BMZ Federal Ministry for Economic Cooperation and Development

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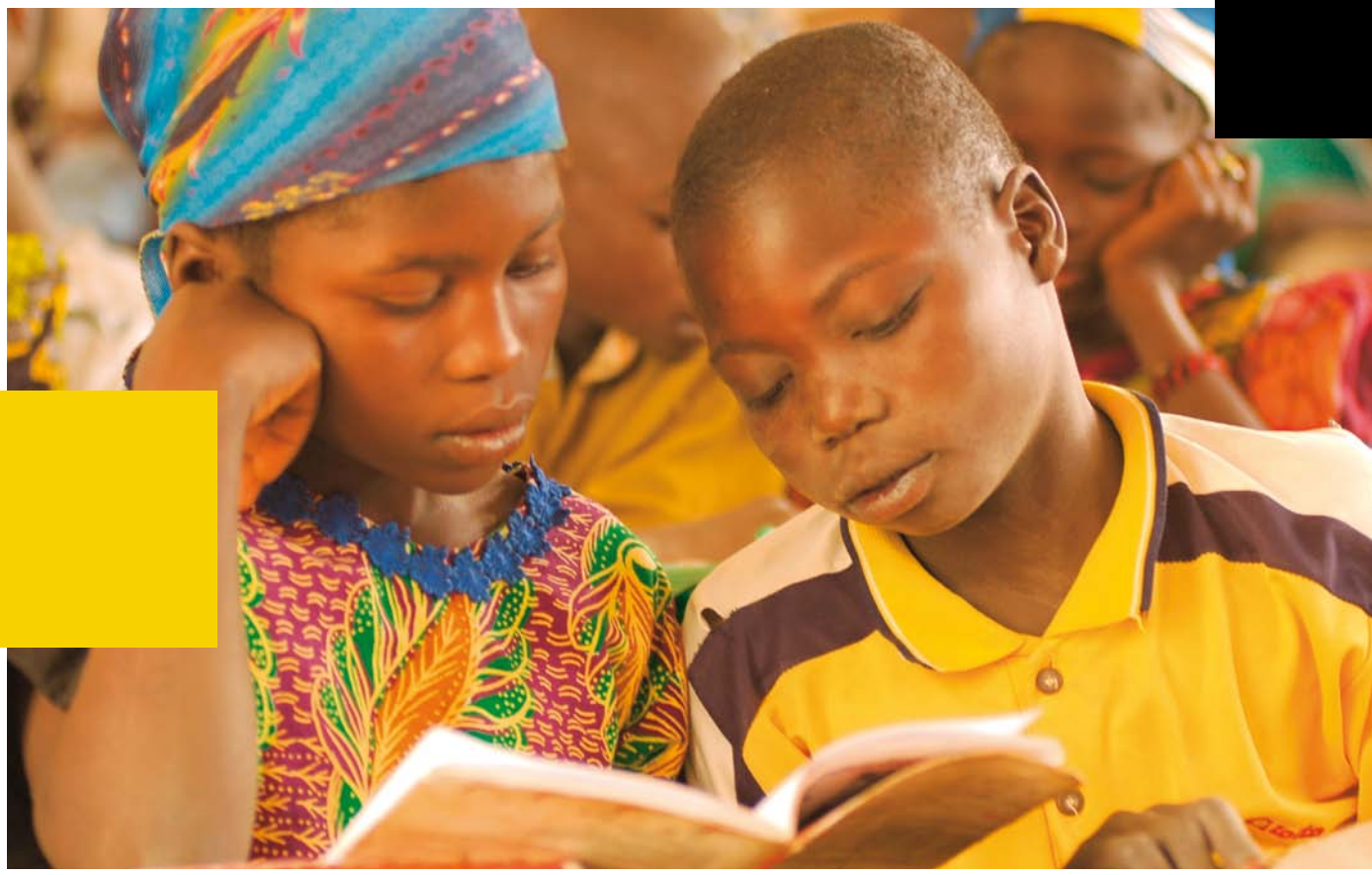
Addressing sexual health and HIV in school

A publication in the German Health Practice Collection



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Acronyms and Abbreviations

BMZ	Germany's Federal Ministry for Economic Cooperation and Development
EFA	Education for All initiative
FGM	Female Genital Mutilation
FIERE	Educated Girls Succeed (Filles éduquées réussissent)
GDC	German Development Cooperation (includes BMZ, GIZ and KfW)
GHPC	German Health Practice Collection
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit*
GTZ	German Technical Cooperation (now GIZ)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
KAPB	Knowledge, Attitude, Practices, Behaviours (surveys)
KfW	KfW Entwicklungsbank Bank (KfW Development Bank)
MDG	Millennium Development Goals
NGO	Non-Governmental Organisation
PAPEBMGUI	Project to Support Basic Education in Central Guinea (Projet d'appui à l'éducation de base en moyenne Guinée)
PASHA	Prevention and Awareness at Schools of HIV/AIDS
STI	Sexually transmitted infection
TGPSH	Tanzanian-German Programme to Support Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing

* The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH was formed on 1 January 2011. It brings together the long-standing expertise of the Deutscher Entwicklungsdienst (DED) gGmbH (German development service), the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German technical cooperation) and InWEnt – Capacity Building International, Germany. For further information, go to www.giz.de.

Addressing sexual health and HIV in school

Four initiatives from Sub-Saharan Africa and Latin America

Acknowledgements

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German Health Practice Collection

Objective

In 2004, experts working for German Development Cooperation (GDC)[1] and its international and country-level partners around the world launched the German HIV Practice Collection and, in 2010, expanded it into the German Health Practice Collection (GPHC). From the start, the objective has been to share good practices and lessons learnt from BMZ-supported initiatives in health and social protection. The process of defining good practice, documenting it and learning from its peer review is as important as the resulting publications.

Process

Managers of GDC-supported initiatives propose promising ones to the Managing Editor of the GHPC at ghpc@giz.de. An editorial board of health experts representing GDC organizations at their head offices and in partner countries select those they deem most worthy of write-up for publication. Professional writers then visit selected programme or project sites and work closely with the national, local and GDC partners primarily responsible for developing and implementing the programmes or projects.

Independent, international peer-reviewers with relevant expertise then assess whether the documented approach represents 'good or promising practice', based on eight criteria:

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

Only approaches meeting most of the criteria are approved for publication.

Publications

All publications in the GHPC describe approaches in enough detail to allow for their replication or adaptation in different contexts. Written in plain language, they aim to appeal to a wide range of readers and not only specialists. They direct readers to more detailed and technical resources, including tools for practitioners. Available in full long versions and summarized short versions, they can be read online, downloaded or ordered in hard copy.

Get involved

Do you know of promising practices? If so, we are always keen to hear from colleagues who are responding to challenges in the fields of health and social protection. You can go to our website to find, rate and comment on all of our existing publications, and also to learn about future publications now being proposed or in process of write-up and peer review. Our website can be found at www.german-practice-collection.org. For more information, please contact the Managing Editor at ghpc@giz.de.

[1] GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organizations: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and KfW Entwicklungsbank. GIZ was formed on 1 January 2011. It brings together the long-standing expertise of DED, GTZ and InWEnt. For further information, go to www.giz.de.

Executive Summary

This publication describes three German-supported initiatives in Africa (specifically in Guinea, Mozambique and Tanzania) and one in Latin America (a six-country regional initiative). All integrate sexual health and HIV prevention within school systems. The three African initiatives operate within generalized epidemics driven largely by unprotected sex between men and women. In Latin America general prevalence in the countries described here is well below one percent, and much less among young people. Sex between men and, to a lesser extent, injecting drug use and sex work, play key roles in concentrated epidemics.

Important sexual health issues in both regions include early sexual debut, low access to information and services (notably inexpensive condoms), and high levels of unplanned pregnancy. In Sub-Saharan Africa, birth rates among girls aged 15-19 in rural areas are almost double those in urban areas. Girls with a secondary education are the least likely to become mothers, while among uneducated girls the birth rate is over four times higher.

Guinea's PAPEBMGUI

The Basic Education Support Project (Projet d'appui à l'éducation de base en moyenne Guinée – PAPEBMGUI) applies a "twin-track approach" (*approche binaire*) that focuses on both young people and their parents. Under PAPEBMGUI, teachers are trained to provide sexuality education in the upper grades of primary school, while in parallel, staff and peer educators were trained to work in existing Young People's Counselling and Advisory Centres.

The programme includes a special focus on girls. Under PAPEBMGUI, 5th and 6th grade girls experiencing difficult situations (family problems, failing at school) receive support classes through a German-supported regional programme called FIERE (*Filles éduquées réussissent* – Educated Girls Succeed). Its goal is to increase the number of girls in school, and to keep them there and help them succeed.

Mozambique's Pacote Basico

In 2003, Mozambique's Ministry of Education for its Programme for Basic and Technical Education and Vocational Training, with German technical assistance, began to develop its Basic Package of Life Skills for Primary Education (known as the *Pacote Basico*), its first HIV-prevention tool aimed at children attending primary schools.

Instructors are trained at provincial and district levels on how to apply the Pacote Basico. School directors and approximately 25% of teachers in each school then receive the training, and they are expected to pass their knowledge on to the rest of the teaching staff. As part of the Pacote Basico, schools receive a variety of learning materials that deal with HIV, sexually transmitted infections, sexuality and life skills.

The Pacote Basico is currently implemented in six of the country's 11 provinces. Between 2009 and 2011, the percentage of teachers in participating provinces who regularly integrate HIV and AIDS modules into their lessons rose from 7% to 35%.

Tanzania's PASHA

The Tanzanian-German Programme to Support Health has supported the Ministry of Education and Vocational Training in implementing the project Prevention and Awareness at Schools of HIV/AIDS (PASHA), with technical support by the Swiss Centre for International Health. The programme concentrates on Grades 5 to 7, with hour-long sessions run

twice a week by peer educators. School counsellors do not attend sessions but assist in planning them, and counsel students when necessary. All sessions take place after school. Peer educators are elected by fellow students and trained to take control of the programme, with counsellors only playing a supportive role.

A 2009 study of 22 participating schools indicated a marked and continued decline of teenage pregnancies from 41 in 2006 to 12 in 2009.

Latin America's Harmonization Initiative

In 2007 six countries – Argentina, Brazil, Chile, Paraguay, Peru and Uruguay – joined in a South-South cooperation initiative called "Harmonization of Public Policies on Sexual Education and HIV/AIDS Prevention in Schools in the MERCOSUL" (MERCOSUL is the Latin American common market). The initiative aims to (a) strengthen sexuality education programmes and HIV prevention in schools, and (b) harmonize public policies and strengthen linkages between health and education sectors.

Each country established a multi-sectoral management committee for sexuality education, including the Ministry of Health, Ministry of Education, and civil society organizations. National policies and national work plans were formulated and implemented, while progress was coordinated regionally through regular regional workshops. Since 2011, a regional network or "Community of practice" has been developed called CoPSexEd, to facilitate the continued technical exchange between countries.

Between 2007 and 2011, sexuality education has reached an estimated 83,000 teachers and 1,500,000 pupils in the participating countries.

A number of innovative practices have been shared through the network, such as Uruguay's "concept maps" of sexuality education, Brazil's approach to the design, planning, management and evaluation of sexuality education programs, mobile schools in Argentina, and community workshops in Chile.

The four initiatives have all built up considerable experience about design and implementation. In line with their experience, they prioritize the following strategies:

- Improve quality of teaching: all the initiatives aim to improve the professional skills and knowledge of teachers, and the capacity of schools as learning institutions.
- Target intentions and behaviour, not just information: Knowing about risk is not enough. Vulnerable young people need new attitudes and specific life skills in order to avoid these risks.
- Include a special focus on girls: initiatives should include measures to help girls stay in school, avoid unwanted pregnancies and sexually transmitted infections, and improve their security and social status.
- Target the social environment of young people: initiatives should involve not only the young people themselves, but also address the conditions they live in.
- Differentiate between priority groups: surveys and other research are vital to identify the needs of different population groups and their levels of knowledge about sexual health and HIV.
- Produce specific tools for each priority group: a variety of media should be used, addressing both in-school and off-school settings.
- Encourage regional and South-South collaboration: Regional cooperation can help share progress made on technical, policy and strategic levels.

Why school-based sexual health and HIV education matters

A variety of factors – social and cultural factors (taboos, traditions, mistaken beliefs), high prevalence of unprotected sex, insufficient information on sexual and reproductive health, lack of effective prevention programming – make young people one of the population groups most exposed to HIV infection, as well as to unwanted pregnancies and sexually transmitted infections. But young people are also the "life force" and the future of their country. Young people need education and information that is adapted to their age, culture, and areas of interest. Equally important, they need people and structures able to support them, advise them, and give them adequate backing. Schools are the best and often the only place to reach the majority of young people prior to the start of sexual activity, and provide them with programming that can help them understand and avoid risky behaviours (WHO, 2003; World Bank, 2002).

This publication describes the approaches of four German-supported initiatives in Africa (specifically in Guinea, Mozambique and Tanzania) and Latin America (a regional initiative that includes Argentina, Brazil, Chile, Paraguay, Peru and Uruguay). The contexts in which each initiative has been implemented are different in each country, yet there are also a number of similarities that should be understood before examining the initiatives in more detail.

Note: the term "young people" is used in this publication as a compromise. In the 1990s, there was an attempt to fix some definitions, with the term "adolescent" used for age 10 – 19 years, "youth" for age 15 – 24, and "young people" for 10 – 24. (WHO, 1989), but these are not used consistently, even by the various United Nations agencies. The UN Convention on the Rights of the Child defines a child as "any human being below the age of 18" (CRC Article 1), while the term "teenager" refers to those aged 13 – 19. Since the different initiatives described in this publication address a wide age range, the term "young people" has been adopted.

HIV prevalence and vulnerability among young people

Current epidemiological data (see Tables 1 and 2) show a considerable proportion of young people are vulnerable to sexually transmitted infections, including HIV. This is especially true of uneducated young people. In many developing countries, girls have less schooling than boys and are less well informed, putting them at high risk of early marriages, sexual violence, and pressure to engage in risky sexual behaviours (particularly transactional sex) in order to escape extreme poverty. In parts of Sub-Saharan Africa, there are additional sexual health hazards such as genital mutilation (FGM).

The three African initiatives described in this report operate in conditions which are similar in causation though very different in scale. Their generalized epidemics are in large part driven by unprotected sex between men and women, although other factors also play a role (UNAIDS, 2010).

- In Guinea, HIV prevalence in the general population is estimated to be 1.3%, while among young people aged 15 – 24, prevalence is 0.9% among females and 0.4% among males.
- In Mozambique, the general prevalence is 11.5%, 8.6% among young females and 3.1% among young males.
- In Tanzania, the general prevalence is 5.5%, 3.9% among young females, and 1.7% among young males.

The huge efforts to fight HIV over the past decades have begun to bear fruit in declining incidences of infection and reduced levels of AIDS-related death. However, Sub-Saharan Africa still represents 68% of the global HIV burden, with over 20 million people living with the disease. Women are disproportionately affected by the virus, with recent prevalence

data suggesting that about 13 women in Sub-Saharan Africa become infected for every ten men.

It is important to stress that the most heartening advances have been made by young people. UNAIDS' most recent global report noted that five countries in the region – Botswana, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe – all registered a significant decline in HIV prevalence among young women or men (aged 15–25), and that this decline was associated with changes in risk behaviour factors such as sexual debut, non-use of condoms, and multiple partners (UNAIDS, 2010).

Table 1. Key indicators on HIV, sexual behaviour and education in three African countries (percentages)

Indicator	Guinea	Mozambique	Tanzania
HIV prevalence in the general population (aged 15–49)	1.3	11.5	5.5
HIV prevalence among females aged 15–24	0.9	8.6	3.9
HIV prevalence among males aged 15–24	0.4	3.1	1.7
Females aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	20	36	39
Males aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	23	34	42
Females aged 15–24 who have had sexual intercourse before the age of 15	29	25	11
Males aged 15–24 who have had sexual intercourse before the age of 15	25	25	10
Unmarried females aged 15–19 who had sex in the last 12 months	28	57	37
Unmarried males aged 15–19 who had sex in the last 12 months	50	67	56
Females aged 15–19 giving birth in one year*	14	13	13
Primary school completion rates (females 15–24)**	47	51	102
Primary school completion rates (males 15–24)**	62	63	

Source: UNAIDS, 2010, *Population Reference Bureau, 2011 **World Bank, 2011. Note that some percentages are over 100% due to census estimates based on old data.

The situation in Latin America is different (see Table 2). About two million people are HIV-positive, with prevalence rates generally registering at less than half a percent. However, in all countries there are concentrated epidemics in which sex between men and, to a lesser extent, injecting drug use and sex work play key roles. Unsafe sex among men who have sex with men is widespread in Latin America, and HIV prevalence rates of between 9% and 20% have been detected among men who have sex with men in at least 12 capital cities across the region. As in Africa, incidence and AIDS-related deaths are declining due to successful interventions (UNAIDS, 2010).

Table 2. Key indicators on HIV, sexual behaviour and education in 6 Latin American countries (percentages)

Indicator	Argentina	Brazil	Chile	Paraguay	Peru	Uruguay
HIV prevalence in the general population (aged 15–49)	0.5	0.3–0.6	0.4	0.3	0.3	0.5
HIV prevalence among females aged 15–24	0.2	0.1–0.4	0.1	0.1	0.1	0.2
HIV prevalence among males aged 15–24	0.3	0.1–0.3	0.2	0.2	0.2	0.3
Females aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	90 (both sexes)	50	85	–	20	44
Males aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		53	78		28	23
Females aged 15–24 who have had sexual intercourse before the age of 15	19 (both sexes)	29	8	–	7	30
Males aged 15–24 who have had sexual intercourse before the age of 15		49	13		12	44
Unmarried females aged 15–19 who had sex in the last 12 months	–	22	–	34	13	–
Unmarried males aged 15–19 who had sex in the last 12 months		63				
Females aged 15–19 giving birth in one year*	5	7	6	7	5	6
Primary school completion rates (females 15–24)**	104	111	88	95	101	108
Primary school completion rates (males 15–24)**	100	110	101	93	101	104

Source: UNAIDS, 2010, *Population Reference Bureau, 2011 **World Bank, 2011. Note that some percentages are over 100% due to census estimates based on old data

Teenage pregnancy

Around the world, the "adolescent birth rate" (number of births per thousand females aged 15 to 19) decreased in the decade between 1990 and 2000. Since then, however, progress has slowed in many regions, and some have even seen increases in teenage pregnancy. The highest birth rate among teenagers is found in sub-Saharan Africa, where the situation has not changed greatly since 1990: the adolescent birth rate was 124 in 1990, and 121 in 2010. Although greater progress has been made in Latin America as a region in the same period (from 91 to 74 births per thousand), the 2010 birth rate is still the second highest in the world (United Nations, 2010).

A study of 24 countries in sub-Saharan Africa showed that adolescents in the poorest households are three times more likely than those from wealthier households to become pregnant and have a baby. Adolescent birth rates in rural areas are almost double those in urban areas, but the most striking differences are associated with education: girls with a secondary education are the least likely to become mothers, while among girls with no education the rate is over four times higher. A 2010 report on the Millennium Goals commented that the widening of disparities over time was of great concern: "The adolescent birth rate declined in 18 of the 24 sub-Saharan countries studied. However, in almost all these 18 countries the decline was largest among adolescents living in urban areas, among those with at least a secondary education, and among those belonging to the richest 20 per cent of households. Thus, disparities between those groups and rural, less educated and poorer adolescents have increased, rather than decreased, over time" (United Nations, 2010).

A part of these pregnancies are unplanned and unwanted. Teenage girls generally face much greater problems than adult women in accessing information and reproductive health services, including family planning services. In urban areas, the time period between sexual debut and marriage has increased so that a rising proportion of young people are experiencing their first sex before marriage. Often, young girls engage in sexual relationships with older men who are wealthier and seek young girls as sexual partners, also because they are deeming them less likely to be HIV-positive and less able to insist on condom use.

In case of an unwanted pregnancy unmarried adolescents often try to get an abortion service and this often happens clandestine under health threatening conditions. Abortion related death is still the main cause of death for female adolescents in most of these countries.

Education: the "social vaccine"

School enrolment, especially of girls, has risen significantly since the late 1980s in many parts of the world, notably Western and Central Africa, the Middle East, and South Asia. While boys' school attendance has risen from 79 to 89 percent in this time period, the rise in girls' attendance is even more striking, from 61 to 82 percent (Lloyd, 2007). This represents an unprecedented opportunity for school-based sexuality education and HIV prevention in schools.

Education is often called a "social vaccine." It is estimated that even without further HIV prevention programming, achieving the goal of Education for All (EFA) would prevent more than 700,000 infections per year – about 30% of all infections in this age group (Oxfam, 2004). Education for all – especially secondary education – would prevent a great deal of unwanted teenage pregnancies, as well as many abortions.

School systems are a powerful platform for information on sexual health and HIV prevention because they reach a large number of young people on a regular basis (WHO, 2003). In the words of a recent

UNESCO report on sexuality education in different countries, "While there are no programmes that can eliminate the risk of HIV and other sexually transmitted infections (STIs), unintended pregnancy, and coercive or abusive sexual activity, properly designed and implemented programmes can reduce some of these risks" (UNESCO, 2010).

Using the school system for sexual health and prevention of sexually transmitted infections and HIV has been tried in many different ways all over the world, with considerable documentation and analysis of different approaches. In broad terms, these focus on different aspects of "actors" and curriculum. Actors may include adults (e.g. teachers, parents, other staff employed in the schools like social workers, and people from outside school such as medical personal or NGO representatives) and young people (e.g. trained peers from within the school or from the outside). Within school curricula, sexuality education and HIV prevention are often integrated within biology and civic education. There are also extracurricular approaches, organized in the school premises but outside of school hours.

Years of research on different curriculum-based HIV and sexuality education approaches in both developing and industrialized countries provides evidence that these approaches do not increase sexual activity (a common concern of parents and educators) and that most showed positive effects on relevant knowledge, awareness of risk, and on values and attitudes. There is also evidence that sexuality education begun before young people are sexually active helps them to postpone first sex and to use protection when they become active (Kirby et al., 2005).

Research on peer education faces the difficulty that peer education rarely is a "stand-alone" intervention, as it is normally part of a number of activities, so it is difficult to evaluate how effective it is (WHO, 2006).

Nonetheless, peer education has the potential to influence knowledge, attitude and behaviour and to reinforce skills and self-confidence (Kirby et al, 2005). In a school context it needs continuous training of new cohorts of peer educators, which can make the approach difficult to sustain over a longer period.

Basic challenges

Although there is now a wealth of experience with school-based sexual health and HIV prevention programming, attempts to introduce it into school curricula may encounter numerous obstacles (UNAIDS Inter-Agency Task Team on Education, 2009; UNAIDS, 2010).

Insufficient consideration of sexual and reproductive health and HIV in education sector strategies:

- Many education sector programmes do not take avoidance of pregnancy and prevention of STIs and HIV sufficiently into consideration.
- Programmes are mostly offered to students in secondary school, whereas students in primary school benefit very little. In many developing countries, only a minority of students continue to secondary level, and the majority leave school without any sound information on sexual health.

Shortcomings or challenges in the educational environment:

- Teachers are usually not trained for teaching these subjects, nor are they used to participatory methods.
- Schools put a lot of emphasis on examinations, and since sexual and reproductive health is rarely assessed in formal exams, it is not a high priority.
- Teachers feel uncomfortable discussing sexual matters with their students. In addition, they are often asked to pass on knowledge concerning subjects for which they have had no training.
- Teaching materials are insufficient and unappealing to a young audience (theory overload, too dry,

not adapted to the areas of interest of young people).
- There are few advisory or counselling structures attached to the school, and these are often unable to guarantee confidentiality.
- Particularly in Sub-Saharan Africa, significant numbers of students in the last two classes of primary school are 15 to 16 years old, having repeated school years a number of times (Lloyd, 2007). Some will be sexually active, but do not benefit from the HIV and sexual health programming that their peers in secondary school receive.
- In high-prevalence countries, schools are challenged by the presence of seropositive and orphaned students from families affected by HIV and AIDS. Teaching staff and administrators lack skills and policy advice to integrate these students, fight discrimination, provide psychological support, and make referrals to medical or counselling structures if needed.

Social and cultural conditions make communication about sex and related issues difficult:
- "Burying one's head in the sand" and stigmatisation continue to be all-too-widespread attitudes towards HIV.
- Parents and their children experience difficulties in communicating, particularly concerning sexuality in young people, because this subject remains socially and culturally taboo.

The way ahead: meeting Millennium Development Goals

In the four initiatives examined in this publication, the integration of HIV prevention activities into the education sector reflect an evolution seen in all countries, both industrialised and developing. While in the 1980s and 1990s the first HIV prevention efforts focused on health-centred approaches, experience has shown that all non-health aspects – social, cultural, religious, individual responsibility, gender – are now commonly taken into account (UNAIDS Inter-Agency Task Team on Education, 2009).

All four initiatives work towards achieving the Millennium Development Goals (MDG), particularly the goals of promoting education, empowering women and girls, reducing maternal mortality and combating HIV and AIDS.

Young people taking responsibility

Leading the prevention revolution: participants at workshop of the Caribbean HIV/AIDS Youth Network (CHAYN) in Dominican Republic, 2006.

In a recent speech Michel Sidibé, Executive Director of UNAIDS, praised young people around the world for taking up leadership of what he called "the prevention revolution." He commented, "They have reduced their new infection rates by almost 25% in the most affected countries. That happened because we changed our approach. We do not deal with young people as passive beneficiaries of programmes anymore. We deal with them as actors of change. We equip them with the skills and knowledge to be able to negotiate their sexuality in a responsible manner."

– Michel Sidibé, "Defining a road map to zero", Speech to International Forum on MDG-6, Moscow, 10 October 2011

Addressing HIV and sexual health in school: Four initiatives

In their various ways, the initiatives described here have all engaged with the need to include sexual and reproductive health and HIV prevention in their activities for young people, both in primary and secondary school. All recognized the need to combine work at national level to develop policies, frameworks, curricula and detailed plans for implementation. They took into account the fact that in order to reach as many young people as possible, particularly in contexts where school enrolment rates are low, it was essential to design programmes targeting both formal and informal education. They also reflected the need to address parents and communities as well as young people and their teachers and school administrations.

Guinea's PAPEBMGUI

The Basic Education Support Project (Projet d'appui à l'éducation de base en moyenne Guinée – PAPEBMGUI) began in 1996, aiming to improve teaching quality and school administration in the regions of Labé, Mamou and Faranah. While school enrolment figures in the country have clearly risen in recent years – including among girls, who are particularly disadvantaged – there are still not enough qualified teachers.

In 2006, PAPEBMGUI was enlisted in the country's national AIDS response. In broad terms, a "twin-track approach" (*approche binaire*) has been adopted, targeting young people in and out of school and their parents. New activities were introduced under PAPEBMGUI to train teachers to provide sexuality education in the upper grades of primary school, while in parallel, staff and peer educators were trained to work in existing Young People's Counselling and Advisory Centres. These activities worked in cooperation with other German-Guinean programmes, namely the GTZ-supported "Health and AIDS Control programme" and the KfW-supported "Cross-sectoral AIDS" project.

Peer education is an important part of the programme, and has been well received by those who have participated. Numerous documented testimonials from peer educators confirm that they felt empowered by the training they received through PAPEBMGUI. They were enthusiastic about the skills it gave them, the role they presently fill within their local community, and the self-confidence they now have in discussing HIV and responsible sexual behaviour not only with their peers, but also with other members of the community. They are eager to learn more so they can better assist others.

PAPEBMGUI involves mothers in their daughter's sexuality education, though this isn't always easy. "I give my daughter advice so she won't get pregnant or catch HIV. But my neighbour thinks I'm encouraging immorality," says a mother in Labé province.

PAPEBMGUI includes a special focus on girls. Under PAPEBMGUI, girls in their 5th and 6th year of school who are experiencing difficult situations (family problems, failing at school) receive support classes through a German-supported regional programme called FIERE (*Filles éduquées réussissent* – Educated Girls Succeed). The goal of this project is to increase the number of girls in school, and to work to keep them there and help them succeed. In addition to basic education, life skills are taught by women teachers selected in line with specific behavioural criteria and who receive additional training on

active learning. Mothers are involved in their daughters' education in order that girls are, for example, excused from certain chores and can continue to attend school. "Mother liaisons" receive training (a Mothers Module) which they in turn spread to other mothers in their neighbourhood. The overall goal of all these measures is to raise women's and girls' knowledge about sexual health and HIV and to increase their self-esteem and their negotiation skills so that they are in a better position to opt out of risky sexual behaviour.

To enhance the effectiveness and sustainability of its activities, PAPEBMGUI aims to engage the community at large in its efforts. For example, to date, 32 parents associations have taken part in education and information events designed to inform them about the PAPEBMGUI approach to sexual health and HIV prevention.

In addition, a standardized curriculum for primary schools has been designed, which has been integrated into the teacher training on a national level.

Mozambique's Pacote Basico

Since 2003, Germany has provided technical assistance to the Mozambican Ministry of Education for the development of its Basic Package of Life Skills for Primary Education (known as the *Pacote Basico*), the government's first HIV-prevention tool aimed at young people attending primary schools. With the assistance of German expertise, the Provincial Directorates of Education in the provinces of Manica and Sofala now implement the programme.

The core aim of the Pacote Basico is to inform young people about unwanted pregnancy, the risks of HIV and other sexually transmitted infections, and ways to protect themselves. Because half of the Mozambican population is younger than 15 years old, the programme forms part of the national "Window of Hope" Campaign for boys and girls aged 10–14. The campaign works on the assumption that young people of this age have not yet initiated sexual activity or, at least, adopted fixed sexual behaviour patterns, so there is a good chance of influencing their future sexual behaviour through school-based education. Life skills are an important part of the approach. Among the specific skills strengthened are: social and interpersonal skills (e.g. communication, refusal skills, assertiveness and empathy), cognitive skills (e.g. decision making, critical thinking) and emotional coping skills (e.g. stress management).

Instructors are trained at provincial and district levels, along with coordinators in the Zones of Pedagogic Influence (ZIPs, decentralized school districts), on how the Pacote Basico should be applied. The curriculum is modular, covering a range of topics including HIV and AIDS. School directors and a number of teachers at each school then receive the training; teachers who have received the training are expected to pass their knowledge on to the rest of their school's teaching staff.

Students at the station on living with HIV at the "Faca Comigo o Percurso", Mozambique's version of the Join-In Circuit (see box on p.16).

As part of the Pacote Basico all schools in the target provinces receive at least one big box filled with a variety of booklets, learning materials and games that all deal with HIV and AIDS, sexually transmitted infections, sexuality and life skills. The box includes appropriate material for the different age-groups targeted, including three booklets of the German-supported series *What They Really Want to Know* on the subjects of growing up, pregnancy, and HIV and AIDS (see GHPC, 2011a). In addition, the *Join-in-Circuit on AIDS, Love and Sexuality* group learning tool, which mixes games, role plays, discussions and exhibits, is also used (see text box).

Part of German support was for what was termed the "Monitoring and Dynamisation System." This has a dual function, both tracking the use of the Pacote Basico and encouraging the participation of schools and teachers in its further development. An evaluation system has also been implemented to provide the Ministry of Education, its partners and the schools themselves with a feedback on the regularity and quality with which the Pacote Basico is being applied in everyday school life.

The Pacote Basico is currently implemented in six of the country's 11 provinces. One indicator of its increasing coverage is that the percentage of teachers in participating provinces who regularly integrate HIV and AIDS modules into their lessons rose from 7% in 2009 to 35% in 2011.

The Join-In-Circuit on AIDS, Love and Sexuality in Mozambique

The Join-in-Circuit on AIDS, Love and Sexuality (JIC) is a highly interactive and participatory sexual health and HIV prevention tool developed by the German Federal Center for Health Education in 1987. It was designed to teach young people and at-risk groups about how to avoid becoming infected with HIV and other sexually transmitted infections using a mixture of games, role plays, discussions and exhibits. To date, the Circuit has successfully been tailored to a variety of target groups and local contexts within 18 countries worldwide. (For more information, see the GHPC publication "Boosting prevention: The Join In-Circuit on AIDS, Love and Sexuality", 2011, available online at www.german-practice-collection.org.)

The Mozambican version of the Join-In-Circuit is called *Faça Comigo o Percurso* and concentrates on three main messages: "Be informed; protect yourself and others; show solidarity." Groups of ten to fifteen persons move through an exhibition of six stations, each of which covers a single topic. These are: Modes of Transmission of HIV; Contraceptives and Correct Condom Use; Sexually Transmittable Diseases; Body Language; Living with HIV (Solidarity); Protection. Each station takes 15 minutes, so the Circuit can be completed by 60 people within 90 minutes.

The Circuit was first pilot-tested and implemented in Manica province in 2005, and then rolled out to Sofala and Inhambane. By 2007 about 150,000 young people had participated in the Mozambique JIC. Many of these were in secondary schools, universities and workplaces, and administered by NGOs. A "mini-version" especially for 10-14 year old school pupils was recently developed for integration into the Pacote Basico (GHPC, 2011b).

Tanzania's PASHA

The Tanzanian-German Programme to Support Health works both at national level and in the regions of Lindi, Mbeya, Mtwara, and Tanga. Since 2003, the Programme has supported the Ministry of Education and Vocational Training in implementing the project Prevention and Awareness at Schools of HIV/AIDS (PASHA). Implemented with technical support by the Swiss Centre for International Health of the Swiss Tropical and Public Health Institute, PASHA aims to improve students' knowledge of sexual and reproductive health and HIV, and enable them to take informed decisions. Its main activities are school counselling services and peer education programmes in schools.

PASHA's peer education approach includes support from adults, but the young people are expected to take control of activities themselves – and can choose the teachers to be trained as counsellors.

The project commenced in 2003 in 25 public and private secondary schools of the Tanga region (eventually all 160 secondary schools in the region joined the project). The two main activities during this phase were training school counsellors and classroom support to integrate reproductive health within biology and civics (i.e. the study of rights and duties of citizenship). Following the initial phase, the peer education programme was expanded to primary schools in regions where levels of teenage pregnancy are disproportionately high. Today, over 1,500 school counsellors and more than 4,000 peer educators have been trained, and with support from other partners, the approach has been implemented in regions not supported by the Tanzanian-German Programme.

In collaboration with the Tanzanian Head of Secondary Schools Association, PASHA trains master trainers, who are in charge of the decentralised training of school counsellors. These then train peer educators at school level. The initial training for school counsellors lasts 5 days, that of peer educators one week. Schools are encouraged to provide support to counsellors through the provision of facilities (e.g. a room for counselling) and through being flexible in allowing teachers time to support peer educators as well as counsel students. School counsellors are chosen by vote of the students in their schools.

Like counsellors, peer educators are elected by their fellow students. They then learn about facilitation skills, HIV prevention, and sexual and reproductive health and rights from the trained counsellors. After this training, the peer educators take control of the programme, with counsellors playing a supportive role. The programme concentrates on Grades 5, 6 and 7, with hour-long sessions run twice a week by peer educators. School counsellors do not attend sessions, but assist in planning them and counsel students when the need arises. All sessions take place after school.

Participatory methodologies are encouraged including games, role play, music and poetry. In an example of South-South cooperation, the programme has adapted the *Auntie Stella: Teenagers Talk about Sex, Life and Relationships* participatory methodology developed in Zimbabwe (TARSC, 2005). *Auntie*

Stella – Shangazi Stella in its Swahili version – is an interactive reproductive health pack for young people using a series of question and reply cards covering a wide range of personal and social issues that affect young people's lives, sexual health and relationships. PASHA also makes use of other media forms. For example, it collaborates with a Tanzanian NGO called HIP which publishes both a magazine called *Femina* and a website (www.chezasalama.com) addressing the sexual health and life skills needs of secondary school students, and supports Femina clubs in schools.

Educational theatre in Tanzania engages young people with information that both informs and entertains.

There has been some research on the effectiveness of PASHA in the past few years. One study found that it was associated with improved knowledge about HIV, sexuality and prevention of sexually transmitted infections, and also that it improved their life skills (Baxen, 2009). It also found that teachers' attitudes towards their students had changed and become more understanding, including a more realistic and supportive attitude towards their sexual behaviour. Another study, which examined data from 22 participating schools, found a marked decline of teenage pregnancies from 41 in 2006 to 12 in 2009, as reported by school directors. While the data did not permit a causal relationship to be established, school heads interviewed for the study believed that PASHA greatly contributed to the decrease (Goergen, 2009).

The impact of PASHA

Peer educators are trained to facilitate interactive sessions using methods like group discussions and role play.

A 2009 study carried out in three provinces found that PASHA had been effective in improving students' protective knowledge and skills (Baxen, 2009). The study included both quantitative and qualitative methodologies. Quantitative data from a purposive sample of 1,099 learners from 25 schools indicated that there were significant differences between school grades and age groups in students' knowledge about sexuality and HIV, as well as their understanding of life skills, and that increased knowledge and understanding were associated with exposure to PASHA sessions during the school year.

Other data derived from focus group discussions with students, parents and school staff included the following (these are given verbatim):

- **The value and immediacy of the content.** [The] utility of both the form and content of the programme should not be underestimated in creating the discursive space for change in student behaviour and increased self-efficacy and self-awareness.
- **The relevance of embedding HIV/AIDS education (and discourses) within the broader framework of sexuality and life skills.** Both quantitative and qualitative data indicate positive correlations between the three suggesting that HIV/AIDS education as an end in itself has limited efficacy.
- **The role and position of peer educators as catalysts for change.** Results point to their effectiveness as mediators of difficult and sometimes contradictory life-worlds, and as such, well positioned to be catalysts for change. In addition, they seemed well-placed to mediate difficult knowledge (even though they admitted to it being a challenge). They seem able to bridge the gap and navigate the worlds of youth and adults in ways that made difficult constructs and concepts accessible to their peers.
- **Value of ownership of the programme by schools.** The positive response and support from School Governing Board personnel is clear. This aspect should be capitalized upon so as to not only facilitate better understanding of the programme, but also more sustainable buy-in from the broader community.
- **Buy-in by the broader community.** Results show that the initial reticence by parents and the broader community has been met with embracement. The fact that parents not only view the programme in a positive light, but also request more active involvement (through the form of programmes for adults) is evidence of their positive response to the PASHA programme.

South America's Harmonization Initiative

In 2007 six countries – Argentina, Brazil, Chile, Paraguay, Peru and Uruguay – joined in a South-South cooperation project called "Harmonization of Public Policies on Sexuality Education and HIV/AIDS Prevention in Schools in the MERCOSUL" (MERCOSUL is the Latin American common market). The process was facilitated by GTZ, the Brazilian Ministry of Health, UNAIDS, UNESCO, UNFPA, and initially with the Brazil-based International Centre for Technical Cooperation (Centro Internacional de Cooperação Técnica, or CICT).

The initiative aims to (a) strengthen sexuality education programmes and HIV prevention in schools, and to (b) harmonize public policies and strengthen linkages between health and education sectors. All countries adhere to a set of guiding principles:

- The education sector should play a leading role in the definition and implementation of public policies for sexuality education from the perspective of human rights.
- Prevention of HIV must be tackled across sectors, as part of sexuality education and promoting overall health.
- Teacher training and continuing training should incorporate a systematic approach to sexuality education that the issue is dealt with in a comprehensive way.
- Sexuality education should adopt a human rights perspective, addressing discrimination against people living with HIV and AIDS and including the topics of gender roles and sexual diversity.
- Comprehensive sexuality education should be part of the curricula of all educational levels.
- The sustainability of public policy for comprehensive sexuality education requires political support and budget allocation.

The initiative has proceeded through several phases to date. In the Project phase (2007 – 2009), each country established a multi-sectoral management committee for sexuality education, including the Ministry of Health, Ministry of Education, and civil society organizations (see Table 3). National policies and national working plans were formulated and implemented, while progress was monitored regionally through regular regional workshops. The Consolidation phase in 2010 continued the work of the Project phase, but also featured reflection on the strengths and weaknesses of the implementation. Identified problems included uneven quality of implementation and questionable sustainability in some countries. Since 2011, a regional network or "Community of practice" has been developed called CoPSexEd, to facilitate the continued technical exchange of experiences between countries (UNAIDS/GTZ, 2009).

A 2009 planning and evaluation session in Uruguay facilitated by the Harmonization Initiative

Table 3. Multi-sectoral participation in national management committees of the Harmonization Initiative

Country	Members of the management committee
Argentina	▪ National AIDS Programme ▪ Programme on Sexual Health and Responsible Procreation ▪ Ministry of Health Under-Secretary for Equity and Quality, Programme for Itinerant Schools
Brazil	▪ Federal Management Group formed by approximately 15 persons from the Ministry of Education, Ministry of Health, and international agencies (UNESCO, UNICEF, UNFPA)
Chile	▪ Ministries of Education and Health ▪ Civil society organizations
Paraguay	▪ Ministry of Public Health and Social Welfare ▪ Ministry of Education and Culture, National Secretary for Childhood and Adolescence ▪ Civil society: the Coordinator for Childhood and Adolescence Rights and a Network of NGOs working with HIV/AIDS. ▪ UNICEF, UNFPA AND WHO/PAHO
Peru	▪ Ministry of Education's Board for Tutoring and Educational Orientation ▪ Members of the Ministry of Health's General Directorate of People's Health (DGSP) and of the Directorate for Health Promotion (DIPROM), with participation from AIDS Network Peru. ▪ Civil society represented by AIDS Network Peru (Red Sida Peru) ▪ Advisory Committee includes UNAIDS, UNESCO, UNFPA.
Uruguay	▪ National HIV/AIDS Programme, Ministry of Public Health; ▪ National Board of Education Public - Elementary Schools Council (ANEP-CODICEN), Ministry of Education ▪ Civil society organizations ▪ UNICEF

Between 2007 and 2011, sexuality education has reached an estimated 83,000 teachers and 1,500,000 pupils in the participating countries.

The Initiative has been particularly successful in promoting South-South cooperation and mutual support. For example, a number of innovative practices and successful experiences have been shared through the network, such as Uruguay's "concept maps" of sexuality education, Brazil's approach to the design, planning, management and evaluation of sexuality education programmes, mobile schools in Argentina, and community workshops in Chile (UNAIDS/GTZ, 2009). The Initiative has also led to enhanced ownership of sexuality education programming by governments and leadership on this issue by ministries of education.

Within the scope of the regional project, the participating countries have implemented their own specific work plans. These have had a wide variety of results, showing the diversity of approaches needed to meet the different conditions. The following provide some examples.

In Argentina, participation in the Initiative has helped put sexuality education firmly on the agenda of the Ministry of Education, both on a policy level and within programming across the country. A set of Curriculum Guidelines for Teaching Sexuality Education was approved by the Federal Council of Education (comprising the provincial ministers of education and chaired by the national Minister of Education). The Curriculum Guidelines cover all levels of teacher training. Notably, the guidelines frame comprehensive sexuality education in human rights terms, recognizing the rights of "adolescents" as autonomous individuals rather than simply as extensions of their parents or families. This was a substantial support to implementing the National Programme for Comprehensive Sex Education across the country. The approach is underlined in statute under National Law 26.150 Article 1, which states that "All students have the right to comprehensive sex education in the public and private educational institutions in all jurisdictions, including the national, provincial and municipal levels and the autonomous city of Buenos Aires. For the purposes of this law, sex education is understood to articulate comprehensive biological, psychological, social, emotional and ethical aspects."

In Chile, the multi-sectoral commission which oversees the National Plan for Infancy and Adolescence (PNAIA) created a sub-commission for integrated sexuality education. The leadership of the sub-commission is shared by the Ministry of Health, the Ministry of Women and Social Development, the Judiciary, the Secretariat of the Council of Ministers, and the Ministry of the Interior. The sub-commission was given the responsibility of working to include comprehensive sexuality education across relevant parts of the curriculum in all levels of education, sectors of the state, and social actors within civil society.

In Paraguay, a variety of activities have been traced to cooperation under the Initiative. Sexuality Education has been incorporated into different strategic documents for national planning, such as the National Plan on Sexual and Reproductive Health. To support this, a technical unit for sexuality education was created at the Ministry of Education, and a National Guideline for Sexuality Education was developed. In the meantime, curricula in all levels of primary and middle education have been reviewed and adjusted to incorporate the subject of sexuality education across different subject areas, with emphasis on gender and human rights.

In Uruguay, more than 900 teachers of all educational levels underwent a course on sexuality education and 400 community activists were trained in 14 different provinces in 2009. Guiding material for teachers and community activists was published and distributed, community activities on sexuality education and HIV prevention have been supported in cooperation with various civil society bodies including organizations of people living with HIV, and 19 supporting centres for inter-sectoral educational activities have been set up across the country. In addition, a joint conceptual framework between the Health Sector, the Education Sector and civil society organizations has been defined and a mechanism set up to coordinate their activities.

Supporting young people where they need it most

All the good work done on sexual health and HIV prevention within school can be frustrated if young people do not have access to services, support and essential supplies (particularly condoms) outside the school walls. Fortunately, there is considerable evidence that community-based services aimed at meeting these needs can be effective if properly designed and funded (WHO, 2005).

Since 2003, Germany has funded a Social Marketing Programme in Central America through KfW Development Bank. Organized by the Pan-American Social Marketing Organisation PASMO, the programme addresses the needs of young people between the ages of 13 and 24 in Guatemala, Honduras, El Salvador and Nicaragua. It features a radio programme, an internet-based information service called *Club en Conexión*, mass media campaigns, a peer educator component, and several activities to improve access to affordable quality condoms for young people. Much of the work is done with and through NGOs, in line with national strategic HIV and AIDS plans of each country.

The peer educator component emphasizes work in low-income or rural areas. Between August 2008 and September 2010, at total of 1,956 peer educators were trained in the four participating countries. These peer educators reached 269,574 contacts, many of whom were receiving information for the first time in their lives about sexual health and where to find assistance if needed. Particular efforts were made to reach out-of-school teenagers at high social risk. In downtown Guatemala City, the programme supports the NGO Trasciende in running the "Hip-hop Centre" which offers vulnerable young people an alternative to gang culture. Approximately 500 young people visit the Hip-Hop Centre each week, and Trasciende has successfully recruited and trained some of these to become peer educators.

In the area of condom promotion and distribution, PASMO has run a campaign called *Tienes? Pidelo!* ("Have it? Ask for it!"), which is not linked to a specific condom brand. Since young people face stigma against purchasing condoms (this is particularly so for girls) and often fear being turned away by disapproving adults in clinics and retail establishments such as pharmacies, the campaign focuses its efforts on non-traditional outlets, particularly in areas where few other sources of condoms are to be found. Agreements are made with participating shops under which owners or employees receive training, and sales materials are supplied that identify the shop as a place that supports condom purchasing. Results from TRaC studies (Tracking Results Continuously) showed that condom use of sexually active young people with any partner increased by an average of 50% between 2005 and 2007 across the four countries where the programme is implemented (KfW, 2011).

Ongoing challenges

Despite the advances that these initiatives have achieved, a number of weaknesses or constraints should also be noted:

- While it is a sign of progress compared to even a decade ago that the use of condoms can be discussed and encouraged in schools, young people's access to condoms remains a huge problem for economic, geographic and cultural reasons, especially in remote rural areas.
- In many countries, most girls who become pregnant are excluded from school, either officially or informally, often on the grounds that their pregnancy reflects "poor moral character" (see, for example, Right to Education Project, 2009, which discusses the situation in Tanzania). In most cases, this will be the end of their school education. In other cases they seek out unsafe abortion, putting their health – and often their lives – in danger. As there is little evidence of consistent efforts being made to help them stay in school or return to it as soon as possible, increased advocacy and sensitization is needed on this issue, which is a serious gender-based obstacle to the achievement of the Millennium Development Goals (Lloyd, 2007).

- Many of the school systems described in this document, particularly in Sub-Saharan Africa, are facing severe resource constraints that affect their "core business" (salaries for teachers, infrastructure, books, etc.) The sustainability of the initiatives described in this publication, or of some of their components, is therefore precarious.

- Governments are unwilling to deal frankly with certain topics, particularly male-male sex (WHO, 2005). In the case of the Harmonization Initiative, for example, it is notable that none of the high-level documents emanating from the Initiative mention male-male sex directly, despite the fact that HIV in Latin America is most prevalent among men who have sex with men. While most policy documents make reference to "respect for sexual orientation and gender identity" and other terms that might be understood to cover men who have sex with men, there is little to suggest that ministries of education should invest resources in the needs of young people from this and other sexual minorities. The work that is being done in this area is largely by NGOs (both national and international) and civil society organizations, with some involvement by ministries of health.

How schools can tackle sexual health and HIV: Lessons learnt

Improve quality of teaching

Experiences in these and other initiatives show that the success of the measures taken to inform and raise awareness in young people is highly dependent on the quality of the educators, contact persons, or resource persons who work with the young people (Lloyd, 2007; WHO, 2006). The common objective of training for these different groups of people is to pass on accurate knowledge about sexual health and HIV transmission and prevention and get young people involved in the response. This means not only providing them with objective information, but refuting mistaken beliefs arising from rumours and gossip and strengthening them as actors.

The training for teachers and counsellors in all three African initiatives are based on the recognition that those who are in contact with young people must improve their communication and dialogue skills. Strengthening teachers' skills in participatory teaching and active learning methods is part of the PASHA approach in Tanzania. This training involves questioning taboos and power relations between teachers and students. It is designed to help adults overcome their own discomfort and communicate frankly and confidently when they want or need to talk about reproductive health issues with young people. An essential part of the training therefore focuses on skills.

In addition to facilitation and communication techniques and training in the available tools, educators must also learn about the limits of their interventions. As is emphasized in the PASHA approach, school staff members need to know when to refer young people to specialists when their needs are medical in nature. Teachers and counsellors are not trained medical personnel, and must learn to recognise the limits of their skills and responsibilities.

Peer education is a valuable approach to sharing information and raising awareness, in which the relevant messages are provided and sometimes modeled by others in the same age group or environment. Peer educators must have good interpersonal skills and be trained in communication and facilitation techniques for discussions about sensitive issues such as sexually transmitted infections, relationships, sexual violence, and other topics concerning health and reproduction. (WHO, 2006). As shown in Guinea's PAPEBMGUI, young people can respond well to such challenges, and derive great personal benefit from them.

Target intentions and behaviour, not just information

HIV prevention is most effective in school settings if taught as one aspect of sexual and reproductive health and rights, rather than as a subject on its own (Rosen, 2004). This allows decision-making and risk behaviours to be discussed in ways that are less coloured by the moralizing attitudes that often accompany discussions of HIV and AIDS, and that relate more closely to situations that young people understand and can relate to.

Far too many school health programmes still rely on traditional "knowledge-based" teaching approaches to sexual health and HIV prevention. The effectiveness of this approach is not supported by available evidence, and it has been criticized for being based on the simplistic belief that the teaching of knowledge (i.e. information in the form of biological facts) leads to behaviour change (Jepson et al., 2010; Hopkins et al., 2007). Teachers trained in active learning techniques contribute not only to improving the quality of education in general, but also to the achievement of sexual health and HIV prevention objectives.

All of the initiatives described here emphasize skills-based learning and the "settings-approach." The latter uses the school as a platform to establish a healthy environment and instill positive health habits among students that potentially last for a lifetime (Tang et al., 2009). Interactive and participatory methods of teaching aim to lead students to awareness of what they truly want and, on this basis, to the need to act responsibly. German Development Cooperation (GDC) supports teaching approaches which target three focal areas of change. These are:

- Knowledge: what are the risks and how can they be avoided?
- Technical skills: how can I effectively teach this knowledge to others?
- Behavioural skills: how do I use this knowledge in everyday life? what should I change in my own behaviour?)

These also represent the steps that should lead to a change in the teachers or peer educators' own behaviour.

Special focus on girls

In many cultures, girls have little access to information, and much less freedom to act or make decisions than boys. Given the "social vaccine" effect of education, a broad objective of many programmes is simply to increase the number of girls in school, and to work to keep them there and help them succeed. A considerable body of evidence shows that simply increasing school attendance of girls has a protective effect, giving them better knowledge and more motivation to avoid pregnancy and sexually transmitted infections than their non-enrolled peers (Lloyd, 2007).

More focused objectives include helping girls avoid unwanted early pregnancies and their related social, psychological, and physical consequences, which of course include HIV infection. It also means raising their self-confidence and improving their future social status as well as their prospects.

Family members can play an important role. In Sub-Saharan Africa, women are traditionally responsible for educating girls. It is therefore essential to inform the mothers and guardians of the measures taken to benefit girls and include them in these measures. They must be able to express their hopes and fears and be informed about sexually transmitted infections including HIV, and the dangers of female genital mutilation. They must also be able to communicate better with their daughters, to transmit the cultural values which seem important to them, and to support them in their studies and their personal growth. This is addressed most clearly by the PAPEBMGUI's reaching out to mothers in Guinea.

Keeping girls in school also requires a change in behaviour by teachers (WHO, 2005). Training efforts for school staff must aim to raise teachers' awareness of the often unconscious attitudes giving preference to boys or discriminating against girls in class. It is also not uncommon for the educational system to be a threatening environment for girls: they may be victims of sexual harassment or forced sexual relations by male teachers and school administrators. The three Sub-Saharan projects focus on training male and female teachers and female peer educators to address this.

Target the social environment of young people

Protecting young people from HIV, unwanted pregnancy and sexually transmitted infections requires a willingness and ability to communicate between parents and their children, parents and teachers, students and teachers, young people in and out of

school, etc. For this to occur, parents must learn to support their children's sexuality education, not just issue prohibitions and punishments.

The goal of the approaches supported by GDC has been to associate and involve not only the young people themselves in the fight against HIV, but also their entire social and cultural environment. Providing sexuality education and information on HIV at school requires that:

- the teachers are trained for this purpose
- the school administration approves and supports the training given
- the parents, religious authorities, leading citizens, and influential members of the community are informed of what is taught and identify with it
- the local authorities support interventions for young people and include them in their development plans
- there are sufficient contact persons for young people to go to (healthcare workers, specialized personnel in young people centres, peer educators).

Involvement of the community also means involvement of the local authorities and administrations. School authorities are stakeholders in all stages of education projects (planning, monitoring, and evaluation) and are valuable and indispensable partners. Political and religious leaders should also be informed and consulted. They are often the best warrants of good communication with the public. Also, as is for example the case in Tanzania, schools are increasingly under the control of decentralised authorities. These authorities should also be involved in discussions around resource allocation to schools for sexual health and HIV prevention activities.

The local health services have a special role to play, because once informed, community members should be able to turn to them with confidence when they need additional information, advice, treatment or other services relating to their reproductive health, such as voluntary counselling and testing, family planning or treatment of sexually transmitted infections. Overall, it means that interventions initiated by the education sector must closely collaborate with local associations, NGOs, young people's organisations, and services such as young people's social centres. It is notable that almost all of the countries in the Harmonization Initiative emphasize this kind of local-level cooperation in support of school initiatives.

Differentiate between priority groups and adjust actions to their needs

Years of experience confirm that correctly identifying and understanding priority groups before interventions are planned and implemented is an important component in project success. Table 4 lists some of the criteria that can be used to distinguish between different groups relevant to basic education projects (e.g., young people, parents, and other stakeholders) and identify how best to work with them.

All three of the African initiatives described here conducted situation analyses to pinpoint the needs of the different target groups and their level of understanding and knowledge about HIV and AIDS. The exact content of the training was defined from the results of these surveys, and the appropriate materials and tools produced (level, language, social and cultural acceptability).

Table 4. Differentiation of priority groups in basic education initiatives

Target Groups	Distinguishing criteria
Young people	▪ Age/gender ▪ Educational environment (primary/secondary) ▪ Off school environment (literate/illiterate) ▪ Urban/rural setting ▪ Prior level of information ▪ Preferred language
Parents	▪ Gender (fathers/mothers) ▪ Literate/illiterate ▪ With children in school/out of school ▪ Involvement in managing the school ▪ Urban/rural setting ▪ Prior level of information ▪ Preferred language
Teachers, trainers, peer educators, school health staff, school administrators	▪ Age/gender ▪ Primary/secondary ▪ Initial training received ▪ Prior level of information

Produce specific tools adapted for each group of interest

Close cooperation between education projects and health projects is particularly important in the production of information, education and communication materials. The chosen pedagogic approach is shaped by the education project objectives, and the correctness of the facts that are taught is checked and validated by the health project.

Materials intended for students aim to provide them with knowledge about their bodies, reproductive health, sexually transmitted infections, and HIV (e.g., prevention, the disease, support for people who are seropositive), but also to motivate them and provide practical training (roleplaying) in less risky behaviour. Versatile materials, i.e. that can be used for both in-school and off-school settings, are the ones most used and appreciated. These include comics, serial stories, and informative brochures which are humorous and are written and illustrated in a style that appeals to young people.

Factors which have a positive influence on the quality of the materials are:

- how carefully the needs and the level of the target group have been studied
- involvement of the target group in developing them
- preliminary verification of their social and cultural acceptability
- use of language and vocabulary that reaches the target group
- clear and simple explanations
- presentation of the material (clarity, use of illustrations).

The best materials produced tend to be those which have been tested during pilot (or experimental)

phases which sometimes lasted for several years. Moreover, it is usually possible to borrow from existing practices rather than "reinvent the wheel," saving time and expense. All three of the African initiatives use booklets from the series "What Young People Really Want To Know" which have been developed in 18 different countries and many languages. Similarly, PASHA uses the Auntie Stella tool developed in Zimbabwe and adapted to the local context in Tanzania (it has also been adapted for use in Mozambique with German support.)

Use different channels of communication

Using different channels of communication generates better access to information and greater community awareness.

Verbal communication is used in local contexts as part of activities specific to each project. In African multilingual contexts, it has the advantage of using the language spoken by the target group without requiring the production of materials in the national languages.

Written communication is of course reserved for the literate, but it plays an essential role in information exchanges between all partners in the projects. The results are most powerful and relevant to the target group if young people are involved in all stages of the development of information brochures on young peoples' sexual and reproductive health. Audio-visual communication can take many forms, including radio and television broadcasts, locally shown films, and increasingly internet and social networks that blend text with graphics and video elements.

Artistic, cultural, and sporting events such as plays, sketches and recitals, "carnivals", local film viewings, and sports events between classes and schools remain important methods of communication, partly because of practical reasons (they are not dependent on electricity) and partly because of their effectiveness in pedagogical terms (their immediacy and potential for "active learning" through audience participation). Mixed approaches have shown good results. For example, the Pacote Basico and several Latin American countries all use the "Join In Circuit" methodology for sexuality education and HIV prevention.

▶ You can download the two mentioned publications in long and short versions from our webpage www.german-practice-collection.org: "What they really want to know: Developing booklets on sexuality, HIV and growing up" and "Boosting prevention: The Join In-Circuit on AIDS, Love and Sexuality".

Use multi-tiered and multi-sectoral approaches
Under a multi-tiered approach, successful initiatives can influence national policies and practices by modelling proven approaches and strategies. In cooperation with the Ministry of Education and the Ministry of Health, knowledge gained through experience is validated (concepts, strategies, and materials to be included in the educational curriculum for example) and innovative practices are integrated into the national strategies.

It has often proven advantageous to "start small" in limited areas (typically regions or provinces, as was the case with the three African initiatives) where baseline conditions can be established, and interventions can be tried out and refined on a relatively small scale. Once the initiative has been "proven" (and if necessary revised), it can be scaled up or adapted to other areas. It is significant that although the three African initiatives described in this publication all began in specific regions of their country, they always retained implementation at

the national level as a project goal, particularly by providing advisory services on national policies.

Cooperation between education and health structures is a determining factor in the success of the measures taken to benefit young people. For example, establishing linkages between these two sectors is crucial in activities to ensure that voluntary HIV counselling and testing services (VCT) are used, or that access to antiretroviral treatment is facilitated. The education sector can provide effective information and counselling, which can serve to increase the use of health sector services. However, if, as a result of schools' information and education activities, teachers and students are motivated to use condoms or to get tested, yet local health services cannot provide condoms or adequate VCT services, the education sector efforts cannot produce any real results. The Harmonization Initiative has been particularly active in promoting such inter-sectoral cooperation to overcome such problems.

Encourage regional and South-South collaboration

Regional cooperation on specific practices, as well as policies and strategies, can be extremely helpful. The Harmonization Initiative in Latin America takes this to a new level with the South-South technical cooperation enabled by its "Community of practice" network. On a smaller scale, PAPEBMGUI's participation in the regional programme FIERE (Educated Girls Succeed) gives it access to experience and technical knowhow from other West African countries in how to retain girls in school and provide them with vital life skills.

Results-based monitoring for sexual health and HIV prevention projects

All German-supported operations are encouraged to incorporate "results-based monitoring" (M&E), in which projects are evaluated according to the results they have actually achieved.

The following are some of the recommended methods and tools used to monitor and evaluate the progress and results of sexual health and HIV prevention projects:

- testing knowledge/evaluating attitudes and opinions of students, e.g. through KAPB surveys (knowledge, attitudes, practices, beliefs) before and after a programme
- analysis of peer educators' reports
- analysis of requests for materials by different population groups
- qualitative interviews at different levels with stakeholders, partners, participants, health service providers
- reports from school supervisors
- monitoring of regional and national statistics concerning school enrolment for girls and how long they attend school

The most important is to plan results-based monitoring from the very beginning of a project or programme, and to budget for it.

Peer review

The German Health Practice Collection (GHPC) has established criteria that programmes and projects must meet to qualify for publication as part of this series. The two expert reviewers of this report have concluded that the initiatives described here are "valuable, interesting, and innovative." As promising practices according the GHPC criteria, the lessons learnt in these initiatives are of potential benefit to policymakers and practitioners working in the fields of health and education.

The peer reviewers offered the following reflections on the specific criteria used by GHPC to identify promising practices:

Effectiveness

Of the four, the Harmonization Initiative has been most visibly effective at reaching its goals of influencing curriculum development and public policy, which were straightforward and reachable in the given time period. The three African schools initiatives are more difficult to evaluate, as they lack clear indicators of success, although the PASHA project appears to have reached large numbers of young people and has attempted to document its impact to some extent. Some qualitative data suggests that the initiatives are appreciated by their beneficiaries, and are thought to make a difference in their lives.

Transferability

The peer reviewers comment that the approaches described in these four initiatives appear "worth being scaled up and transferred," although much greater detail would be necessary if they were to be transferred to another context. Some of this information may be available in documents in the references and resources lists at the end.

Participatory and empowering approach

All of the initiatives emphasize active participation by young people, and there is testimony that they do lead to empowerment. One reviewer noted with approval that in all of the initiatives, "young people are seen as actors rather than passive recipients."

Gender awareness

One reviewer praised the initiatives' efforts to address the needs of "the girl-child,"and particularly the outreach work of PAPEBMGUI to mothers. The focus of all three African initiatives on prevention of unwanted pregnancy is of particular value. However, it is pointed out that none of the initiatives directly address the attitudes and behaviours of young males, or young people with same-sex orientations.

Quality of monitoring and evaluation

As with many such projects, evaluation is a serious weakness, since reliable quantitative evidence is largely missing. One reviewer described the monitoring system included in the Pacote Basico as promising, but noted that it does not appear to have yet produced useful data. Overall, these shortcomings highlight the need to plan, budget and implement a results-based monitoring and evaluation scheme from the very beginning of such projects.

Innovation

The reviewers felt that the initiatives could be described as innovative. This is particularly so in regard to their activities focused on primary schools because (as one review put it) "this is where the majority of young people can be reached prior to

the development of risky behaviours." They also noted that some of the initiatives show innovation in combining different methods for transferring information, and in linking school-based activities to out of school and community approaches. One reviewer noted that none of the initiatives explored the possibility, particularly in places where access to condoms is limited or intermittent, that "non-penetrative forms of sexual expression" be promoted as an option.

Comparative cost-effectiveness

The reviewers noted that there was no data allowing cost-effectiveness to be assessed.

Sustainability

One reviewer commented that sustainability seems likely for the initiatives that have succeeded in integrating their activities into national curricula. However, the reviewer found it questionable whether those requiring regular re-training (including for peer counsellors) and outside activities (such as those engaging with parents' associations) can be sustained by poorly resourced Ministries of Health without ongoing external assistance.

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Resources

See the **GHPC online toolboxes** "Toolbox: Education" and "Toolbox: Booklets/livrets" for a variety of relevant materials, including the "What they really want to know" series of booklets for young people. These can be found at

- www.german-practice-collection.org/en/toolboxes/hiv/education and at
- www.german-practice-collection.org/en/toolboxes/sexual-health-and-rights/booklets-livrets

Other useful resources include:

Confemin (2006). "Le projet PAPEBMGUI et la formation continue des maîtres en Guinée," *Confemin Infos.* Dakar.

GTZ (2005a). *HIV/AIDS and education Information sheet*, Eschborn.

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