone the onset of AIDS cost up to \$15,000 annually per patient. Hence they have been inaccessible in the developing world – and particularly in the poor countries with the largest number infected. Even if the costs are reduced to less than 5 per cent, massive drug distribution would be beyond the means of the world's poorest nations unless financed by industrialized countries.

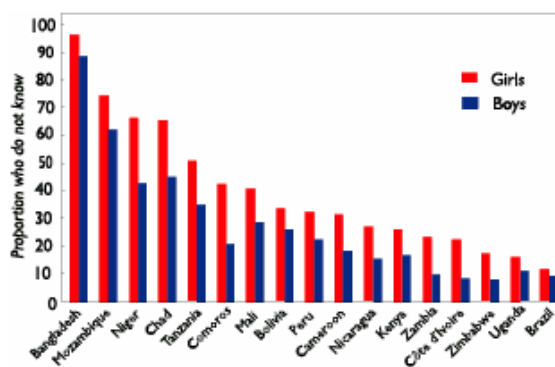
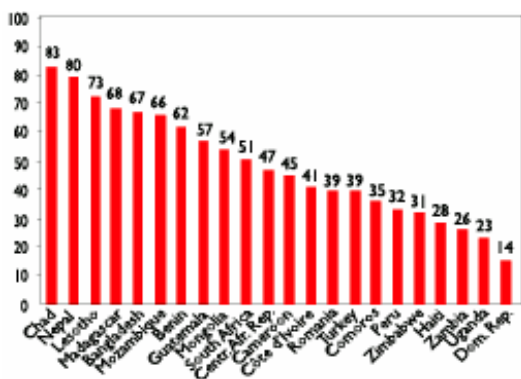
There are additional problems. The side effects of the drugs are often agonizing. The necessity of lifelong use increases the likelihood of mutant forms of the virus able to resist the drugs commonly used for treatments. Even worse: new infections are increasingly likely to come from these mutants. Developing new medicines that can keep pace with mutations may become more difficult. Cheaper medicines will increase the need for care and hence the need for resources.

Yet treatments are vital, not just to raise hopes and lengthen lives. They are also important for another reason: they increase the interest in HIV testing because something can be done about the illness.



**Many girls do not know that an HIV-infected person may look healthy**

**Large numbers of girls and boys do not know how to protect themselves**



Sources: DHS surveys and other nationwide surveys, 1994–99, Demographic and Health surveys, Macro International, USA; UNICEF.

## The extent of ignorance

Too many know too little about the disease:

### **1. Most of those infected by the disease do not know it.**

Some 36 million people are now estimated to be infected with HIV. Being an estimate, this means that though it is valid, most of those infected have undergone no test – there is no medical service to do it, and often the incentives to take tests may be negative because of the social stigma associated with knowing that one is infected. The nature of the disease inhibits its discovery – the incubation period between the infection and its manifestations is long. This also accounts for its particular social and cultural dimensions: not only do the infected not know, but neither can those not infected, because for so many years there are no outward signs of disease.

### **2. Most of those affected do not know what the disease is – neither do most of those immediately exposed.**

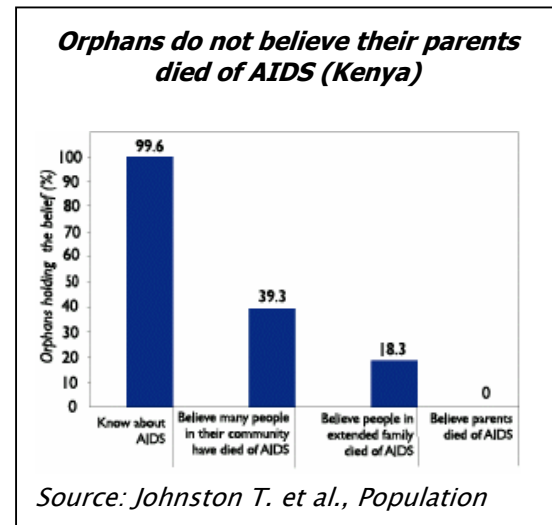
Even in the most advanced education systems children learn little about viruses and understand little about infections during their first five years of schooling. General knowledge is important at this stage, while the next five years are critical for more specific knowledge about HIV/AIDS. Yet a great part of those exposed to the virus do not have that much education – while the illiterate have less access to information. Nearly a billion people in the world are illiterate – and many more are scientifically illiterate in the sense that they know little about the basics of biology and physiology and hence understand little of what is going on. This is also the case for many teachers in the developing world.

### **3. In many communities beliefs about what causes the disease are misconstrued and actions taken to escape it are misguided – or even counterproductive for the infected themselves, as well as destructive for others.**

Misconceptions, beliefs and customs span from use of ineffective or damaging concoctions to resorting to sexual practices involving children. Diseases, their spread and their remedies, are shaped by cultural patterns of human behaviour. In preventive education, knowledge based on science is often countered by conventional tenets, creeds and traditional ways. The effect of education programmes may be annihilated by information circulated by peers. For countermeasures to be successful, changes in mores are as important as changes in medication. For a virus like HIV it is important to know not just patterns of sexual behaviour, but also how they are affected by other social norms as well as by traditional medicine, which, if nothing else, can offer psychological relief.

### **4. Misconceptions lead to prejudice, discrimination and exclusion.**

Social silence results in soaring infection. Faulty knowledge results in careless behaviour. Lack of knowledge leads to lack of care for those that are infected – and to stigmatization that turns the infected into outcasts. Denial may hasten death.



*Ignorance is a major reason why the epidemic is out of control. The need for preventive education flows from the types of ignorance closely associated with the epidemic, particularly in the most affected developing countries. Preventive education must make people aware that, they are at risk, and why – and how prevalence can be reduced. However, knowledge is often not enough to change behaviour. Preventive education must address mentalities and the culture within which they are embedded in order to generate the attitudes, provide the skills and sustain the motivation necessary for changing behaviour to reduce risk and vulnerability. For now, preventive education is the best vaccination.*

# The commitment of the United Nations to fight HIV/AIDS

*Fighting HIV/AIDS is one of the top priorities of the United Nations. The Secretary-General has declared the epidemic "The most formidable development challenge of our time".*

## Some examples of UNESCO's efforts against HIV/AIDS

*Over the years UNESCO, its sectors, institutes and field offices have engaged in a wide range of activities against HIV/AIDS:*

**1986:** *The Division for Life Sciences developed jointly with UNAIDS a programme 'Man against virus' to stimulate health-related biological research.*

**1987:** *Responding to the urgent appeal of the International Conference on Education at its 40th session held in 1986, UNESCO drafted a Plan of Action in Education for the prevention and control of AIDS.*

**1990:** *The Section for Preventive Education developed a conceptual framework for identifying strategies and priority areas for preventive education programmes.*

**1993:** *UNESCO entered into a collaborative project with the World Foundation for AIDS Research and Prevention. Publication (jointly with WHO) of School Health Education to Prevent AIDS and Sexually Transmitted Diseases (1993): A resource package for curriculum planners, adapted to different socio-cultural contexts and translated in more than ten languages.*

**1994-98:** *Six regional conferences were organized for the development of effective preventive national programmes, involving high-level officials from ministries of education.*

**1998:** *UNESCO/UNAIDS developed the project A cultural approach to HIV/AIDS prevention and care which has carried out 12 country assessments.*

**2000:** *Co-publication with UNAIDS of Migrant populations and HIV/AIDS. Publication of Media and HIV/AIDS in East and Southern Africa: a Resource Book.*

**UNESCO's Institutes** *have been active in HIV/AIDS prevention. For example, IIEP in 1993 held a seminar and produced a report on The impact of HIV/AIDS on education. Another one took place in 2000.*

**UNESCO's field offices** – *e.g. in Almaty, Brasilia, Dakar, Harare, New Delhi, Phnom Penh, Rabat and Santiago de Chile – have initiated a wide range of activities, spanning from Teacher training programmes to non-formal education.*

The Secretary-General recommended that the Millennium Summit adopt as an explicit goal:

- the reduction of HIV infection rates in persons 15 to 24 years of age – by 25 per cent within the most affected countries before the year 2005 and by 25 per cent globally before 2010;
- and to that end, he also recommended that governments set explicit prevention targets: by 2005 at least 90 per cent, and by 2010 at least 95 per cent, of young men and women to have access to the information, education and services they need to protect themselves against HIV infection.

Over 30 per cent of people living with HIV/AIDS are young, under the age of 25. In other words, reaching the young under the age of 25 before they are sexually active, among whom about half of new infections are found, is put at the top of the agenda.

UNESCO, whose efforts against HIV/AIDS go back more than a decade (see box), will find its new role within the new United Nations Framework for global leadership on HIV/AIDS and will map its strategy in close co-ordination and co-operation with the other UN agencies. It will draw on its specific strength and mobilize all its sectors for the common goal.

## UNAIDS Priorities and division of labour

All major UN agencies have over the past few years initiated a broad range of measures to meet the challenge of HIV/AIDS. Since it was set up in 1996, UNAIDS has had the co-ordinating role for these efforts. UNAIDS has taken the lead

in setting a common agenda as well as in recommending a division of labour to implement it. A plan for the next five-year period is being developed in broad consultation with the UN system and other partners. The new global strategy – Framework for global leadership on HIV/AIDS – seeks to advance “a common understanding of the pandemic and its diversity, and share a sense of urgency in responding at scale.” Its overarching aim is to “support communities and countries to reduce risk and vulnerability to infection, to save lives and alleviate human suffering, and to lessen the epidemic’s overall impact on development.” On the basis of this Framework, the first UN System strategic Plan for HIV/AIDS is due to be completed by June 2001 under the co-ordination of the UNAIDS Secretariat.

At the 21st Special Session of the United Nations General Assembly in July 1999, Member States addressed four broad themes in confronting the HIV/AIDS epidemic: to mobilize and commit top-level leaders, to reduce the spread of the epidemic, to better the situation of those affected and to protect and strengthen key social institutions. These were expressed in 12 specific leadership commitments adopted by the PCB in December 2000 (see box below). The focus is to help countries improve the reach and effectiveness of programmes delivered through schools and other means to reach children and young people. UNESCO will support these efforts through intensified measures and enhanced co-operation with the other co-sponsors of UNAIDS: UNICEF, UNDP, UNFPA, UNDCP, WHO and the World Bank, other specialized agencies such as those undertaken by ILO.

UNESCO’s role is not to produce primary medical knowledge. UNESCO’s key task is to engage in advocacy, share information about the epidemic, build capacity to reduce risk, and improve care and lessen the institutional impact of the epidemic, through intensified preventive education.

### **Leadership commitments adopted by the Programme Co-ordinating Board, December 2000**

- 1. To ensure an extraordinary response to the epidemic which includes the full engagement of top-level leaders to achieve measurable goals and targets.*
- 2. To reduce the stigma associated with HIV and AIDS and to protect human rights through personal and political advocacy and the promotion of policies that prevent discrimination and intolerance.*
- 3. To affirm and strengthen the capacity of communities to respond to the epidemic.*
- 4. To protect children and young people from the epidemic and its impact – especially orphans.*
- 5. To meet the HIV/AIDS-related needs of girls and young women and to minimize the circumstances that disadvantage women with respect to HIV/AIDS.*
- 6. To protect those at greatest risk of HIV/AIDS, including sex workers and their clients, injecting drug users and their sexual partners, men who have sex with men, refugees and internally displaced people, and persons separated from their families due to work or conflict.*
- 7. To ensure the provision of care and support to individuals, households and communities affected by HIV/AIDS.*
- 8. To promote the full participation of people living with and affected by HIV/AIDS in the response to the epidemic.*
- 9. To actively support the development of partnerships required to address the epidemic, in particular those required to improve access to essential information, services and commodities.*
- 10. To intensify efforts in sociocultural, biomedical and operations research, to accelerate access to prevention and care technologies, to improve our understanding of factors that influence the epidemic, and enhance actions to address it.*
- 11. To strengthen human resource and institutional capacities required to support service providers engaged in the response to the epidemic, in particular those in the education, health, judicial and social welfare sectors.*
- 12. To develop enabling policies, legislation and programmes that address individual and societal vulnerability to HIV/AIDS and mitigate its socio-economic impacts.*

# UNESCO's strategy

## One theme –

### Multiplex agenda –

#### Holistic approach

With respect to HIV/AIDS, there are two striking differences between the industrialized countries and the developing world. One is in the access to treatment – bluntly put: the disease is in the south and the treatment is in the north. The other fact, even more striking, is the difference in the rates of infection. In many countries in the north the proportion infected has remained nearly level for the past decade – in many countries in the south, and in some countries under great social stress such as parts of the former Soviet Union, the epidemic is snowballing. The AIDS epidemic aggravates discrepancies between developing and industrialized countries and exacerbates inequalities within them. Low infection rates are above all due to successful preventive education. Hence, while every effort must be made to develop the medical means for prevention and care, the immediate and overriding priority must be given to preventive education for behaviour change to reduce infection rates.

A vaccine is desperately needed and treatments that can make it possible for those infected to live longer and with fewer ailments must be made available. UNESCO will strongly support the initiatives and efforts to provide them. UNESCO itself will invest most of its resources in preventive education broadly defined, where UNESCO, due to its mandate, experience and expertise can make the greatest difference.

As long as no vaccine exists and treatments are unaffordable, education is the most effective strategy. So far prevention is not only the most economical response – it is the most patent and potent response, i.e. changing behaviour by providing knowledge, fostering attitudes and conferring skills through culturally sensitive and effective communication. An approach based on human rights is fundamental for both providing preventive education and treatment as well as in combating stigma and improving living conditions of the infected and affected.

UNESCO's commitment to fighting HIV/AIDS has since 1987 been confirmed on repeated occasions. UNESCO's strategy on HIV/AIDS will take as its point of departure: collaboration among UN agencies and the specific contributions that UNESCO can make.

Fighting HIV/AIDS through preventive education is no single-point programme. UNESCO's priority in preventive education is directed towards five core tasks:

1. advocacy at all levels;
2. customizing the message;
3. changing risk behaviour;
4. caring for the infected and affected;
5. coping with the institutional impact of HIV/AIDS.

Different settings require a different balance and focus between these five elements. This agenda is also the crux of UNESCO's mission with its interdisciplinary approach.

But curbing the infection rate is not enough – preventive education must address caring for the infected and affected. Moreover, if the epidemic is not curtailed, the very institutions that are to foster development will wither – poverty as well as misery will increase. Likewise a strategy of preventive education must also tackle how the key institutions for development can be protected to perform their core functions. Through a holistic approach based on its interdisciplinary experience, UNESCO can play a lead role in these areas.

## **Making a difference – Mobilizing the sectors**

The cost of non-intervention – of not initiating the huge efforts in preventive education needed – can be counted in millions of lives lost, in the destitution of communities and in reversals that will last throughout the whole century.

Hence a renewed effort of preventive education must be a top priority: if done right, it works. If done immediately it will have long-term impacts. If done massively, it can turn the tide. UNESCO can make a difference – by focusing on one theme and mobilizing its experience in the various fields of its competence.

Developing preventive education is a key concern for UNESCO. Content is a vital ingredient of any education programme. More than that: preventive education is imperative for protecting the core functions of the educational system itself so that it can serve learners in and out of school even under the onslaught of the epidemic, and it is essential to ensure that those affected and infected can continue to learn and work with dignity. Consequently, preventive education must be an integral part of education for all and hence is a major concern of the Education Sector.

In its preventive education efforts, UNESCO will work closely with other UNAIDS co-sponsors

### **HIV/AIDS and the Dakar Education Forum 2000**

*At the World Education Forum in Dakar in April 2000, the international community reaffirmed the need to combat HIV/AIDS as a matter of urgency. By affecting the demand, supply and quality of education, it was seen as an immense challenge to the education sector, and as already undermining progress towards the goal of education for all (EFA) by the year 2015, particularly in sub-Saharan Africa. As the lead agency for the Dakar follow-up, UNESCO has made a commitment to putting HIV/AIDS as the highest priority in its follow-up strategies and actions. The Dakar Framework for Action highlights three ways that health interacts with basic education for all: as a condition required for learning; as an outcome for children; and as a sector to collaborate with education in achieving EFA.*

*Two of six inter-agency flagship programmes in the Dakar follow-up focus on HIV/AIDS: AIDS, School and Education, and the FRESH initiative (Focusing Resources on Effective School Health). Young people, especially adolescent girls, face risks and threats that limit learning opportunities and challenge education systems. These include exploitative labour, lack of employment, conflict and violence, drug abuse, school-age pregnancy and HIV/AIDS. Youth-friendly programmes must be made available which provide the information, skills, counselling and services needed to protect them from these risks.*

and mobilize all its sectors. Hence, these efforts will be:

- advised by the Natural Science Sector about what are the latest messages to deliver and about the broader science literacy within which they have to be placed;
- informed by the Social and Human Sciences Sector about the social context within which actions are to be taken and the ethical considerations that must be made;
- sensitized by the Culture Sector about the cultural complexities that must be taken into account in the implementation of policies;
- supported by the Communications and Information Sector to provide effective advocacy, clear awareness and helpful instruction.

HIV/AIDS is a dynamic epidemic – its nature and the human reactions to it change as it proceeds. A strategy to fight the epidemic must therefore be dynamic in its responses – in the messages developed and the methods for transmitting them.

## **Five core tasks**

### **1. *Advocacy at all levels***

The critical factor for a renewed and effective strategy for preventive education is the massive, unflinching and unrelenting advocacy and support of political authorities at the highest national level.

If the epidemic is to be confronted, the message to the people must be valid, it must get across and it must be acted upon. All must be reached – first those most at risk. Indeed, the audience to be addressed is the widest in the history of communication. Yet it can be reached if the messages are cast in culturally appropriate ways and communicated in manners relevant for local mind-sets and motivations. All institutions must be mobilized to become media for renewed efforts in preventive education: ministries, schools, businesses, trade unions, newspapers.

Hence UNESCO will:

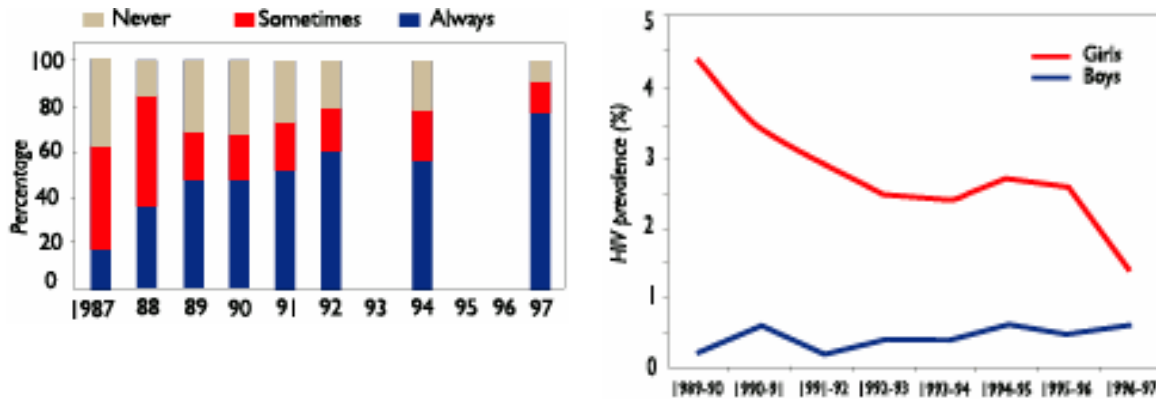
- engage in high-level advocacy for preventive education through effective leadership, mobilization and co-ordination of all sectors and levels of government in the fight against HIV/AIDS;
- engage particularly relevant ministries, agencies and non-governmental organizations, in particular those for education, science, culture, communication and sports;
- engage in advocacy towards non-governmental organizations, civil society and the private sector to muster support and focus energy and resources on preventive education.



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### ***Preventive education works***

Condom use for casual sex in the past six months, HIV prevalence rate among 13 to 19-year-olds, Uganda  
17 to 30-year-olds, Switzerland



Sources: University Institute of Social and Preventive Medicine, Lausanne, Switzerland, 1999; Kamale et al. AIDS 2000.

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## ***2. Customizing the message***

AIDS is the body's loss of capacity to hold a wide range of diseases away or at bay due to the infection of a virus – HIV – that razes the body's own defence systems. Understanding of what an infection is – and how the virus is disseminated – is the precondition for changing the behaviour that causes it.

Many infectious diseases – such as the flu, children's diseases such as measles or mumps – are highly contagious. For some, just proximity to an infected person may be sufficient for contracting them. The spread of HIV, on the other hand, is relatively easy to prevent and it can be prevented by informed and motivated individuals. For most at risk, as long as sex is voluntary, people can on the whole choose not to be infected.

The uneven infection rates worldwide are in no small part due to uneven distribution of knowledge. Where knowledge is brought to bear on practices, risk is reduced. Where knowledge reduces superstition and removes misconceptions it can lessen vulnerability. Knowledge about what to avoid – not to engage in unprotected sex, not to share needles – has contributed to reducing infection rates in developed countries.

However, campaigns that are only negative can lead to stigmatization and discrimination – even to increased hazard. Hence, changing attitudes by preventive education is necessary not only for those directly affected, but for the whole surrounding community so that it can remain inclusive and supportive. Skills are not just a question of avoiding disease, but also of interacting with the infected in a considerate way. Since the disease itself is not highly infectious, everyday interactions are generally safe.

In preventive education the scientific validity of the message is essential. Hence UNESCO, working with its partners in UNAIDS, will:

- stay informed of the latest developments on HIV transmission as well as in its prevention provided by the natural and social sciences;

- base its own recommendations on such updated knowledge, particularly as distilled by UNAIDS co-sponsors and Secretariat, and on other research into cultural and social factors, including its own;
- quickly share such information within its own sectors and with its partners;
- foster inclusive and compassionate attitudes towards the infected and affected based on human rights;
- promote an AIDS research network in preventive education with technology transfer to developing countries, e.g. in co-operation with the World Foundation for AIDS Research and Prevention.

The validity of the message is essential. But what is understood and absorbed depends not only on its scientific soundness, but also on the frame of reference within which it is interpreted. Comprehension and appreciation depends on many social factors, such as age, gender, educational opportunities, economic conditions, religious beliefs, etc. The message must be tailored to the recipients – what kind of understanding they already possess and the physical context and social environment in which they live. It is essential that those who get the message grasp it, act on it and pass it on. Hence UNESCO will:

- actively take part in the development and dissemination of curricula tailored to recipients at different levels of understanding of HIV/AIDS;
- prepare such content by basic science education;
- include and support the development of knowledge, attitudes and skills in health education and other school subjects;
- assess, develop and communicate effective teaching and learning methods as well as materials for preventive education suitable for different levels and types of education;
- improve peer education and reduce peer pressure through formal and non-formal education and by participatory and experiential learning;
- evaluate what messages result in behaviour change in different sub-groups;
- assess, develop and communicate preventive messages and methods for target groups not reached by the ordinary education system and for use in other social institutions;
- improve teaching of life skills inside and outside the ordinary education system, in programmes for adult education and through the media;
- attend to modes of communication that can effectively reach illiterate groups;
- support communication networks that can contribute to this work both regionally and nationally.

### **Preventive education**

*A remarkable fact about the HIV/AIDS epidemic is the difference in infection rates between countries. In most industrialized countries the infection rates have remained fairly stable over the past decade. Several developing countries have also implemented successful HIV programmes. Low infection rates are above all due to effective programmes in preventive education – preventive education works. HIV transmission is affected by many factors, such as personal behaviour, family conditions, position of women, power relations, community norms, poverty, educational attainment, discrimination, availability of treatment and health care – as well as changes in the rates of new infections and related illnesses. For preventive education to be effective, all these factors must be recognized and addressed.*

**The purpose of preventive education is to promote health and prevent disease by providing the knowledge, the attitudes, the skills and the means to foster and sustain behaviour that reduces risk, improves care and lessens the impact of illness.**

*Preventive education is evidence based: building on systematic knowledge of what has worked elsewhere, but also on the unique circumstances of each nation and community. Preventive education, recognizing the interaction between psychological, social, economic and cultural influences on health, is comprehensive and multidisciplinary, bringing together contributions from the natural, social and human sciences to change risk, vulnerability and impact.*

*Preventive education entails general programmes as well as targeted efforts towards groups of high risk – including those of low power and high vulnerability. Concrete plans are attentive to timeliness as well as to the health needs and issues of particular importance in a community. Since public policies may inhibit or promote health interventions, preventive education also includes advocacy directed towards policy-makers and leaders as well as ensuring that data are available when important decisions are to be made.*

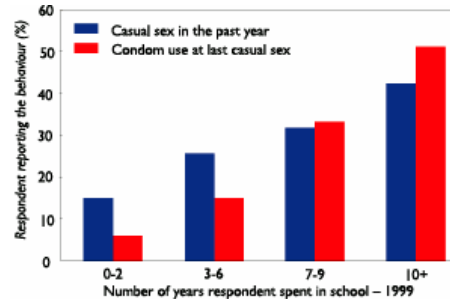
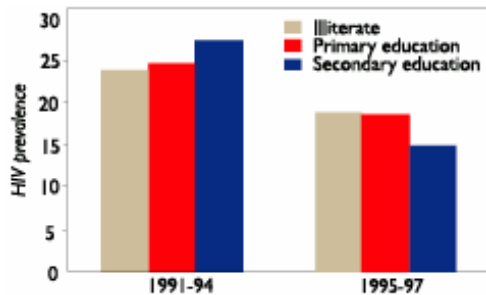
*Preventive education uses all channels that can reach the targeted audience – schools, mass media, informal networks and opinion leaders from different spheres. The communication skills required include the capacity to listen and learn as well as to effectively address sensitive issues.*

*Preventive education has to keep pace with an ever-changing epidemic and hence has to follow interventions and research closely in order to update practice in the field. Learning through trials provides crucial information on effectiveness and hence for how programmes must be modified as well as on how they can be funded, implemented, sustained and refined.*

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### ***Preventive education works***

HIV prevalence is reduced by preventive Condom use increases with education education (Mozambique)



Sources: Killian, A. et al., *AIDS 1999*; Agha, S. et al., *The promotion of safer sex among high-risk individuals in Mozambique, Population Service International, USA, 1999*

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If the knowledge, attitudes and skills transmitted are not culturally adapted, preventive education can be undercut and defied by traditional creeds and customary ways of life. Precepts and practices are embedded in local mores and reinforced by more comprehensive systems of behaviour and thinking. They are also buttressed by norms of propriety, customs of marriage or religious beliefs which may sustain the silence about the epidemic, its causes and consequences. Communities and cultures interact with the epidemic and undergo changes from this interaction. Preventive education must likewise keep pace with the dynamics of the epidemic.

However, preventive education is misguided if it is aimed solely at overcoming traditional barriers and conventional obstacles. For communities and cultures have dynamic elements that can be mobilized for changing behaviours and adapting customs, particularly when faced with a deadly challenge.

If preventive education is to be effective, the specifics of the social and cultural context within which communication takes place must actively be taken into account not just as possible encumbrances but also as potential resources. Hence UNESCO will:

- actively share in the development and communication of educational material and methods that are sensitive to culture as well as potent for practice;
- develop educational material within a broader context of communicable diseases, from tuberculosis and malaria to STD and substance abuse;
- support and take part in the training of curriculum developers, teacher trainers and teachers to adapt and use such material and methods;
- work to overcome teacher discomfort about addressing sexuality issues and mobilize other professions, such as health personnel, to take part in formal and non-formal preventive education programmes;
- contribute to national efforts for building networks among different kinds of community leaders and communicators to use a similar approach;
- mobilize other professions, e.g. in the health sectors, to take part in teaching where cultural barriers present obstacles for traditional modes of teaching.

### 3. *Changing risk behaviour and vulnerability*

The critical factor for an effective strategy on preventive education is the sustained support of political authorities at the highest national level. The critical test is the extent to which the key messages reach the grass roots, particularly the most exposed groups, and change their behaviour. Changing conceptions and attitudes require effective communication – knowing the audience, developing the message and getting it across. Effective communication is needed to translate knowledge into changes in behaviour.

Most children and young people are HIV-free. To curb the epidemic, those not infected must know how it spreads and act on this knowledge, and those infected must learn to become protective of others. The highest priority is the age group between 10 and 25, in which about half of new infections take place. This is also an age group that to a large extent can effectively be reached through schools. But the basis for knowledge, skills and attitudes about what an epidemic is and how infectious diseases spread must start at lower age levels and as part of primary education.

To the extent that they are accessible, schools reach further into communities than any other institution, hence they are critical for reducing the vulnerability and risk among young people.

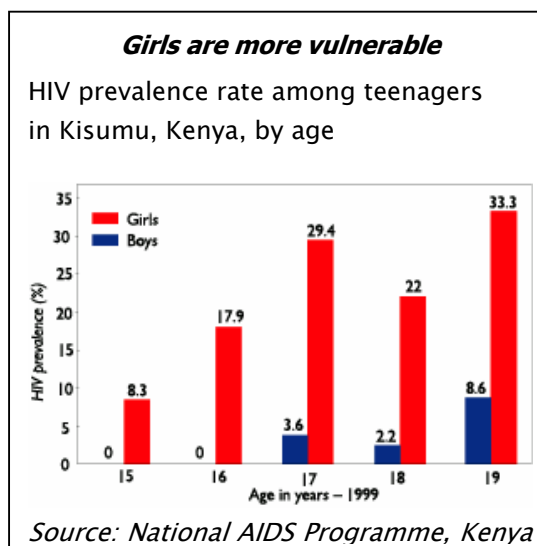
However, in many places schools themselves put children, especially girls, at risk. Hence, for schools the primary Hippocratic rule is valid: 'First do no harm!'

More generally: behaviour can be risky – but groups can be exposed and vulnerable when they have little control over the conditions of their life or can exercise no autonomy over critical choices affecting their welfare. When they are powerless or unprotected, children, women or minorities may be in jeopardy from diseases inflicted by others. In addition to higher biological vulnerability, the social, economic and gender dependency of women increase their exposure to HIV/AIDS. Hence men have to use their positions of power and privilege to exercise responsibility and leadership, not only at the pinnacles of society, but at every level down to its grass roots – to involve themselves and their communities in facing an awesome challenge, including elimination of some untenable habits of men themselves.

Education for all is the prerequisite for effective preventive education for all – one that is cumulative and encompassing.

Hence UNESCO will:

- support programmes for schools that are healthy, child- and adolescent friendly and protective, particularly for girls, and ensure that these concerns are enforced by translating them into laws and regulations;
- promote educational – formal and non-formal – programmes so that all young know the facts about HIV/AIDS and how to prevent it;
- support development of curricula sensitive to gender and culture;
- promote preventive education in all education as part of the provision of education for all, so that children and the young acquire the attitudes, knowledge and skills to protect themselves;



- support programmes to equip pupils with general knowledge of health and diseases from their starting at school as a basis to build on at later grades;
- stress the continuation of preventive education programmes for all types and all levels of education, including universities and adult education;
- develop non-formal and peer education programmes for adolescents and young adults, in particular for girls and women, who do not have access to schools or leave them for social or economic reasons;
- support the activation of local communities to promote a safe environment as well as preventive education;
- promote educational efforts addressing the issues that put women at risk, such as violence and powerlessness, and support education and counselling that equip them better to cope and protect themselves.

Though no institution reaches wider than schools, it is nevertheless a fact that many children are out of school, and more and more drop out with increasing age. In many countries, more than half of the young have left the education system by the time they reach puberty. In many countries, the young also receive faulty or bogus information as gossip or word of mouth from peers.

Hence preventive education is too important to be left to schools alone – schools do not reach all, and they reach fewer in the age groups most at risk. Moreover, schools do not reach other highly exposed groups such as migrant workers, soldiers or sex workers.

This is the key reason why non-formal education – indeed all media – must spread socially targeted and effective messages and skills about communicative diseases. And it is a key reason why all social institutions must become institutions for renewed preventive education – businesses, religious institutions, organizations. It is necessary to distill the best practices from experience and use them in the design of concrete programmes for action.

Hence UNESCO will:

- mobilize its expertise and networks in communication to provide effective preventive messages for targeted audiences;
- convey such messages through different channels, from booklets to radio messages and informal communication;

- assist in the training of journalists to better prepare them for preventive health communication;
- train teachers and health workers to be motivated to protect themselves and their children;
- help mobilize opinion leaders, traditional and modern to serve as prevention educators;
- try out and assess the effectiveness of different modes of communication – from plays to simulations – tailored to different audiences;
- actively promote preventive health information, attitudes and skills through adult and non-formal education;
- co-operate with the private sector in providing effective preventive education through enterprises as well as trade unions and other interested organizations.

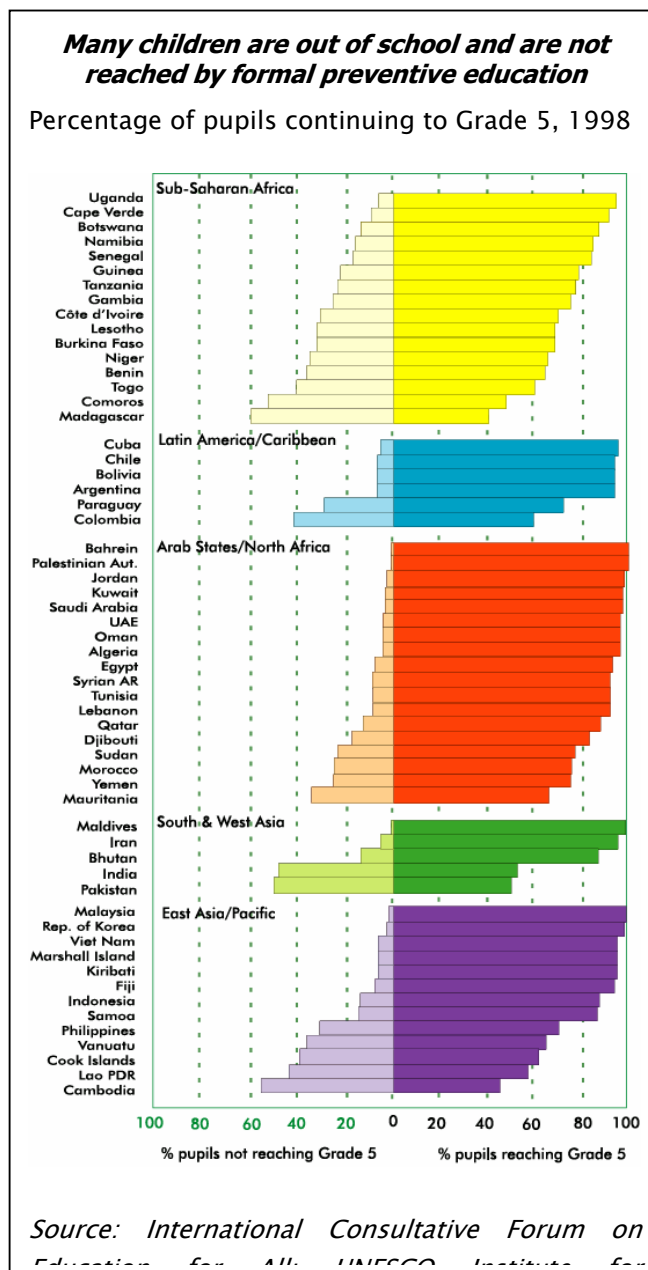
#### 4. ***Caring for the infected and affected***

The Universal Declaration of Human Rights also encompasses health care: ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and the right to security in the event of sickness or disability.’ People can live productively with HIV for many years if they are given treatment, social support and better nutrition. It is important not just to improve and prolong lives through treatments, but also to provide hope and encourage testing since something can be done.

However, the right to health care is far from fulfilled and medical treatment is not truly available in a non-discriminatory manner to all.

A key task for preventive education is to battle complacency, advance commitment and improve care. Successful long-term care for the infected requires full co-operation and open communi-cation, conscientiousness and compassion, on all sides – not just between patients and health personnel, but also among family and friends, colleagues and community.

The knowledge, attitudes and skills to provide care for the affected and infected are therefore a vital part of any programme of preventive education. The infected and affected must be actively engaged and supported in their efforts to address the epidemic in communities around the world. Preventing infection is inseparable from care for them.



The HIV/AIDS epidemic raises ethical issues on a vast scale. Many of these issues concern the actions and interactions of governments – e.g. about international funding of treatments, providing support for the sick, investing in research on vaccines or testing of medication in developing countries. Some of these issues directly concern responses in local communities as well as responses towards the infected or towards relatives, orphans or other affected groups. Yet other issues concern individual choices on behaviour – e.g. on lifestyle and risk behaviour, or on submitting to testing: those who are found infected face personal dilemmas if recognition of one's disease means rejection by one's community.

Such normative and ethical issues must be explicitly addressed if the gap between those who have the knowledge and those who need it is not to widen, or if the gap between personal knowledge and personal behaviour is to be bridged.

At the heart of reflection, discussion and action must be values and human rights, defending the dignity of all and calling on the solidarity of everyone. For the task is no less than to promote prevention, to supply care and to secure support for individuals, communities and indeed whole nations at severe risk – all in one go. Hence UNESCO will:

- support education programmes that ensure that all know the facts about HIV/AIDS so that fear and discrimination do not reduce the availability of care;
- ensure that gender issues are explicitly addressed in formal and non-formal education;
- advocate compassion and care for those infected and affected to reduce trauma and stigma;
- in its preventive education programmes, identify and mobilize social and cultural resources for helping and caring for vulnerable groups;
- support UN efforts to provide affordable treatments to reduce transmission from mother to child, to make for improved and longer lives and better care for those infected;
- assist in the provision of a broad-based approach which includes adequate care for individuals, households and communities;
- support effort to make education provision more flexible so as to better meet the needs of orphans;
- host and actively engage in the debate on the ethics of preventive action, care and research – such as experimental treatments for groups in the Third World;
- translate ethical principles into Codes of Practice for relevant sectors – i.e. education, science, culture and communication – on issues ranging from behaviour towards the infected, to the care for orphans, sexual harassment, or rights and responsibilities of teachers with HIV/AIDS;
- identify and communicate effective community strategies for helping vulnerable groups, particularly orphans, girls and out-of-school groups to access preventive education;
- share information on best practices;

#### **Why prevention programmes fail:**

*Preventive education programmes have had great successes – but also notable failures:*

- *the audience is elsewhere – e.g. children having dropped out of school;*
- *focus on knowledge, attitudes and skills not embedded in a broader, consistent and sustained programme;*
- *poor implementation of otherwise good programmes – e.g. by lack of commitment, unease of teachers, mixed messages, no access to related health services, etc.;*
- *fear – unjustified – that preventive education leads to increased sexual activity;*
- *fragile education systems – overcrowding, unsafe schools, poor classroom facilities and teaching materials, irregular salaries and teacher attendance, etc.;*
- *the availability of treatments can lead some to more risky behaviours.*



- increase attention to linking preventive education to treatment and care;
- provide information to increase awareness and reduce stigma in the general public.

### **5. *Coping with the impact***

The HIV/AIDS epidemic will have a greater impact on the size of the population of several developing countries than the Second World War had on any society. The increased demand for care stretches already overburdened health and education systems. With infection rates reaching a third of the population – and as many as half of the young in some countries – no institution will remain untouched: health services, educational institutions, public administration – all will be undermined and may become demoralized. Governance itself may be threatened and could become destabilized by the enormous loss of personnel and capacity.

When the health of a society – indeed in some cases its very survival – is at stake, it is no longer an issue just for ministers of health or the medical community. It is an emergency that in each country must be met by mobilization from the highest level of government and from all ministries – particularly ministries of finance, health and education. For any minister of finance, the infection rate is therefore more important than the interest rate. The epidemic will erode the basis for taxation and deplete funds for development. The more that has to be spent to cope with AIDS, the less is left for everything else.

A strategy for preventive education, therefore, cannot address the epidemic just as a health issue or as a medical emergency. A critical task will be to protect the core functions of the key social, economic and political institutions under the onslaught of HIV/AIDS – i.e. those that supply treatment, secure care, provide education, run the government – indeed also the institutions in the private sector that offer work, goods and services. For example, it is imperative to continue to provide schooling that will enable children to shape their own future by means of knowledge and skills. What is lost in education now, will hurt the developing countries for the rest of this new century.

Hence UNESCO will:

- develop and disseminate tools for monitoring and assessing the impact of the epidemic on students, schools, teachers, educational and other related institutions amongst others, through its Institute of Statistics (UIS) and the International Institute for Educational Planning (IIEP);
- share best practices and disseminate them widely, through a clearing house on curriculum-oriented issues by the International Bureau of Education (IBE); and through a clearing house on education sector impacts of and responses to the epidemic by the International Institute for Educational Planning (IIEP);
- analyze the impacts and implications of HIV/AIDS on the organization of education, both formal and non-formal, and review different modes of financing;
- develop materials, courses and provide training for planners, administrators and managers of key institutions, such as schools, universities and ministries;
- increase the capacity of countries to research, monitor and evaluate progress in preventive education;
- train planners and managers to assess and address the impact of HIV/AIDS on education systems and other vital social institutions;
- integrate better HIV/AIDS preventive education into other social and health programmes – particularly poverty programmes.

## **The institutional impact on education of AIDS**

*The World Forum on Education for All adopted a Framework for Action. It stated that the last decade had shown that the pandemic has had, and will increasingly have, a devastating effect on education systems, teachers and learners, with a particularly adverse impact on girls. Stigma and poverty brought about by HIV/AIDS are creating new social castes of children excluded from education, and adults with reduced livelihood opportunities. A rights-based response to HIV/AIDS mitigation as well as monitoring of the pandemic's impact on EFA goals are therefore essential. This response should include appropriate legislation and administrative actions to ensure the right of HIV/AIDS-affected people to education and to combat discrimination within the education sector.*

*Education systems in many countries must go through significant changes if they are to survive the impact of HIV/AIDS and counter its spread, especially in response to the impact on teacher supply and student demand. To achieve EFA goals will necessitate putting HIV/AIDS as the highest priority in the most affected countries, with strong, sustained political commitment; mainstreaming HIV/AIDS perspectives in all aspects of policy; redesigning teacher training and curricula; and significantly enhancing resources for these efforts.*

*Educational institutions and structures should create a safe and supportive environment for children and young people in a world with HIV/AIDS, and strengthen their protection from sexual abuse and other forms of exploitation. Flexible non-formal approaches should be adopted to reach children and adults infected and affected by HIV/AIDS, with particular attention to AIDS orphans. Curricula based on life-skills approaches should include all aspects of HIV/AIDS care and prevention. Parents and communities should also benefit from HIV/AIDS-related*

*programmes. Teachers must be adequately trained both in-service and pre-service in providing HIV/AIDS education, and teachers affected by the pandemic should be supported at all levels.*

*What the Dakar Framework said about educational institutions is to a large extent valid as a description of other sectors as well.*

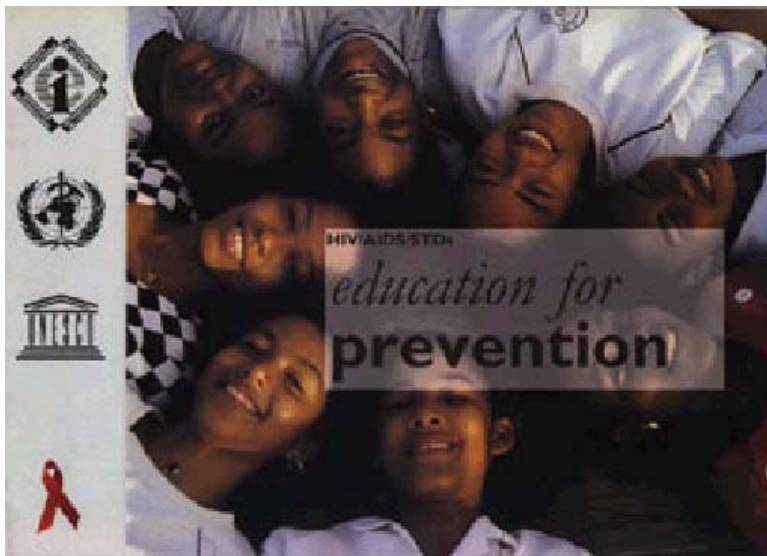
## **Modes of operation: working in partnership**

*UNESCO will work to ensure that preventive education is included as a key focus in international agendas on HIV/AIDS issues. The strategy on preventive education will be the primary part of UNESCO's contribution to the United Nations Strategic Plan for HIV/AIDS for 2001-2005.*

Co-ordination at the level of planning as well as implementation is crucial for success against HIV/AIDS, both at the national level and internationally. At a time when the number of actors as well as available resources are increasing, co-ordination becomes even more imperative to focus efforts and avoid duplication.

Hence UNESCO will collaborate closely with UNAIDS and its co-sponsors in the UN system. In addition, it will:

- reinforce its partnership with G8 countries to mobilize financial resources;
- address the needs of the regions hardest hit, such as southern Africa and South-East Asia;
- work in close co-operation with national authorities in Member States as well as
- with other organizations, national and international;
- enhance co-operation with and support for regional initiatives such as the Southern African Development Community (SADC) HIV/AIDS Strategic Framework and Programme for Action, the Association for the Development of Education in Africa (ADEA), and the Economic Community of West African States (ECOWAS);
- as the lead agency in the follow-up of the Dakar Framework for Action on Education for All, prioritize HIV/AIDS particularly within the UNAIDS/UNICEF-led Working Group on AIDS, Schools and Education;
- work closely with NGOs, such as the Education International and the World Foundation for AIDS Research and Prevention, in strengthening the responses of communities to the challenge;
- give high priority to gender issues and women's empowerment and work closely with UNIFEM on this issue;
- closely involve UNESCO's Institutes, Regional Education Offices, Cluster Offices and National Offices in the implementation of preventive education.



## Expected results

*The key outcome hoped for is reduction of the number of HIV/AIDS-infected young people by 25% by 2010 – but in different ways all groups must be reached. The expected results of preventive education are to be found in effective advocacy, customized educational material, changed risk behaviour, enhanced care and better coping with the impact of the epidemic.*

- Commitment at the highest level of government and strong political support for prevention programmes.
- Well co-ordinated international efforts and stronger links between the different UN agencies.
- Policies, legislation, programmes and funds to enable the young, as well as teachers and managers, both in education and in the community at large, to protect themselves against the epidemic and play an active role in prevention, care and amelioration.
- New policy guidelines for preventive education to be disseminated and implemented in Member States and other organizations.
- Incorporation of effective measures for preventive education in the plans to be developed in connection with Education for All.
- Integration of results from the natural and social sciences in the messages to be formulated and transmitting them in ways that combine cultural sensitivity with effective communication.
- Interdisciplinary guidelines on methods and means for designing and delivering effective preventive education for behaviour change by appropriate knowledge, skills, and attitudes disseminated to Member States.
- Schools with effective preventive programmes in place.
- Empowerment of vulnerable groups, particularly the young, women, minorities and migrants.
- Effective programmes for reaching the young and adults out of schools, by means of public information.
- Stronger links between educational institutions and community programmes to promote prevention among families and children.
- Procedures for evaluating programme impacts and learning from such evaluations.
- Trained national and local decision-makers, managers and planners, particularly personnel in education, health care and communication. These can play a key role in prevention not just to provide effective programmes, but also to cope with the institutional impacts of the epidemic.

- Capacity at the national level to research, monitor and evaluate interventions and progress in preventive education.
- Establishment of two clearing houses, one for curriculum and one for the impact of HIV/AIDS on education and responses to these impacts.
- Networks for information exchange and policy assessment.
- Co-operative projects across the boundaries of Members States and regions.