

THE RESPONSE OF THE EDUCATION SECTOR IN JAMAICA TO HIV AND AIDS

DRAFT REPORT



UNESCO Office for the Caribbean

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Treatment
BCC	Behaviour Change Communication
BCIC	Behaviour Change Intervention and Communication
CAIC	Caribbean Association of Industry and Commerce
CAPNET	Caribbean Publishers' Network
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community Based Organisation
CCDC	Caribbean Child Development Centre
CDB	Caribbean Development Bank
CHARES	Centre for HIV/AIDS Research Education and Services (UWI)
CHART	The Caribbean HIV/AIDS Regional Training Network
CHASE	Culture, Health, Arts, Sports and Education Fund.
CIDA	Canadian International Development Agency
COHSD	Council for Human and Social Development (CARICOM)
CRIS	Country Response System
CSW	Commercial Sex Worker
EBSP	Enhancement of Basic Schools Project
EDC	Education Development Centre
EFA	Education for All
ESD	Education for Sustainable Development
ESP	Expanded Secondary Programme
ESSD	Environmental Education for Sustainable Development
EU	European Union
FBO	Faith Based Organisation
FRESH	Focusing Resources on Effective School Health
GBV	Gender-Based Violence
GC	Guidance Counsellor
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOJ	Government of Jamaica
HAC	Health Advisory Committee (MOEYC)
HEARD	Health and HIV/AIDS Research Division (University of Natal)
HEART	Human Employment and Resource Training (HEART) Trust
HFLE	Health and Family Life Education
HISEP	High School Equivalency Programme
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Specialist
HRT	HIV and AIDS Response Team (MOEYC)
IBRD	International Bank for Reconstruction and Development
IDB	Inter-American Development Bank
IEC	Information, Education and Communication
IFC	International Finance Corporation (World Bank)
ILO	International Labour Organisation
IOE	Institute of Education (UWI)
JAMR	Jamaican Association on Mental Retardation
JAS	Jamaica AIDS Support
JBTE	Jamaica Board of Teacher Education
JHANSP	Jamaica HIV/AIDS/STI National Strategic Plan
JICA	Japan International Co-operation Agency
JOCV	Japan Overseas Cooperation Volunteers
KABP	Knowledge, Attitudes, Behaviour and Practices
KVAP	Knowledge, Values, Attitudes and Practice

M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Programme
MOEYC	Ministry of Education, Youth and Culture
MSM	Men who Have Sex with Men
MTSEPF	Medium Term Socio-Economic Framework
MTT	Mobile Task Team
NAC	National AIDS Committee
NCE	National Education Council
NEEC	National Environmental Education Committee
NGO	Non Governmental Organisation
NHCP	National HIV/STD Control Programme
NHP	New Horizons for Primary Schools
NTA	National Training Agency
ODL	Open and Distance Learning
OPEC	Organisation of Petroleum Exporting Countries
OVC	Orphans and Vulnerable Children
PAC	Parish AIDS Committee
PAHO	Pan American Health Organisation.
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PAR	Participatory Action Research
PASS	Programme for Alternative Student Support
PATH	Programme of Advancement Through Health and Education
PCU	Project Coordinating Unit
PESP	Primary Education Support Project
PLHA	People Living with HIV and AIDS
ROSE	Reform of Secondary Education Project
RPC	Revised Primary Curriculum
SEP	Schools Environment Programme
SIRHASC	Strengthening Institutional Response to HIV/AIDS and other Sexually Transmitted Diseases in the Caribbean.
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
ToT	Training of Trainers
TVET	Technical and Vocational Education and Training
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO-	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group
UPE	Universal Primary Education
USAID	US Agency for International Development
UWI	University of the West Indies
UWI-HARP	University of the West Indies HIV/AIDS Response Programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

1. This study was funded by the UNESCO Office for the Caribbean as a contribution to supporting capacity building of the education sector in Jamaica to implement an effective response to HIV and AIDS. It aims to assess the current state of Jamaica's current and planned response, highlighting strengths and identifying areas where more investment is required. It makes recommendations for consideration by the Ministry of Education, Youth and Culture (MOEYC) and development partners to be considered as inputs into the development of a strategic plan on HIV and AIDS for the sector.

2. The study is a contribution to EDUCAIDS which is the UNAIDS global initiative on education and HIV and AIDS. Jamaica has been selected as one of four countries in the first wave of countries to pilot an approach to capacity building. This report is a first step in that process.

3. The report is based on data obtained through a review of documents, stakeholder interviews and field visits in Kingston, Browns Town and Ocho Rios. The education sector response is analysed in terms of its actions in four key areas which were derived from a literature review including relevant toolkits. These are:

- Policy, strategic planning and institutional capacity;
- HIV Prevention;
- Impact mitigation; and
- Leadership.

4. The review attempted to identify what was working well and should be continued or expanded, what was not yet working but should be continued, what is not working and needs a new strategic approach and what is not relevant and should be dropped. The following paragraphs provide a summary of the key findings.

5. The education sector response to HIV and AIDS is at an early stage of development. Some essential steps have been taken which provide a platform for further and more comprehensive action. This is a crucial phase for mobilising the sector to address a broad range of challenges including, prevention, access to treatment, support and care, impact mitigation and preventing stigma and discrimination. By providing young people with the skills and knowledge to live healthy and productive lives in a world with HIV and AIDS, education can make a key contribution to poverty reduction and sustainable development in Jamaica. This is an issue that needs to be included within the mainstream current of educational reform in the current and not an add-on at the margins.

6. **What is working well and needs to be continued or expanded?**

- **Policy for schools.** The Government of Jamaica has put in place a policy for all schools on HIV and AIDS (National policy for HIV/AIDS management in Schools). This provides a reasonably comprehensive platform for action in early childhood, primary and secondary education. There are gaps in the

policy and areas of under-emphasis which should be reviewed in the short to medium term. Developing monitoring and evaluation capacity to assess progress in and outcomes from policy implementation will be critical to success.

- **Policy dissemination**. Policy dissemination has been actively undertaken by MOEYC in the 2004/5 school year and is being continued in the current school year. All junior high schools and a large number of primary schools have sent representatives to dissemination workshops which have been organised on a decentralised basis through Regional Education Offices. While there have been some shortcomings in the workshop process chiefly in terms of consistency of approach, quality of delivery and representation, this has undoubtedly raised the profile of HIV and AIDS as an educational issue and led to growing engagement with the policy at school level. Steps can be taken to address qualitative improvements in the dissemination process.
- **Capacity building** through the establishment of the HIV and AIDS response Team (HRT) in MOEYC Headquarters and all 6 Regional Education Offices. Without this intervention the policy dissemination that has taken place would have been impossible to implement. The HRT provides full time professional staff to work on HIV and AIDS, a significant institutional development which needs to be continued and strengthened as the sector response is taken to scale. The involvement of Japanese volunteers through JOCV and JICA funding to support regional education offices has been an innovative feature. It is at the school level that capacity to implement policy must be developed and sustained with appropriate support from the various arms of the ministry. This will be the most significant challenge for the HRT approach which to date offers a model of innovative good practice in capacity building.
- **Higher Education policy making on HIV and AIDS**. The University of the West Indies (UWI) which has a campus in Jamaica (Mona campus) has developed a comprehensive policy on HIV and AIDS, while the University of Technology, Jamaica has also developed a multi-component policy. In both instances these provide platforms for action. Like the MOEYC policy these both have their various shortcomings which need to be reviewed as part of the monitoring and evaluation process. Unlike MOEYC, policy dissemination processes do not seem to have been addressed very strategically at least in the case of UWI. The development of the National Workplace Policy on HIV/AIDS will likely provide an opportunity to address those related to workplace rights and issues. There is currently no guidance for post secondary education policy development on HIV and AIDS in Jamaica and each institution appears to take its own initiative which risks policy incoherence and inconsistency across the sub-sector.
- **Capacity building for HIV and AIDS in Higher Education** through the UWI HIV/AIDS Response Programme (UWI-HARP). UWI-HARP represents a second innovative approach to institutional capacity building for HIV and AIDS which can be viewed as a model of good practice. Like the HRT, the

sustainability of UWI HARP is fragile as it is donor funded and programme based. Its benefits have largely accrued to health-related capacities in teaching and research. The outcomes for students appear less clear and a comprehensive independent evaluation of UWI-HARP process and products would likely be beneficial for the university. The establishment of the UNESCO Chair in Education and HIV and AIDS at UWI (St Augustine campus) is another innovation which presents an opportunity to provide strategic support for national education responses by stimulating educational debate and thinking on HIV and AIDS, research, capacity building in key areas such as prevention education, gender analysis and monitoring and evaluation.

- **Research**. The knowledge base on young people, education and HIV and AIDS is relatively rich in both qualitative and quantitative terms. This has been commissioned from a number of sources including the National Programme on HIV and AIDS, development partners (e.g. UNESCO, UNFPA, UNICEF, the European Union), NGOs (e.g. Save the Children UK and Human Rights Watch) and by UWI. An issue is to make it more accessible to education practitioners. Capacity to undertake good quality research exists in Jamaica and the region, which is greatly needed particularly in relation to further research on HIV prevention, addressing stigma and discrimination and gender inequalities in education. It would be desirable to create a research strategy for the sector.
- **Development assistance**. The support provided by Jamaica's development partners has been key in achieving outcomes to date and for providing the platforms for further action. It appears to have been relatively well co-ordinated, strategic with some important innovative developments being supported. Much of the financing and technical support for the education sector so far has come from development partner assistance. Such assistance needs to be continued but with a longer planning time frame and an increased commitment from the Government of Jamaica. An inventory of current interventions is given at Annex 7.

7. What is not yet working, but should be continued?

- **Health and Family Life Education** (HFLE). HFLE is the chosen vehicle for HIV and AIDS prevention education including both knowledge and skills acquisition. HFLE has not enjoyed much success to date despite having been some 20 years in development. However, the HFLE curricular scope and sequences for early childhood, primary and junior high levels of education have recently been revised to make better inclusion of HIV and AIDS. Although mandatory in policy, systemic capacity to implement HFLE is still at a very early stage. Areas to be addressed include materials development for teaching and learning, teacher training, orientation for school principals, parents and community leaders, linkages with youth friendly services and monitoring and evaluation of processes and outcomes. A pilot programme involving 24 schools in grades 5-8 in 4 regions will introduce the new HFLE

curricula this school year with plans to scale up to 200 in the next school year. This is a most important strategic development and needs to be adequately monitored and evaluated including for learning outcomes.

- **Health Advisory Councils** (HACs). The setting up of HACs at school level as the main institutional vehicle for policy implementation represents another innovative approach to the education response in Jamaica. As yet this approach is untested and unproven. It therefore, as with any innovation, needs to be appropriately piloted and evaluated formatively before going to scale.
- **HIV and AIDS in co-curricular education**. The need for co-curricular interventions is recognised in the MOEYC policy in relation to sports activities. Capacity needs to be developed to undertake this professionally. At the same time an assessment should be made of other opportunities to address HIV and AIDS through existing co-curricular activities or through developing specific innovative approaches. There is scope for peer education initiatives for example.
- **HIV prevention in special needs education**. A good start has been made in this area through the KVAP survey undertaken among adolescents with disabilities. A strategic approach to teaching and learning about HIV and AIDS in this vulnerable group needs to be developed for special education.

8. What is not working and needs a new strategic approach?

- **Leadership**. Leadership at all levels in the sector need to strengthen their engagement with the implementation of the HIV and AIDS policy. This applies to school principals, Regional Education Directors and senior officials. Commitment should be visible, continuous and consistent. A strategy needs to be developed to mobilise and support educational leadership throughout the system.
- **Addressing stigma and discrimination**. The severity of stigmatisation of people living with HIV and AIDS (PLHAs) in Jamaica is well documented. It remains an area where policy is being contested at school level in relation to the schooling of children infected with HIV or affected by AIDS. The current approach to stigma and discrimination in MOEYC is reactive, in addition a proactive approach is required to prevent and move towards eliminating them. A strategy for a more comprehensive approach to reduce stigma and discrimination at school level would likely be beneficial.
- **Impact Mitigation**. MOEYC policy is silent on addressing the impact of AIDS on education demand or supply. Particular attention needs to be paid to meeting the needs of orphans and vulnerable children (OVCs) whose concerns are omitted in the current policy and a strategic approach needs to be developed to meeting their needs in and through education.

- **Gender responsiveness.** The MOEYC policy is silent on gender equality in education and gender-related issues relevant to HIV and AIDS. A particular gender issue that needs to be addressed is the underperformance of boys at schools. Capacity in gender analysis needs to be developed in the HRT and gender needs to be mainstreamed throughout the education response to HIV and AIDS. This requires a strategic approach.
- **Monitoring and evaluation.** This is a key capacity issue. A comprehensive monitoring and evaluation framework is an essential component of a sectoral response and needs to be developed for the education response to HIV and AIDS. The development of an approach to school based HIV prevention for example such as HFLE requires a robust monitoring and evaluation framework and professional capacity to use it.
- **Strategic planning.** MOEYC has developed a national policy on HIV and AIDS for education and established institutional capacity to disseminate and support implementation. The missing key element is a comprehensive strategic plan for implementation. The first priority for MOEYC should be to develop a detailed costed comprehensive strategic plan for the education sector response to HIV and AIDS for 2006-2010 involving all key partners and stakeholders. The plan can support the development of the next National multi-sectoral strategic plan on HIV and AIDS.

9. What is not relevant to current needs and should be dropped.

- No evidence was found of any redundant or irrelevant programmes.

1 Introduction

1.1 Purpose of the Study

This study aims to assess the effectiveness of Jamaica's current and planned response to HIV and AIDS in the education sector, highlighting strengths and critical gaps. It outlines parameters for a strategic planning exercise that will develop an action plan for the period 2006-2010 for the education sector which in turn will contribute to the preparation of the National AIDS strategy for the same 5 year period (see [Annex 5](#)). The report provides recommendations in the section which contains a detailed analysis of the response as an input to the planning process (see [Annex 6](#)). Terms of reference (TORs) are included in [Annex 1](#).

The study is a contribution to the development of the EDUCAIDS initiative, a global initiative on prevention education. Jamaica has been selected as one of 4 countries, along with Cambodia, Namibia and Moldova to pilot this initiative. EDUCAIDS was formally launched in mid-2005 and is supported by UNAIDS cosponsors to provide support to selected countries to strengthen the education sector response to HIV and AIDS within the national multi-sectoral framework. EDUCAIDS will have two main thrusts. First, it will provide evidence-based guidance to education sector policy makers and those responsible for its implementation. Secondly, it will support the capacity of the education sector to implement effectively an appropriate response.

This study attempts to provide a quantitative and qualitative analysis of the education sector response to HIV and AIDS. It is guided by UNAIDS guidance (1999) on undertaking a response analysis, but this has been adjusted for application to the education sector. Accordingly, it seeks to:

- Consider the response of all the education sub-sectors;
- Concentrate on responses in priority areas;
- Examine whether responses are appropriate to the situation;
- Identify gaps in the response and consider why they exist;
- Analyse why some initiatives are working well and why others are failing.

It also attempts to provide answers to a fundamental set of questions:

- What is working well and needs to be continued or expanded?
- What is not yet working, but should be continued?
- What is not working and needs a new strategic approach?
- What is not relevant to current needs and should be dropped?

1.2 Methodology

This report is based on data obtained from documents, stakeholder interviews and field visits in Kingston, Browns Town and Ocho Rios.

1.2.1 Documentary Sources of Evidence

Documentary sources of evidence included the following:

- Existing programme reviews and reports;
- Individual project and programme evaluations;
- Government of Jamaica policies and other strategic documents;
- Caribbean regional strategic documents;
- Published qualitative and quantitative research;
- Development agency and NGO grey literature;
- Web-sites of international and national organisations supporting Jamaica's HIV and AIDS response;
- International literature and guidance on the education response to HIV and AIDS.

A list of print sources of information which were consulted in this exercise is given in [Annex 2](#).

1.2.2 Analytical Framework

On the basis of existing frameworks and checklists for assessing the education sector response to HIV and AIDS an analytical framework was constructed to guide the collection, organisation and analysis of data obtained. Of particular importance in this regard were:

- [Rapid Appraisal Framework for HIV/AIDS and Education](#) (M. Kelly and B. Bain. 2003. Included in [Education and HIV/AIDS in the Caribbean](#));
- [Mapping Matrix \(draft\)](#). EDUCAIDS. UNESCO, Paris.
- [HIV/AIDS and Education. A Toolkit for Ministries of Education](#) (UNESCO. Bangkok);
- [Guidelines for the Assessment and Endorsement of the Primary Education Component of an Education Sector Plan](#) (EFA FTI Secretariat. 2005)

Four key parameters in the education response were identified. These were:

- Policy, strategic planning and institutional capacity;
- HIV prevention;
- Impact mitigation;
- Leadership.

These four headings are broken down into sub-components in the framework. The complete analytical framework is to be found at [Annex 3](#).

1.2.3 Stakeholder Interviews

Stakeholder interviews were undertaken and these included a wide range of actors in the education sector response to HIV and AIDS. They included representatives of:

- Ministry of Education, Youth and Culture (MOEYC);

- National AIDS Committee (NAC);
- University of the West Indies (UWI);
- Jamaica University of Technology;
- UN Theme Group;
- UNAIDS Cosponsors;
- Bilateral development agencies;
- NGOs;
- Publishers.

A list of persons consulted is given at [Annex 4](#).

1.2.4 Field Visits

Field visits were limited on account of the school holidays. It was possible to visit offices in the Kingston area, the Regional Education Office in Browns Town and a brief visit to the Jamaica Teachers' Annual Conference in Ocho Rios. The stakeholders met on these visits are included in the list of persons met.

1.2.5 Limitations

The timing of the visit coincided with the school holidays. It was therefore not possible to visit schools and to observe teaching and learning taking place. Nor was it possible to meet school principals, teachers and students. It was not possible to obtain a meeting with a representative from the Ministry of Health (MoH).

1.3 Background

1.3.1 HIV and AIDS in the Caribbean Region

HIV in Jamaica is related to the wider Caribbean epidemic, which has the second highest rate of HIV prevalence after sub-Saharan Africa, with high population mobility across the region acting as a facilitating factor (IOM, 2002. UNESCO, 2004). Jamaica's response therefore needs to be seen not only as a national issue, but also as an important contribution to the regional effort.

According to UNAIDS (2004a), around 430,000 people are living with HIV in the Caribbean region (within a range of 270,000 to 760,000). In 2003, some 35,000 people died of AIDS and 52,000 were newly infected. AIDS has become the leading cause of death among the 15-44 age group (CEC, PAHO/WHO. 2004). The HIV epidemic in the region is predominantly heterosexual where it has been concentrated in vulnerable and socially marginalized populations such as sex workers, but the virus is now spreading in the general population with the potential for rapid growth in transmission. The unequal social and economic status of men and women is acting as a powerful dynamic in epidemics which are growing in the context of stigma, misconceptions and denial.

Three countries have HIV prevalence rates greater than 3% (the Bahamas, Haiti and Trinidad and Tobago). A further three (Barbados, the Dominican Republic and

Jamaica) have rates in excess of 1% - the threshold for a generalised epidemic. Comprehensive national responses are required in these countries in particular to reduce transmission HIV rates and to provide treatment and care to those living with HIV and AIDS.

Young people are increasingly emerging as a vulnerable population, particularly young women. Among young people (15-24), 2.9% of women and 1.2% of men were living with HIV by the end of 2003. Ensuring that they have the knowledge, values and skills to prevent HIV transmission should be a high priority for governments in the region. This is a role where the education sector can make a significant contribution. At the same time the sector is vulnerable to the social and economic consequences of AIDS. The impacts of AIDS on the family affect children disproportionately often undermining their ability to enrol in or continue at school. The percentage of children in the region who are orphans has been rising (UNAIDS, UNICEF and USAID, 2004) with AIDS as a significant contributing factor.

Stigma and discrimination against people living with HIV and AIDS (PLHA) constitute a serious impediment to the development of effective programmes across the region, whether in prevention or treatment and care (Aggleton et al, 2003, UNAIDS, 2004b, CAREC, 2004). Fear of discrimination prevents people from getting tested, acknowledging they are HIV positive and from seeking treatment on diagnosis. It prevents national authorities from obtaining a true picture of the epidemic. HIV and AIDS-related stigma creates and is reinforced by social inequality. Manifestations of AIDS-related discrimination in the region include denial of access to primary school on account of parental fears and anxieties. Stigma and discrimination are also encountered in health care delivery. Established stigma against sex-workers and men who have sex with men (MSM) is exacerbated by HIV and AIDS. It is a complex phenomenon and requires a multi-faceted response as a key component of the national response including in and through the education sector.

UNAIDS (2004a) cites the lack of good quality HIV surveillance data in most Caribbean countries as hampering the ability to design and run effective prevention programmes and will almost certainly undermine effort to expand access to antiretroviral treatment. UNAIDS (2004b) however, reports that the region has a new and real opportunity to scale up national responses to HIV and AIDS, but this will require that some major challenges be addressed. These include strengthening leadership for better governance and management of resources, facilitating the availability of strategic information and ensuring efficient co-operation between different partners. This agenda also applies to the education sector.

The education sector response to HIV and AIDS in the region will be critical to HIV prevention among young people in general. Those at high risk will need additional targeted interventions. There is a great deal to do in the short and medium term. The education sector has been lagging in the first two decades of the epidemic which has largely been considered as a health sector responsibility (Kelly and Bain, 2003. Morrissey, 2005). The response, generally, is still at an early stage and little has changed at the classroom level (Morrissey, op cit). The main regional focus to date has been on delivering school-based HIV prevention through the Health and Family

Life Education (HFLE) approach, which after more than two decades of development, still has to prove its effectiveness in providing knowledge, skills and behaviour change. Providing effective HIV prevention through the vehicle of HFLE then represents a major challenge to all countries participating in the regional curriculum approach.

Ministries of Education in the region have been slow to set policy and undertake comprehensive strategic planning for HIV and AIDS, reflecting technical, human and financial constraints and the climate of stigma and discrimination. Jamaica, however, exemplifies good practice in the former and Haiti, the latter. Higher education has been able to take a lead in the region on developing technical capacity to address HIV and AIDS. The University of the West Indies (UWI) has been able to embark on developing a comprehensive response to HIV and AIDS at the regional level because of its multi-campus set up. This should serve capacity building of national responses. A significant challenge facing countries in the region in education is to develop a sector-wide policy and planning approach to HIV and AIDS in a context of piecemeal sector project-based responses.

The UNAIDS family, particularly UNESCO and UNICEF, together with the European Commission and JICA have played a significant role in providing technical and financial support for the nascent regional education sector response.

1.3.2 HIV and AIDS in Jamaica

Jamaica is the third largest island in the Caribbean with a population of approximately 2.6 million (2002). Tourism is the country's main source of income, followed by bauxite mining/processing, agriculture and light manufacturing. Tourism and mining are associated with factors which drive HIV epidemics and at the same time are vulnerable to their impacts. A macro-economic AIDS impact assessment (Nichols et al 2000) projected that HIV and AIDS would result in a substantial impact on employment and labour supply in Jamaica. It is estimated that AIDS will reduce employment in the agriculture sector by 5%, by 4% in manufacturing and by 8% in services. Assuming a prevalence rate of 1.5% among Jamaicans between 15 and 49, the IFC (2003) estimated that there may already be 16,500 people living with HIV and AIDS in the national workforce.

In common with other countries in the Caribbean region, the main mode of HIV transmission is heterosexual sex. The epidemic in Jamaica is generalised with an estimated adult HIV prevalence rate of 1.2% in the 15-49 age group (UNAIDS 2004a) with a range of 0.6% to 2.2% (low to high estimates). Some 22,000 to 25,000 are living with HIV and AIDS, making it the third largest PLHA population in the Caribbean after Haiti and the Dominican Republic (UNAIDS. 2004b). Jamaica has the second highest annual number of AIDS and deaths in the region after Haiti (UNAIDS. 2004a). There is a concentrated epidemic in commercial sex workers (CSW), MSM men and those with an existing sexually transmitted infection (USAID. 2004). As elsewhere in the Caribbean, stigma and discrimination are obstacles in Jamaica to effective HIV and AIDS responses. Homophobia and violence are particular concerns (Human Rights Watch. 2004).

Young people, particularly females, constitute a vulnerable group to HIV and at the same time are disproportionately affected by the impact of AIDS on the family. In 2003, AIDS was the second leading cause of death in children aged 1-4 and there are an estimated 5,125 children under the age of 15 that have lost a mother or both parents to AIDS. The number of children orphaned is set to rise to 5% of all children by 2010. (UNAIDS, UNICEF and USAID. 2004). Adolescent females aged 10-14 and 15-19 had twice and three times respectively the risk of HIV infection as boys of the same age groups. This is ascribed to social factors whereby adolescent girls are having sex with HIV-infected older men. While young Jamaicans have high rates of early and unplanned pregnancy and sexually transmitted infections (STIs), those at greatest risk of HIV infection are male youth who have sex with men and all youth who engage in transactional sex (USAID. 2004).

The national response is set out in the Jamaica HIV/AIDS/STI National Strategic Plan (JHANSP) for 2002-2006 (Ministry of Health, 2002). This recognises the gravity of the HIV epidemic and its negative consequences for development in both the nation and the region. HIV and AIDS are identified as a high government priority within government. Alleviating the effects of stigma and discrimination is one of several broad policy issues that are identified to be addressed. The goals of the JHANSP are:

- To build an effective multi-sectoral response to HIV and AIDS;
- To mitigate the socio-economic and health effects of HIV and AIDS;
- To decrease individual vulnerability to HIV infection;
- To reduce the transmission of HIV infection; and
- To improve care, support and treatment services of PLHAs

Developing the education sector response as part of the national multi-sectoral approach is the responsibility of the Ministry of Education, Youth and Culture (MOEYC). Its contribution to reduced individual vulnerability to HIV infection is through *revision of the HFLE curriculum to include HIV prevention and awareness and messages* (p15). This forms a sub-component of the Behaviour Change Intervention and Communication (BCIC) component and with development and dissemination of sectoral HIV and AIDS policy (p17) these represent clear responsibilities for the education sector during the plan period. The strong emphasis on prevention is appropriate and is arguably the first priority for the education sector though at the same time potentially the most difficult to achieve because of the multiple levels of intervention that are required for effectiveness. This is seemingly recognised by MOEYC and reflected in its draft workplan for MOEYC is provided within the JHANSP (pp 26-30).

Four priority objectives are set. These are to:

- i) regain momentum on the HIV/AIDS/STI component of the HFLE programme;
- ii) produce appropriate teaching and learning materials to generate awareness;

iii) provide training for teachers in order to develop competence in the delivery of the HIV/AIDS/STI education programme including the development of peer educators;

iv) increase awareness by the Ministry's personnel and stakeholders of the need for greater responsibility for adopting programmes and workplace policies relating to HIV/AIDS/STI.

A number of key gaps and constraints were identified that would have to be overcome to achieve these objectives. These were:

- Lack of adequate support materials for teachers and students;
- Inability to sustain a high level HFLE programme due to budgetary constraints;
- Inadequate resources (human and financial);
- Inadequate knowledge base of MOEYC personnel;
- Insufficient appreciation of the connection between irresponsible behaviour and the consequence in contracting HIV/AIDS/STI –combined with denial and cultural myths.

The core barriers relate to resources, human and financial. They argue implicitly for a capacity building approach involving the recruitment of technically capable staff specifically for the HIV and AIDS response which would leverage greater sums of money from both government and development partners for programme activities to provide support for teachers and learners.

Four strategies were proposed in the JHANSP:

1. MOEYC would **regain the momentum on the HIV/AIDS/STI component of the HFLE programme**. Policies that impact on HFLE would be strengthened and implemented. HIV/AIDS/STI would be integrated in the core curriculum of HFLE. The number of Guidance Counsellors would be increased. Partnerships with NGOs would be strengthened to deliver programmes in schools and parents would be involved to arise awareness and provide information.

2. MOEYC would **produce appropriate learning and teaching materials to generate awareness**. The relevance and quality of materials for target group and educators would be strengthened and opportunity for tertiary level institutions created to facilitate teaching and /or dissemination of information. Out of school education would be strengthened and the education of the public about children's needs.

3. MOEYC would provide **training for teachers in order to develop competence in the delivery of the HIV/AIDS/STI education programme including the development of peer educators**. Training would be strengthened for teachers, principles, education officers and Guidance Counsellors. The career structure and opportunities for Guidance Counsellors to upgrade would be strengthened. Peer education would be developed in schools.

4. MOEYC would **increase awareness by the Ministry's personnel and stakeholders of the need for greater responsibility for adopting programmes and workplaces relating to HIV/AIDS/STIs**. Information and news within MOEYC and schools would be strengthened.

Although these do not add to a fully comprehensive education sector response and do not match the full scope of the MOEYC policy, they do comprise a set of priority actions that are appropriate to the challenges of the national epidemic identified for the plan period. They provide a set of benchmarks for assessing progress in developing the sector response. A weakness is that they do not seem to address all of the key gaps and constraints identified above and in particular the need to build technical capacity and to obtain an increase in financial resources. The workplan lacks a detailed budget, detailed strategies and performance indicators. It may therefore be considered as an indicative guide rather than a strategic plan. MOEYC progress in achieving its stated objectives for the strategic plan period are described in section 3 below.

1.3.3 Education in Jamaica

Universal Primary Education (UPE) was achieved in Jamaica more than decade ago. The Net Primary Enrolment Rate in 2001 was 97.8% (MOEYC, Statistics Unit). However, the survival rate to grade 5 is in decline from 96.5% in 1999/2000 to 87.6% in 2001/2. This is attributed by the World Bank (2004) to the 1998 policy prohibiting automatic promotion to grade 5 with promotion being performance based in the National Grade 4 Literacy Test. The increasing drop out rate should be a cause for concern for government and civil society alike.

High levels of participation in primary education and lower secondary education such as found in Jamaica are likely to be a strong contributory factor towards reducing the vulnerability of children to HIV transmission. In general, children out of primary school are exposed to greater life risks including sexual risks than those in school. At the same time the widespread primary schooling means that the majority of young children can be easily reached through the school for HIV prevention education through HFLE rather than through the more difficult to implement outreach programmes.

Despite the achievement of UPE the education system faces profound challenges. The Task Force on Educational Reform reported (2004) that after substantial financial investment in education - Jamaica spends an average of 6% of GDP on education, more than most countries - the outcomes are cause for concern. Attendance is low, averaging 78% at primary level. Learning outcomes are poor; about 30-40% of grade 6 leavers are functionally illiterate. The expansion of the education system and the achievement of UPE arguably came at the cost of quality and poor education outcomes. Implementing HFLE in this context without improving the performance of the system is likely to provide sub-optimal results. At the same time those who are performing most poorly at school may be those most in need of HFLE. Improving the quality of education processes and outcomes therefore is an

agenda that is fully congruent with addressing HIV and AIDS and HFLE needs to be fully considered as a contribution to improving the quality of education on offer.

Education system performance is uneven. The quality of schools is variable. The number of classroom hours is low by regional standards, partly because crime and civil disturbances force schools to close (World Bank. op cit). Poor students have less educational opportunity. They enrol into lower quality schools and difficult home circumstances can undermine their education. Generally, children of the poor end up with less education and this perpetuates a vicious cycle of poverty. This is likely a contributing factor to the HIV epidemic and needs to be addressed through a more pro-poor approach to education. The World Bank (op. cit.) recommends an increased focus on early learning to raise grade 6 functional literacy to 100% through teacher training, setting standards of service, providing educational materials to improve overall education outcomes. It also recommends that Government of Jamaica (GoJ) improve incentives and facilities for below average schools and make school results public. These issues resonate with the shortcomings already identified with regard to HFLE.

The Task Force on Educational Reform Final Report (op cit) included a short term plan to March 2005 to establish a Transformation Team to lead the recommended restructuring and transformation of the education system together with a Medium Term Plan to March 2007 for the transformation of education in terms of:

- Institutional arrangements;
- Accountability for performance;
- Terms and conditions of Principals and Teachers;
- Chronic underachievement of the education system;
- Anti-social behaviour;
- Curriculum Development and implementation;
- Student assessment;
- Management of Teaching Staff;
- Access to Schools;
- School Capacity and physical plant;
- Special Needs Education;
- Role of students; and
- Stakeholder partnerships.

This a comprehensive list, but the Task Force on Educational Reform Final Report did not address HIV and AIDS education in any of its thematic area assessments apart from remarking that as a cross-cutting curriculum issue it is not always given the prominence necessary for the holistic development of the child. This may be because the focus was on improving educational efficiency and performance of the system as a whole. However, the failure to consider HIV and AIDS systematically is perhaps indicative of a lack of due priority being given to the problem. This highlights the need to demonstrate that HIV and AIDS education should be seen by MOEYC as a contribution to improving the quality of the education on offer in terms of classroom pedagogy and the relevance of the curriculum to young peoples' lives. At the same

time, the risk of poor education performance at the system to effective implementation of HIV and AIDS education through HFLE needs to be recognised and mitigated with some urgency.

The GoJ is responding to the issue of poor attendance and the need for pro-poor policies by linking social safety net support through the Programme of Advancement through Health and Education (PATH) to families to promote regular school attendance. Other support programmes include a school feeding programme in all primary schools and the free provision of primary textbooks to all children. These programmes have the potential to provide support for children affected by HIV and AIDS, the orphans and vulnerable children (OVCs).

Gender is a significant issue. Progress towards eliminating gender disparity in primary and secondary education has been assessed as 'lagging' (Government of Jamaica, 2004). In contrast to the prevailing situation in much of the world, it is boys not girls who are missing out on education. Males are under-represented at upper secondary and tertiary education. A significant gender disparity is to be found in learning outcomes. Male students are underperforming in relation to girls in reading in particular. Some 45% of male students assessed passed the grade 4 literacy test in contrast with 70% of the girls. Large numbers of those who are functionally illiterate at grade 9 and unable to either read or write are boys. Motivation has been identified as a critical factor (op cit). This surely signals the high priority that should be given to gender analysis and sensitivity in reforming Jamaican education and at the same time developing the response to HIV and AIDS at school.

Perhaps significantly, males are also underrepresented in the teaching force. The majority of teachers at primary and secondary levels are female: over 17,200 out of a total of 22,363 in 2004 (op. cit). This may mean a shortage of male role models at school and contribute to the alienation of boys. To conclude, the Jamaican education system faces a particularly difficult challenge in improving the quality of education delivery and learning outcomes. Addressing HIV and AIDS is likely to be a significant litmus test of efforts to bring about educational reform and the ability of government to take tough decisions.

2 Response Analysis. How Education in Jamaica is Challenging HIV and AIDS.

2.1 Overview

The parameters identified earlier will be used to frame the assessment of the education response. These are:

- Building sustainable capacity to respond to the HIV epidemic;
- Prevention;
- Mitigating the impact of AIDS on the education sector;
- Leadership and commitment to action.

The section on prevention will address the strategies on HIV prevention contained in the MOEYC work plan in the JHANSP. The analysis will:

- Consider the response of all the education sub-sectors;
- Concentrate on responses in priority areas;
- Examines whether responses are appropriate to the situation;
- Identifies gaps in the response and considers why they exist;
- Analyses why some initiatives are working well and why others are failing.

It seeks to provide answers to the fundamental set of questions mentioned in the section on methodology (1.2).

2.2 What is working well and needs to be continued or expanded?

It must be stressed at the outset that the education sector response to HIV and AIDS is at an early stage of development and the effects of interventions are only just being felt at school level. It is too early to say with confidence backed by objective evidence that any action is yet delivering significant benefits to the national response. The position taken in this analysis is that some activities appear to be working well enough and promise results in the short to medium run.

2.2.1 Policy

The most significant step taken by the Jamaican Government in supporting an education sector response is to agree a national policy for HIV and AIDS in schools. Technical and financial support were provided by UNICEF and CIDA. Although drafted in 2001 it took until 2004 to be endorsed suggesting a cautious approach to the issues to be addressed. That the government now has an official set of positions on prevention and non-discrimination provides it with a platform for initiating comprehensive action in early childhood, primary and secondary education in public and private schools. HIV and AIDS policies for higher education fall outside with the risk that this brings about a disconnect between the two sub-sectors.

The **National Policy for HIV/AIDS Management in Schools** covers a range of issues many of which could be considered as workplace issues. These include non-

discrimination, HIV testing in relation to admission and appointment, attendance of children with HIV, disclosure and confidentiality and HIV prevention through education and in the school setting. It is reportedly the first comprehensive HIV and AIDS policy for education in the Caribbean region. Jamaica is now in a position to implement a policy-based approach, which is judged necessary for a scaled up response in the sector which will require investment in strategic planning.

There are gaps in the policy and some areas which could benefit from further definitional detail. There is a lack of attention to the impact of AIDS on education whether on the staff or students and orphans and vulnerable children (OVCs). There is no mention of gender issues or access to treatment, care and services. The policy on HIV education could be usefully augmented with details about curriculum content, teacher preparation and support, timetabling and assessment of learning outcomes. Responsibilities at all levels of the system for implementing the policy could be made more explicit. In the short run, however it is recommended that the Ministry of Education, Youth and Culture (MOEYC) continue with the process of policy dissemination in schools and complete national coverage. MOEYC should consider capacity building at central and decentralised levels to monitor the effectiveness of the policy in practice in bringing about intended changes and behaviours in schools and to plan for subsequent revisions within a five year-period in the light of experience and international best practice.

A number of immediate concerns arise. First, there is the emergence of a number of policies on HIV and AIDS. Awaiting government approval are the National HIV/AIDS Policy and the National Workplace Policy on HIV/AIDS drafted by the Ministry of Health and Ministry of Labour respectively. The National Policy for HIV/AIDS Management in Schools preceded both and this presents a challenge and an opportunity. The challenge is to maintain policy consistency on education in these different emerging policy documents. The opportunity is to develop an approach to policy that is dynamic and informed by different perspectives and line ministries. It will require dedicated capacity to develop policy on HIV and AIDS in MOEYC linked to that which is needed for monitoring and evaluation. A second concern is that policy needs high-level political support, the power of sanction and the application of resources, both human and financial to make it work. While some of these elements are in place not all are sufficiently present to provide confidence of success. The necessity for building ownership of the policy within the sector during the dissemination process suggests that stakeholder participation in policy formulation may have been limited.

2.2.2 Policy Dissemination

MOEYC embarked on an active programme of policy dissemination in school year 2004-5 with support from UNICEF and CIDA which has greatly raised the profile of the HIV and AIDS response. The approach has involved a programme of workshops targeted at school level stakeholders implemented through the 6 Regional Education Offices. PLHAs through JN+ have been involved in workshop delivery. This decentralised approach has enabled some 1570 representatives from 440 schools out of a total of around 1000 to be oriented to the new policy. All junior high schools

have now been covered and the programme must now reach all the remaining primary schools and early childhood programmes. Policy dissemination thus represents work in progress. Issues about the quality of and consistency of the programme and the level of stakeholder participation in the process have been raised and will need to be addressed. This can be assisted by developing a resource bank of good quality workshop training materials. It is of critical importance for school principals to engage with the policy seriously and support the creation of an enabling environment for its implementation in the school. Holding school level workshops would assist this process. It is vital that MOEYC has a monitoring and evaluation framework in place for assessing progress in and obstacles to implementation.

2.2.3 Capacity Building Through the Establishment of the HIV and AIDS Response Team (HRT) to Operationalise Policies and Plans.

The setting up of the HRT in 2004 has been the most significant practical achievement by MOEYC and offers a model of good practice. There is now dedicated institutional capacity at MOEYC headquarters in the Guiding and Counselling Unit and health promotion expertise in all 6 Regional Education Offices. This team comprising 16 persons is now responsible for disseminating and subsequently supporting the implementation of the MOEYC policy. It represents a key strategic advance without which dissemination and implementation of policy would have been much more problematic. Support for this initiative was provided by UNESCO, UNICEF, JICA and the World Bank.

The HRT has already been formatively evaluated. The findings of the evaluation process were generally positive resulting in an endorsement for a continuation of the approach. GFATM support together with that of JICA through its financing of JOCV volunteers will help to sustain the HRT in the short run. In the longer run MOEYC will need to determine whether it wishes to sustain the HRT and if so at what level of human resources. Currently only one member of the team is being funded by Government of Jamaica.

The demands that will be put on the HRT are likely to intensify as momentum builds up around the different strands of policy implementation. Strategic planning needs to take place to consolidate the work of the team at all levels and to ensure that its resources are used to the best effect and that further resources are budgeted for if need be. Additional resources are likely to be required as are training and better IT access. Consideration needs to be given to developing capacity in monitoring and evaluation.

Regarding the forthcoming work of the HRT in policy implementation, it is recommended that a practical guide be developed for school principals and staff on the details of policy implementation. This should also include guidance on establishing HACs and their activities.

2.2.4 University Policies on HIV and AIDS.

Policies on HIV and AIDS have been formulated and approved by the University of the West Indies (UWI) which has a campus in Jamaica (Mona) and University of Technology, Jamaica. The former is a regional institution, the latter Jamaican. Higher education policies lie outside the framework established by MOEYC policy as its title suggests this is for schools only. Achieving consistency and complementarity between the two levels of policy is a challenge for the national Jamaican HIV and AIDS response, especially as UWI is a regional entity.

As with MOEYC policy there are strengths and weaknesses of the two higher policies. Neither policy is as comprehensive as it might be. Both can serve as a vehicle for mobilising the institution to support the response to HIV and AIDS through addressing them through the core functions of university in teaching, learning and research. Both address stigma and discrimination. There are striking differences between the two in terms of their content and coverage of potential issues. Both are light in terms of the details of the prevention education to be available to students and responsibilities for policy implementation. Further work is needed in developing a wider coverage of workplace issues. Fostering active student participation in policy formulation and implementation appears to be a key challenge for UWI in particular. Both universities need to focus on developing more effective policy dissemination strategies as well as ensuring that HIV and AIDS is appropriately included in university strategic plans.

2.2.5 Capacity Building for HIV and AIDS in Higher Education.

An innovative capacity building programme has been implemented at UWI. This is the UWI HIV/AIDS Response Programme (UWI HARP) which has been supported by the EC. New professional staff members have been taken on in health economics, communication, behavioural sciences, medicine and public health. There is the perception that the programme is health biased as it is based in the Medical Faculty. The recruitment described above seems to manifest a prioritisation of investment in the health sector. To date there appears to have been very little added value for the education sector response in Jamaica or elsewhere. The challenge for UWI then is to broaden the scope of capacity building to include other disciplines such as law and education. The latter will be catered for to some extent by the establishment of the **UNESCO Chair in Education and HIV and AIDS**. The position is being funded by the Commonwealth Secretariat and a professor has recently been appointed following a recruitment exercise.

The main concern about UWI HARP is its reliance on donor funding which is coming to a close. UWI needs to allocate its own finances to consolidate the gains made by UWI HARP and institutionalise them. This ideally should be done through the development of a strategic plan for a 5-year period in the context of the university's own strategic plan development. To assist this process an independent review of the effectiveness of policy implementation would be a useful input.

In education, the UNESCO Chair can help accelerate the regional response to HIV and AIDS and support national efforts by addressing key areas such as educational

debate, research, capacity build expertise in key areas such as life skills education, gender analysis, monitoring and evaluation, and document best practice.

2.2.6 Research

There has been some very relevant research on young people carried out during the last 5-10 years by academics and NGOs through various initiatives which should be familiar to education policy makers. Some has been focused on HIV and AIDS, some on issues which are relevant to vulnerability and risk in young people's lives. In aggregate, they provide a reasonably good knowledge base for policy makers and practitioners to plan a comprehensive response to meet their needs. Research on what young people say they want or need in relation to HIV and AIDS is conspicuously missing.

Among the key sources of information are the **National Knowledge, Attitudes, Behaviour and Practices (KABP)** Survey carried out under the aegis of the JHANSP and the **Knowledge, Values, Attitudes and Practice (KVAP)** survey among adolescents with disability supported with UNFPA funding. Additional qualitative research is needed among young people to complement these. A study of adolescent reproductive health and survivability (Gayle et, 2004) in urban St Catherine yields many insights into the constellation of risk and vulnerability that young people face in their daily lives. This includes, hunger, fear of violence, physical abuse by parents, teachers and others, sexual abuse and prejudice against them. HIV and AIDS interventions need to take these contextual factors into account in a multi-factorial approach. Similarly the insights into gender and masculinity in particular that are provided by Chevannes (2001) need further exploration and programmatic responses to address male under-performance at school.

Research is particularly needed in relation to:

- Implementation of HFLE;
- Preventing and responding to HIV and AIDS-related stigma and discrimination at school;
- Gender and masculinity in education.

There is a need for a more strategic approach by MOEYC and development partners to the commissioning of research and ensuring that it informs both policy and practice. The success of MOEYTC policy implementation and HFLE in particular will be determined by this to a significant extent.

2.2.7 Development Assistance

The support provided by Jamaica's development partners has been key in achieving outcomes to date and for providing the platforms for further action. It appears to have been relatively well co-ordinated, strategic with some important innovative developments being supported. Much of the financing and technical support for the education sector so far has come from development partner assistance. Such

assistance needs to be continued but with a longer planning time frame and an increased commitment from the Government of Jamaica.

2.3 What is not yet working, but should be continued?

2.3.1 HFLE

Implementation of HIV and AIDS prevention education within **Health and Family Life Education** (HFLE) represents arguably the greatest challenge for MOEYC in achieving its policy objectives. HFLE has been identified in MOEYC policy as the main vehicle for HIV prevention education and which 'must be implemented through integration in the curriculum for all students and school personnel'. Currently it is unclear to what extent HFLE is being implemented in schools. It has a low status in the curriculum because it is not a core subject and not examined.

Currently MOEYC is attempting to build stakeholder support in schools through its policy dissemination workshops. This needs to continue. The piloting of the revised HFLE curricula is about to take place in 24 schools in 2005 with a plan to scale up to 200 in 2006. Support for this project is being provided during this period by UNICEF in collaboration with UNESCO, GFATM, the World Bank and UWI-HARP. This is an important strategic intervention which will require the development of a robust monitoring and evaluation framework to measure progress towards objectives and outcomes.

In preparing for the HFLE pilot and ensuring it works effectively in supporting behaviour change, lessons can be learned from international experience in introducing skills based health education as a means of HIV prevention education. The UNAIDS Benchmarks provide pointers towards good practice in this field and should be referred to in programme development. Some of the issues to be faced include:

- **Time on task.** HFLE is broad in content and this limits time available for teaching and learning about HIV and AIDS;
- **Teacher preparation.** Teachers need adequate training preparation to teach the new content and to use participatory methods effectively. In the short run, in-service training at the project level can be used to kick start the approach, but in the longer run investments must be made in pre-service teacher training and in developing a national programme of in-service training and professional support. In a separate project, HFLE is to be piloted in 4 teachers colleges in what should be a linked initiative with the schools' pilot.
- **Participation of young people.** It is unclear to what extent young people participated in the revision of the HFLE curriculum. The new curriculum must motivate the students, both boys and girls, and feel that it is relevant to their lives, and is not messages being broadcast to them. The introduction of good quality peer education may assist this. JRC are to pilot a peer education approach in a separate initiative.
- **Teaching and learning materials.** Materials need to be developed to support both teaching and learning. This could include textbooks, teachers' guides and

readers. Currently no materials are available apart from IEC pamphlets although readers developed for Africa will be piloted this school through Jamaica Library Service Mobile Bus in a separate initiative and a **Lesson for Life Activity Pack** has been prepared for World AIDS Day in another separate initiative;

- **Building community level support.** Attention needs to be paid to building stakeholder support at community level by working with the church, faith based organisations and parents;
- **Linkages with youth friendly services.** This is lacking in the MOEYC Policy yet critical to success in relation to HIV prevention.

As can be seen, there are a number of initiatives taking place concurrently in different project frameworks all related to HIV prevention education. A detailed implementation plan is needed for all school-based interventions and HFLE in particular over the next 5 years to bring coherence to this work and to facilitate planning, resource mobilisation, co-ordination, capacity building, monitoring and evaluation. Early childhood HFLE should be included within this plan as the new curriculum will need piloting at this level.

2.3.2 Health Advisory Councils (HACs)

The MOEYC Policy specifies that each institution should establish its own HAC and develop action plans to give operational effect to the policy. This is as yet untested. There is no detailed guidance available and no resources for HACs to use. Setting up HACs might best be approached in a pilot project approach on a limited scale so that lessons can be learned through formative monitoring and evaluation about what makes for an effective HAC and these can then inform subsequent scaling up. It is therefore recommended that establishing HACs be subject to a strategic planning discipline.

2.3.3 HIV Prevention in Co-curricular Education

Although the MOEYC policy usefully encourages the integration of HIV and AIDS education in sport, further exploration is needed in relation to making good use of co-curricular opportunities for prevention education. Staff involved in sport will need specific training and guidance/resource materials to undertake their new work effectively. Peer education programmes could be supported. This needs to be incorporated in strategic planning.

2.3.4 HIV Prevention in Special Education

Mention has been made already of the KVAP survey among adolescents with disabilities. They represent a vulnerable group with special needs. This needs to be recognised in policy and practice. A strategic approach needs to be taken within MOEYC's framework for special education.

2.4 What is not working and needs a new strategic approach?

2.4.1 Leadership

There appears to be an insufficiency of leadership support for the MOEYC policy and its implementation at all levels. Stronger and more consistent engagement is needed in particular from senior officials, Regional Directors of Education and School Principals. MOEYC needs to show its commitment to addressing HIV and AIDS in the education sector on its website and through regular communications to stakeholders about policy implementation.

2.4.2 Addressing Stigma and Discrimination

The persistence of stigmatisation of children living with HIV and AIDS is a reality in Jamaica and results in children facing exclusion from education despite unambiguous MOEYC policy. Unless addressed it will tend to undermine prevention efforts. A more comprehensive approach to preventing stigma and discrimination is needed in schools. It is unclear at the moment whether the revised HFLE has the potential to achieve any impact in this field. Consideration needs to be given to fostering the development of innovative activities in this field. It may be an area of policy implementation that the HAC will want to take on.

How can education comprehensively tackle stigma and discrimination? Kelly (2003) advocates a multiple response involving the following set of actions:

- Establishing a clear regulatory framework which is rights-based and including a manual for use by school boards and parent teacher associations;
- Ensuring that every educational institution manifests a welcoming approach for infected and affected children and staff with zero tolerance for discriminatory behaviour;
- Ensuring that every pupil has sufficient knowledge of HIV and AIDS to dispel common myths about HIV transmission and prejudices about and intolerance towards those infected with HIV or affected by AIDS;
- Including education on ethics, values and human rights. Aggleton and Parker (2002) recommend the promotion of human rights generally and in particular of PLHAs as well as the implementation of lifeskills education.

2.4.3 Impact Mitigation

The impact of AIDS on the education sector is omitted from the MOEYC policy. While attention is paid to protecting the rights of children living with HIV and AIDS, there is no mention of orphans and vulnerable children (OVCs). Quantitative data on OVCs appear to be lacking in relation to education, possibly a consequence of fear or stigmatisation. Qualitative research provides evidence for OVCs suffering significant disadvantage as a result of stigma, deepening poverty and social disruption. Attention needs to be given to developing a policy-based response to the educational disadvantage being faced by OVCs. The strategies for the education sector in the **National Plan of Action for Orphans and Other Children Made Vulnerable by HIV and AIDS** were developed prior to the approval of the MOEYC Policy on HIV and AIDS and need to be revisited and updated/revised.

2.4.4 Gender Responsiveness

Addressing gender inequalities is going to be critical not only for developing an effective response to HIV and ASIDS, but also for the future of educational reform in Jamaica. The MOEYC Policy currently does not explicitly address gender issues. Gender needs to be mainstreamed throughout the MOEYC HIV and AIDS response at all levels including HFLE. Institutional capacity needs to be created within the HRT to enable it to undertake gender analysis and monitor programmes from a gender perspective.

2.4.5 Monitoring and Evaluation

The need for monitoring and evaluation capacity is a theme throughout this report. Currently this is an area where capacity is conspicuously lacking. It is particularly needed for assessing the effectiveness of HFLE and HIV prevention efforts in general. What is needed is a monitoring and evaluation framework for policy implementation and HRT staff trained in M&E. This would be best addressed through a strategic planning exercise which would identify SMART indicators and institutional capacity needs for the medium term sector programme.

2.4.6 Strategic Planning

The lack of a detailed and comprehensive strategic plan for the sector is a major impediment to building a scaled up response. There are numerous initiatives on HIV and AIDS being planned for or already under way in the education sector. These need to be included within a single strategic sector plan for HIV and AIDS to enable co-ordination of effort, coherence of implementation, adequate resource mobilisation, sustainable capacity building and effective monitoring and evaluation.

2.5 What is not relevant to current needs and should be dropped.

No evidence was found of redundant or irrelevant programmes.

3 Detailed Analysis of the Education Response.

3.1 Building Sustainable Capacity to Respond to the Epidemic

The three essential elements of this for the education sector to respond effectively to the multiple and changing challenges of HIV and AIDS are:

- a comprehensive policy,
- a costed strategic plan; and
- institutional capacity at all levels to implement.

The three elements are interlocked and interrelated. Deficiencies in any one of these will tend to undermine the contribution of the others. Progress needs to take place on all three fronts simultaneously to achieve the maximum synergies. The complexity of this task is arguably a major reason why the education sector response has been slow in taking off in differing contexts around the world. It requires that governments realise that HIV and AIDS are integral to the core business of education systems and take action to build the necessary capacity to develop and sustain a comprehensive response. This is what is meant by 'mainstreaming', a much misunderstood term, which is infrequently applied in practice. Taking this agenda seriously is an indicator of good governance and the processes by which they are accomplished are indicative of a government's commitment to the well being of all its young people and the future of the nation.

3.1.1 A Policy Based Approach

The development of comprehensive policy is essential to guide the education sector response to HIV and AIDS (Kelly, 2003). Such policy is additional to developing the National AIDS Policy, because the latter being a broad enabling document would lack attention to the detailed needs of education institutions and processes (MTT, 2004). Current appraisal toolkits for assessing the education response to HIV and AIDS tend to take a binary approach (UNESCO, 2003, MTT, 2004, Kelly, 2003); either there is a policy in place or there is not. The former indicates achievement, the latter a deficit.

There is less clarity and consensus on the key policy areas of content, process and power (Walt, 1994). There is, for example, currently no equivalent for the education sector of the ILO Code of Practice on HIV/AIDS and the World of Work (2001), a product which has been influential in guiding the development of both national workplace policies and education sector policies. Neither is there any international guidance on the process of how to develop and implement an education sector policy on HIV and AIDS. This a gap which could be usefully addressed by the EDUCAIDS initiative.

Recommendation 1: *It is recommended that EDUCAIDS consider the development of evidence-based guidance on education sector policy formulation and implementation on HIV and AIDS for Ministries of Education,*

National AIDS Committees, civil society organisations and development partners.

The approach taken in the analysis below is to draw on the literature of health policy, education and HIV and AIDS, together with reference to examples of policy from Africa.

3.1.2 Policy in Place

The Government of Jamaica has put in place an education policy on HIV and AIDS: the **National Policy for HIV/AIDS Management in Schools** (Ministry of Education, Youth and Culture, 2004). Work on this commenced in 2001 and following extensive stakeholder consultations it was approved by Cabinet in 2004. Technical and financial support were provided by UNICEF and CIDA. It is the first comprehensive education sector policy in the Caribbean region (Morrissey, 2005). This is a significant achievement in itself and provides an invaluable platform for comprehensive strategic planning and capacity building.

The Ministry of Education, Youth and Culture (MOEYC) policy is assessed below from a content perspective in terms of key areas which are suggested by the available literature on policy development and actual policy documents.

3.1.3 Policy Content

a) Political endorsement. Policies once approved may include a forward by the Minister of Education (e.g. Zambia) or Ministers of Basic Education and Higher Education (Namibia) which provide overt indications of political support, ownership and legitimacy to the document. The Jamaican MOEYC policy carries no such endorsement.

There is currently no reference to the National HIV/AIDS Policy (MoH, 2005) in the MOEYC policy. This is because the MOEYC policy predates the national Policy which still awaits formal government endorsement.

Recommendation 2: It is recommended that subsequent versions of the MOEYC policy carry high-level political endorsement in the foreword to the document.

b) Guiding Principles and definitions. It is becoming common practice to include within the policy document a definition of technical terms and to provide broad guiding principles (e.g. Uganda, Zambia and Namibia). These can help demonstrate conformity with international conventions, national laws, guidelines and regulations. They are therefore a means of outlining the human rights underpinnings of the policy. Guiding principles can include:

- A multi-sectoral approach;
- Mainstreaming HIV and AIDS

- Rights to privacy and confidentiality;
- Legal framework (Constitution, laws, statutes, policies etc)
- Zero tolerance of sexual harassment, abuse and exploitation;
- Right to protection from stigma and discrimination;
- Gender equality and responsiveness;
- Greater involvement of people living with HIV and AIDS (GIPA)

The MOEYC policy includes neither definitions nor guiding principles. It misses the opportunity to link with human rights and education on human rights. It does provide a section on the Legal Framework.

Recommendation 3: *It is recommended that subsequent versions of the MOEYC policy include a section on its guiding human rights principles and a list of key definitions.*

c) Scope of application

The scope includes direction as to which institutions fall under the policy remit. In Namibia, for example, policy is clearly applicable to all government and private education institutions. It therefore covers both basic and higher education. The MOEYC policy applies to ***all educational institutions that enrol students in one or more grades and at all levels***. Implicit in this statement is that coverage of the policy extends to private schooling. There is no mention of HIV and AIDS in special needs education at school level.

As the title of the document suggests the policy concerns schools. It does not apply to higher education institutions. In some cases these have developed their own institutional policies on HIV and AIDS (UWI and University of Technology, Jamaica). The two sub-sectors have developed their policies independently of each other with no explicit linkages resulting in a degree of policy incoherence in the sector as a whole. There is no mention of either adult education, though delivery in this area appears to be linked to higher education. It may be worth MOEYC developing policy guidelines on HIV and AIDS for post secondary education institutions that are based in Jamaica.

Recommendation 4: *It is recommended that subsequent versions of the MOEYC policy include further clarity on its scope of application especially in relation to private education provision, special needs education, adult and higher education institutions. Guidelines should be prepared for those sub-sectors which fall outside the remit of current policy.*

d) HIV Prevention

HIV prevention encompasses a number of areas for policy guidance. It is here that government can specify how prevention education will be implemented. This may be in terms of:

- Provision of information on HIV and AIDS (e.g. access for all to current, accurate, appropriate and complete information)
- The curriculum (including for students, teachers and co-curricular activities). Curriculum policy might include inclusion of HIV and AIDS in the official curriculum, options include a) as a stand-alone subject, b) integrated within a main carrier subject c) as a cross curricular issue or d) infused throughout the curriculum. Specification may also include time allocations, assessment of learning outcomes and contents of HIV education;
- Curriculum approach such as a skills-based health education approach (life skills), edutainment and peer education;
- Access to prevention services (e.g. health services, condoms).

The MOEYC policy provides some policy guidance in all four areas in the section on 'Education on HIV/AIDS' (p. 12-14): -the provision of information, the curriculum content, approach and access to services. The main vehicle for HIV prevention education will be Health and Family Life Education (HFLE) ***which must be implemented through integration in the curriculum at all school and institutions for all students*** (in pre-primary, primary and secondary schools) ***and school personnel***. HFLE should include appropriate prevention and avoidance measures, including abstinence, faithfulness to one's partner and the use of condoms, obtaining prompt medical treatment for STIs and the application of universal precautions.

HFLE will also include information on the role of drugs, sexual abuse and violence in the transmission of HIV. Participatory methods of learning are encouraged including games, role and play. Children 'should be encouraged to ask questions' and receive 'reasonable, comprehensible and appropriate answers'. Life skills for HIV prevention will be developed.

Gaps

There are some significant gaps, however, in policy specification.

- The policy makes no explicit mention of the teacher in relation to the delivery of HFLE in the classroom. There needs to be policy on teacher training either in-service or pre-service to prepare teachers to teach HFLE effectively in the classroom as intended by the curriculum. It is unclear whether the HFLE for all school personnel is intended to address the professional preparation of teachers.
- There is no mention of any assessment of HFLE learning outcomes, peer education or of co-curricular activities apart from sport where staff are encouraged to educate about safe sex and seem medical and counselling help where appropriate
- There is a lack of specificity about how students will be assisted in accessing health services.

Recommendation 5: It is recommended that in future versions of the MOEYC policy consideration be given to making clearer statements on teacher preparation and responsibilities for implementing HFLE, how HFLE learning outcomes will be assessed and how students will be supported in accessing services.

Issues

A significant challenge to implementation is likely to arise from the vagueness of the status of HFLE in the official curriculum and will likely require additional guidelines for implementation in schools. There is a lack of precise specification as to how HFLE would be integrated or infused in the official curriculum. It should be noted that the curriculum infusion approach is generally considered to be ineffective (UNESCO. IBE. 2005).

Recommendation 6: It is recommended that clear practical guidelines be developed for school principals and teachers on the delivery of HFLE at school level as a means of ensuring consistent policy implementation.

e) Impact mitigation

The impact of HIV and AIDS on education sectors affects both the demand for and supply of education with a strong tendency to exacerbate existing weaknesses in the quality of provision and learning outcomes. With regard to the impact on demand, this mainly involves how children are negatively impacted by the sickness and loss of parents to AIDS. These children are often referred to as **orphans and vulnerable children** or OVCs. The impact on supply refers to the loss of productivity and expertise when school staff are living with HIV and AIDS without access to treatment. Some of these issues resulting are probably best handled though the development of a comprehensive workplace policy.

Education sector policies may make reference to National Policies on Orphans and Vulnerable Children (e.g. Uganda). Areas of policy support for OVCs include:

- Elimination of financial barriers to education (fees and non-fee costs);
- Support to maintain school attendance and learning including nutrition, psychosocial counselling, cash transfers etc;
- Establishing early childhood care, education and development programmes;
- Capacity building including through training school principles on school management in AIDS-affected communities;
- Mobilising community networks to support monitoring of OVCs.

The MOEYC Policy contains no reference to OVCs or children affected by HIV and AIDS. The focus rather is on children who are infected with HIV.

Recommendation 7: It is recommended that attention be paid to developing policy guidance on education for children who are affected by HIV and AIDS such as orphans and vulnerable children (OVCs) to complement that already in place on children infected with HIV.

f) Treatment, Care and Support

Sections on treatment and care may include policy guidelines on how access to treatment will be facilitated by the education sector for its employees and learners. It would also guide on access to VCT. Ideally, this would refer to provisions of the School Health Policy or its equivalents. There may also be reference to support for treatment literacy/education, but this is a new and emerging area.

There is no mention of access to treatment and care in the MOEYC policy.

Recommendation 8: It is recommended that policy guidance be developed for the education sector on access to treatment, care and support for staff and for learners.

g) The Education Workplace

Guiding principles for workplace policy process and content are defined in the ILO Code of Practice on HIV/AIDS in the World of Work (2001). Typical areas that would be covered in a workplace policy include:

- Prevention;
- Workplace testing;
- Confidentiality;
- Non-discrimination in relation to recruitment, training and promotion;
- Gender equality;
- Managing illness and job security;
- Health and safety: First Aid; security, sexual harassment codes of conduct
- Protection against victimization;
- Care and support for PLHAs;

The education workplace is different from most others in that in the care of the workers are children. Their rights need to be considered within the framework of the workplace policy. It would include, for example, policy on admission and continued attendance at school and educational institutions.

The MOEYC policy includes the following policy areas:

- Non-discrimination and equality;
- HIV testing, admission and appointment;
- Attendance at institutions by students with HIV and AIDS;
- Disclosure and confidentiality

- A safe institutional environment;
- Prevention measures related to play and sport;
- Refusal to study with or teach a student with HIV or AIDS or work with or be taught by an educator with HIV or AIDS.

Policy coverage relates to protecting the employment and education rights of children and staff living with HIV and AIDS. Health and safety is to be ensured through first aid training for staff and students and an emphasis on dealing safely with blood through the adoption of universal precautions.

Gaps

There are gaps. These include a lack of reference to gender issues, school security, sexual harassment and abuse. Health and safety does not include hygiene and sanitation at school. It says little about HIV and AIDS education for staff except in relation to HFLE.

Clearly relevant to the MOEYC Policy is the National Workplace Policy on HIV/AIDS which has been drafted (Ministry of Labour and Social Security, 2004) with support from the World Bank and currently awaits government approval. Its scope of application applies to all workers, current and prospective in the public and private sectors and all employers of labour in the public and private sectors. It therefore applies to the education sector, both public and private.

All workplaces are encouraged to adapt or adopt the policy. This would include schools. The policy aims to promote and sustain equity in the workplace and remove discrimination. It also aims to empower working adults with the knowledge and skills necessary to initiate and sustain healthy relationships which would reduce vulnerability to HIV. In assigning roles and responsibilities, it was decided that the Ministry of Labour and Social Security would represent the government, the Jamaica Confederation of Trade Unions the workers and the Jamaica Employers Federation (JEF) would represent the employers. Implementation would include the following steps:

- Every workplace should designate a Focal Point on HIV and AIDS and establish a working HIV and AIDS Committee to implement the workplace policy;
- The HIV and AIDS Committee should have representatives from all categories of worker and co-opt if possible PLHA from outside the organisation;
- The HIV and AIDS Committee should lead the process of developing and implementing annual workplans to implement the policy.

The National Workplace Policy on HIV/AIDS, if approved in its current draft, would present a number of opportunities and challenges to the Education sector.

First, there would need to be a comprehensive dissemination process which would cover all schools and education institutions. Experience with disseminating the MOEYC Policy has shown this to be a complex project which requires strategic

planning and adequate resourcing, human, material and financial to be successful. It would likely require a sub-regional workshop approach which would lead to school-based dissemination.

Secondly, The Jamaica Teachers Association, the MOEYC and the MOLSS would need to meet together to agree an approach to implementation of the workplace policy either fully adopted in its current form or adapted.

Thirdly, the proposed position of Focal Point for HIV and AIDS would need to be carefully considered in the light of existing school-level commitments on HIV and AIDS. It may be necessary to consider aligning the HAC with the Focal Point responsibilities.

Fourthly, the proposed HIV and AIDS work plan will be additional to the HAC workplan intended to implement the MOEYC policy. This would entail that 2 separate HIV and AIDS workplans will be current for each school and again these would need to be linked, aligned or harmonised for ease of management.

Fifthly, the new workplace policy will present additional monitoring and evaluation requirements on MOEYC and partners. Capacity building should be considered in advance of any further policy implementation.

Finally, the workplace policy could usefully consolidate the MOEYC policy and even contribute to addressing some of the pertinent gaps in the latter particularly those relating to teachers and school staff.

A new development is the development of A Workplace Policy on HIV/AIDS for Educational Institutions in the Caribbean Region which is a product of ILO and UNESCO collaboration. This is an adaptation of the ILO code of Practice applied to the education sector. If agreed at the regional level this document could then serve as a means of tailoring the National Workplace Policy on HIV/AIDS for the education sector.

Recommendation 9: It is recommended that the current MOEYC Policy be aligned with the National Workplace Policy on HIV and AIDS and reviewed from the perspective of a comprehensive workplace policy consistent with ILO and UNESCO guidance.

h) Management/Implementation

It is important for effective policy implementation that responsibilities are clearly specified. In particular, who is responsible for implementation at Ministry Headquarters, Regional Offices and schools?

The MOEYC Policy is vague on specific responsibilities for implementation. Overall responsibility will lie with MOEYC and all education institutions should develop action plans to give operational effect to the policy. Each institution should establish its own

Health Advisory Committee (HAC) as a committee of the governing body or council. There is a lack of clear direction as to who is responsible for establishing HACs and who should be a member. It is stated that membership should include educators and other staff, representatives of parents of students and from the medical or health care professions.

The HAC will be responsible for developing the institution plan for implementing policy and for reviewing it from time to time, 'especially as new scientific information becomes available'.

Recommendation 10: *It is recommended that further clarity be provided on roles and responsibilities for policy implementation and which would include monitoring and evaluation. Guidance needs to be provided on how to establish Health Advisory Committees (HACs) and what their precise remit should be, including in relation to other local actors in the HIV and AIDS response. This would be likely best achieved through the development of implementation guidelines or handbook for the MOEYC policy. It is further recommended that the setting up of HACs be piloted initially and formatively evaluated before going to scale.*

3.1.4 Policy Process

It is unclear from the MOEYC policy document itself what processes were involved in formulating and agreeing it. It is therefore difficult to make any judgements about the participation of key stakeholders in these processes and the extent to which they feel any sense of ownership. The only consultation that is explicitly referred to is with the Attorney General regarding the legal framework which will support the MOEYC policy.

Issues relating to implementation of policy have been discussed above. A key concern is how policy will be monitored and reviewed. It is stated that the policy will be reviewed '***within a five year period to take into account any new developments in the methods of infection and treatment of persons with HIV/AIDS.***' It does not mention that the review will take into account the performance of policy implementation in meeting stated goals or whether it will be participatory.

Recommendation 11: *It is recommended that SMART performance indicators be developed for monitoring and evaluating the implementation of the MOEYC policy.*

3.1.5 Policy Power

A policy provides a platform for action. It is a quasi-legal document which should provide both incentives for compliance and sanction in cases of overt resistance if implementation is to be effective.

It is likely to be helpful if top down and bottom approaches are combined. The former would include explicit commitments on the part of Government and at senior Ministry level together with clear lines of responsibility and accountability for implementation. The linking of the policy to rights already enshrined in the laws of the country and supporting policies within the sector or at a national level may help strengthen its legitimacy. A bottom up approach would involve civil society build local level capacity to implement policy and have responsibility for monitoring it in practice.

We have already seen that the MOEYC policy lacks explicit commitment by senior officials and that lines of accountability for implementation are fuzzy. There is no reference to supporting legislation on either the right to education or on anti-discrimination. The only legislation that is referred to is the Public Health Act and the Education Regulations (31.1) of 1980 and the Education Act (1965, section 24) concerning communicable disease and grounds for exclusion from attendance at school. There is currently no specific legislation in Jamaica regarding HIV and AIDS issues (Ministry of Labour and Social Security, 2004).

There is no reference in the MOEYC policy to other related policies. In the education this could have included the Policy for the Management of Substance Abuse in the Education System (MOEYC. 2004), development of which was supported by the European Union. Neither is there reference to the National Policy on HIV/AIDS (May 2005) which is excusable as it predates it, but this should be addressed in the next reprinting once the National HIV/AIDS Policy has been approved by parliament. The National HIV/AIDS Policy mentions the MOEYC policy as an indication of the strong commitment of the Government of Jamaica to addressing HIV and AIDS. What is striking is the lack of consistency between the two on what they prescribe for prevention education. The MOEYC policy takes a strong position on the role of HFLE as the vehicle for HIV prevention, while the National HIV/AIDS Policy is silent on this, advocating the incorporation of age-appropriate reproductive and sexual health education into curricula for all students at school and made accessible to out of school youth. Earlier in the document, it is stated that information on HIV and AIDS should be disseminated within a 'life skills context'. There appears to be a lack of clarity on what should be implemented in schools and this risks causing confusion among all stakeholders including policy implementers.

Recommendation 12: *It is recommended that steps are taken to ensure consistency between the MOEYC Policy and other national policies on HIV and AIDS and policies on education.*

A further means of strengthening legitimacy is to refer to international agreements, conventions and regional frameworks. The MOEYC Policy fails to mention the Declaration of Commitment on HIV/AIDS (United Nations, 2001) while it is referred to in the National HIV/AIDS Policy. Similarly, there is no reference to the Caribbean Regional Strategy Plan of Action for HIV/AIDS (CARICOM. 2000) which highlights HFLE for HIV prevention at school. There is no mention either of the Havana Commitment of Caribbean Minister of Education (2002) which endorsed the need for an enhanced education sector response to HIV and AIDS.

Recommendation 13: *It is recommended that consideration be given to including relevant international agreements on education and HIV and AIDS in future versions of the MOEYC Policy document.*

3.1.6 Policy Dissemination

It is unclear whether MOEYC has a standard approach to policy dissemination. In the case of the HIV and AIDS policy a tailor-made process of dissemination is being carried out with external assistance.

A decentralised approach is being taken through the 6 Regional Education Offices to bring to the attention of schools the new policy directives. The process has involved the delivery of dissemination workshops. A total of 58 workshops have taken place involving 1570 representatives from 440 schools (out of a total of 989 at primary and junior high level, both public and private, in addition to which there are a further 139 secondary high, 14 technical high and 2 vocational/agriculture schools). There are some 22,000 teachers serving in the school system, roughly half at the primary level.

All junior high school (grades 7-9) have now been reached and the task is now to cover all primary level schools. A concern is that school representation at dissemination has been uneven and that the participation of school principals has been variable in part reflecting their own priorities and their non-participation may undermine the effectiveness of the dissemination process. This underlines the importance of a strong monitoring framework for the dissemination process to ensure that all key stakeholders at school level take part.

Recommendation 14: *To ensure that all staff are familiar with the policy directives on HIV and AIDS it is recommended will that schools hold dissemination sessions themselves, supported or conducted by staff by who have attended dissemination workshops.*

Posters providing information about the policy have been developed with UNICEF and CIDA support. These address: stigma and discrimination, managing HIV and AIDS in the school environment, rights of infected people in the school environment and universal precautions in school. These are likely more effective as sources of information for school staff. There is a need to develop posters for school which have been tailored to the needs and interests of children. There also is a need to inform parents about the policy and the Community Peer Educators (CPE).

It is unclear that the decentralised dissemination process has sufficiently engaged the MOEYC headquarters at senior level or in the departments responsible for strategic reform, youth development, human resource and administration, planning and development. Policy dissemination requires a system wide response and visible participation by leadership at all levels.

Recommendation 15: *It is recommended that a rapid participatory assessment be undertaken of the MOEYC Policy dissemination process to date so that strengths and weaknesses of the process can be identified with a view to strengthen the system for policy dissemination. This would take into account the perspectives of key stakeholders such as MOEYC officials at headquarters and regional education offices, the school principals, teachers and other school staff, guidance counsellors and parents. It should be designed to provide qualitative and quantitative data on how the process is rolling out and help build monitoring and evaluation capacity.*

3.1.7 Policy Implementation and Strategic Planning

Implementation comprehensive policy on HIV and AIDS requires a strategic planning approach for what will be a multi-component set of interventions. In many countries the National AIDS Strategic Plan has preceded the formulation of education sector policy and has contributed to its development. Jamaica is in the mainstream in this regard. The Jamaica HIV/AIDS/STI National Strategic Plan (JHANSP) was developed for the period 2002-2006. It provides the basis for the education sector response.

The plan includes policy, advocacy, legal and human rights, integrated and multi-sectoral response; prevention, treatment, support and monitoring surveillance and evaluation (UNAIDS 2004b). The JHANSP is not costed and it has not been revised in the planning period.

The JHANSP observes a lack of adequate commitment from ministries other than Health. Accordingly the development of an integrated and multi-sectoral response was identified as one of five priority areas for the plan. The role identified for the education sector relates to HIV prevention and to '*reduced individual vulnerability to HIV infection-behavioural change*'. The main activity proposed in the revision of the HFLE curriculum to include prevention and awareness issues. The details of this are included in what is called the Outline HIV/AIDS/STI Work plan for MOEYC.

Four priority objectives are set. These are to:

- i) regain momentum on the HIV/AIDS/STI component of the HFLE programme;
- ii) produce appropriate teaching and learning materials to generate awareness;
- iii) provide training for teachers in order to develop competence in the delivery of the HIV/AIDS/STI education programme including the development of peer educators;
- iv) increase awareness by the Ministry's personnel and stakeholders of the need for greater responsibility for adopting programmes and workplace policies relating to HIV/AIDS/STI.

A number of key gaps and constraints that would have to be overcome to achieve these objectives. These were:

- Lack of adequate support materials for teachers and students;
- Inability to sustain a high level HFLE programme due to budgetary constraints;
- Inadequate resources (human and financial);
- Inadequate knowledge base of MOEYC personnel;
- Insufficient appreciation of the connection between irresponsible behaviour and the consequence in contracting HIV/AIDS/STI –combined with denial and cultural myths.

Four strategies were proposed:

1. MOEYC would **regain the momentum on the HIV/AIDS/STI component of the HFLE programme**. Policies that impact on HFLE would be strengthened and implemented. HIV/AIDS/STI would be integrated in the core curriculum of HFLE. The number of Guidance Counsellors would be increased. Partnerships with NGOs would be strengthened to deliver programmes in schools and parents would be involved to arise awareness and provide information. **(Partly achieved. Policy is now in place and curricula are being revised.)**

2. MOEYC would **produce appropriate learning and teaching materials to generate awareness**. The relevance and quality of materials for target group and educators would be strengthened and opportunity for tertiary level institutions created to facilitate teaching and /or dissemination of information. Out of school education would be strengthened and the education of the public about children's needs. **(Not achieved)**.

3. MOEYC would provide **training for teachers in order to develop competence in the delivery of the HIV/AIDS/STI education programme including the development of peer educators**. Training would be strengthened for teachers, principles, education officers and Guidance Counsellors. The career structure and opportunities for Guidance Counsellors to upgrade would be strengthened. Peer education would be developed in schools. **(Not achieved)**

4. MOEYC would **increase awareness by the Ministry's personnel and stakeholders of the need for greater responsibility for adopting programmes and workplaces relating to HIV/AIDS/STI**. Information and news within MOEYC and schools would be strengthened. **(Partly achieved)**

The outline work plan does not include detailed year by year objectives and activities, targets and performance indicators. There is no budget. It therefore falls short of being a strategic plan and might be seen as a precursor of such a plan. Moreover, it addresses one area only of the HIV and AIDS response - HIV prevention - though arguably one of the most important. It is notable that the MOEYC Policy is fully consistent with the JHANSP at least with regard to HFLE.

JHANSP was reviewed at mid-term (2004). The Mid-Term Review (MTR) report is unfortunately not readily available. As a consequence, it is unclear to what extent the MOEYC work plan was reviewed in terms of achievement of its priority objectives and if so how open and participatory that review was. The MTR process proposed some new directions for the JHANSP. These are as follows:

- Expanding HIV testing as an entry point for both treatment and prevention services;
- Expanding treatment with ART;
- Prevention;
- Policy, human rights and stigma reduction;
- Monitoring and evaluation
- Capacity building
- Expanding the sectoral response.

Education is mentioned in relation to HIV prevention for youth in schools and out of school approaches. The critical role of the education sector in reaching young people is acknowledged in discussing the expansion of the sectoral response and supportive strategies would feature a) tertiary institutions and b) life skills, health and family life, sex education. This seems to imply no major change of direction, rather an intensification of work already in progress.

It would appear that progress towards stated objectives within the JHANSP period has been limited and that the key gaps and constraints identified in 2001 remain pertinent. There has been no progress to date in delivering for the classroom adequate support materials for teachers and students. Resource constraints, financial and human, still constrain programme development. Stigma and discrimination also pose significant barriers to progress. The main achievement has been the preparation and dissemination of policy which contains key elements of workplace policy within it, but implementation awaits the establishment of HACs. A more in-depth situational assessment of HFLE is given below.

HIV and AIDS do not appear to be a high priority yet for education sector planning. The Task Force Report makes no mention of planning in order to implement the HIV and AIDS policy.

Recommendation 16: It is recommended that MOEYC undertake to develop a fully costed strategic plan for HIV and AIDS for the period 2006-2010 as a high priority. At minimum, this would provide a strategic framework for implementing the education sector response and would set out the fundamental principles, broad strategies and the institutional framework. It should build on the current framework as set out in the JHANSP providing the more detailed strategies needed to change the current situation with successive steps needed to reach stated objectives. This should be a participatory process involving regional bodies.

3.1.8 Regional Strategic Planning

The Jamaican response to HIV and AIDS should be contextualised in terms of the Caribbean Regional Response. This is set out in the *Caribbean Regional Strategic Plan of Action for HIV/AIDS* (CARICOM. 2000). An *Action Plan on Law, Ethics and Human Rights* was prepared in 2003 under the aegis of the Pan Caribbean Partnership on HIV/AIDS (PANCAP). PANCAP is considered to be one of the most vibrant, fully functioning multi-sectoral regional AIDS partnerships (UNAIDS and CARICOM. 2004) and is still developing and strengthening.

The main benefits from a regional response accrue in the areas of advocacy and awareness raising, capacity building through training and cross-country learning. The UNAIDS Caribbean Inter-Country Team has played a key role in the establishment of a Monitoring and Evaluation (M&E) Task Force to work with a variety of national, regional and international organizations (UNAIDS. 2004b). Training has been provided to technicians in M&E and the Country Response Information System (CRIS).

However, it is action at the national level that will result in the necessary policies, strategies and programmes to reverse HIV epidemics and manage their socio-economic impacts. Regional support can only complement such effort and cannot substitute for it.

Recommendation 17: It is recommended that Caribbean regional initiatives on education and HIV and AIDS should plan to include concerted follow up at the national level within their monitoring and evaluation frameworks. EDUCAIDS could provide evidence based guidance on how regional approaches can best add value to national capacity building for the education response to HIV and AIDS.

3.1.9 Institutional Capacity Building

Implementation of the JHANSP is under the technical guidance of the **National HIV/AIDS Control Programme**, (Ministry of Health), and is being executed through 6 line ministries, NGOs community and faith based organisations. The NSP encourages the broad participation of all sectors of society including young people, PLWHAs and women's groups. Five line ministries have prepared workplans (Industry and Tourism, Labour and Social Security, **Education, Youth and Culture**, Local Government and National Security). These are being implemented with World Bank support.

The **National Aids Committee** (NAC) was established by the Ministry of Health in 1988 to coordinate the national multi-sectoral response to HIV and AIDS. Its primary functions are to advise the ministry of Health on policy issues and to mobilise different sectors in the response. The NAC is an umbrella organisation which represents non-governmental, community-based and faith-based organisations with direct reporting to the National Planning Council, chaired by the Minister of Finance.

USAID (2004) reports the following achievements in the past 2-3 years:

- Most Jamaicans are aware of HIV/AIDS
- More Jamaicans use condoms than ever before
- Rates of syphilis and other STIs are declining
- Jamaica's blood supply is safe
- The spread of HIV may have slowed (but published statistics do not yet support this).

Despite these achievements, the Jamaican response to HIV and AIDS is assessed as 'lagging.' The cultural context is considered to be a major impediment to progress. At the same time HIV and AIDS are not sufficiently prominent on the government agenda.

UNAIDS (2004) identify seven key issues and challenges for the national response to HIV and AIDS. These are:

- There is a lack of adequate commitment from non health ministries and agencies to a truly multi-sectoral response;
- There are weak multi-sectoral co-ordination mechanisms for HIV at all levels, national, community and donor;
- There is under-utilization of people living with HIV and AIDS in planning and implementation of activities;
- Capacity building outside the Ministry of health, especially at the regional levels, and among civil society requires attention;
- Policy, legal protections and support for HIV infected and affected persons need to be better developed;
- HIV speciality care and support need to be more generally accessible, and stigma and discrimination need to be systematically addressed;
- There is no specific AIDS legislation. Many areas of weakness within the existing legislature fuel discrimination, notably homophobia. Commercial sex work is illegal.

The World Bank (2005) cites an independent mid-term review of the NSP which found that ownership of the NSO outside the Ministry of Health is weak, while the NAC is 'viewed as an extension of and too dependent on the Ministry of Health.' To facilitate development of the multi-sectoral response, a co-ordinator for line ministries has been appointed in the Project Coordinating Unit (PCU) of the Jamaica HIV/AIDS Prevention and Control Project.

In the JHANSP under the rubric of Organisational development, MOEYC would designate a link coordinator for all HIV/AIDS/STI activities within the Ministry itself and schools, liaise with MoH/NAC and NGOs and act as the representative of MOEYC on the NAC.

This step, which could be regarded as necessary but not sufficient for a comprehensive education sector response, has been accomplished. The focal point on HIV and AIDS for MOEYC is situated within the Educational Services Section of the Ministry responsible for oversight of early childhood, primary, secondary and tertiary education, career guidance and counselling, technical and vocational education, the core curriculum, student assessment, media services and special education. This set encompasses much of the core business of the Ministry.

3.1.10 The HIV and AIDS Response Team (HRT)

In January 2004, MOEYC embarked on a **Project for Education Sector Capacity Building for HIV/AIDS Response**. This has been supported by UNESCO, UNICEF, JICA through JOCV and the World Bank. One of the objectives of this project was to establish an HIV and AIDS Response Team (HRT) in the Ministry's Headquarters Guidance and Counselling Unit, and its six Regional Education Offices to operationalise the HIV and AIDS policy and plans. The team has the remit of developing teacher education materials for both initial and in-service education and preparing a cadre of trainers in the regions.

The team comprises the leader of the HRT who is also the HIV and AIDS Co-ordinator for the MOEYC and a Promotions Specialist who is responsible for all promotional activities, liaising with international agencies, NGOs, private and public sector organisations, web-site maintenance, equipment procurement, workshop coordination, managing accounts and preparing programme and status reports. The proposed position of Programme Implementation Specialist was not filled and funds were reallocated.

The HRT also comprises Health Promotion Specialists (HPS) who were initially recruited on a one-year basis. Six have been recruited, one for each of the six education regions. At MOEYC headquarters, in the Guidance and Counselling Division, a Co-ordinator and a Public Relations Specialist (Promotions Officer) were appointed. The Health Promotion Specialists have a multi-faceted role which includes:

- Policy dissemination;
- Training of Guidance Counsellors, Principals, PTA Presidents, Board Chairpersons and students;
- Facilitating the relationship between school, parents, the Guidance Unit and the Regional Office;
- Coordinating the delivery of HFLE with the HIV and AIDS component in schools
- Assist in evaluating HFLE in the region;
- Assisting the Guidance Officer in visiting and monitoring schools;

- Liaising with Literacy Centres on materials development and training;
- Liaising with Parish Aids Authorities;
- Preparing programme and status reports as required.

JICA has been supporting this project through its volunteer services (JOCV). It has been central to the work of the HRT at Headquarters and through providing Japanese volunteer counterparts to the HPS in the six education regions. The volunteers, who have been carefully selected to perform the role of Health Promotion Facilitator (HPF), which mirrors that of the HPS, have been valued contributors to the team and there is a JICA commitment to continue the programme until 2007. Equipment comprising a computer, printer and DVD player were provided to the coordinating unit of each of the 6 regional education offices. A document printer has been installed at HQ and is being used for the production of HIV and AIDS materials for all 6 regional offices.

The HRT programme was subject to a preliminary evaluation in April 2005 (Chambers, 2005). The programme has been well supported by MOEYC. However constraints on the effectiveness of the HRT were noted in terms of limited access to the internet and telephone and limited travel allowances. The review concluded that the HRT provides an invaluable service and should be sustained. The GFATM will provide funds to sustain the HRT from 2005 until 2006 (UNESCO, 2005a). The Jamaican Government is providing finance for the HIV/AIDS Co-ordinator post, communication costs, secretarial services and contributes to the cost of accommodation for the volunteers.

The establishment of the HRT has given MOEYC much needed capacity to disseminate policy, co-ordinate activities and train staff at regional level. A particular strength is the link to the 6 regional offices through the HPS. The structure however is still young and needs further time to establish its full potential. Of the 16 persons comprising the HRT, only one is currently on Government of Jamaica funding, the others being donor-funded. In the short run this is practical, but in the medium term the sustainability of these positions will need to be considered. A number of issues arise.

First, is the institutional capacity for HIV and AIDS at MOEYC headquarters sufficient? The current institutional endowment in terms of the HRT has been able to manage the policy dissemination process to date and to plan for the HFLE pilot and several other initiatives such as World AIDS Day (WAD) activities. The roles and performance of the Co-ordinator and Promotion Officer have been recognised as important to programme effectiveness and are functioning well (Chambers, 2005). With increased levels of activity this may be stretched, especially if capacity is to be built in the area of monitoring and evaluation, which is currently a weak point. It will be important to engage other divisions of MOEYC more when expanding programme activity.

Second, is current HRT support for regional Education Offices sufficient? While good progress has been made in developing the HIV and AIDS capacity of Regional Education Offices through the appointment of HPSs and HPFs, further investments

are likely to be required. Operational effectiveness has been largely a function of the work of the HPS (Chambers. 2005). Training plans have been developed and workshops delivered. There has been some variation in activity level between regions largely due to personnel issues. It has been recognised that there is variation in skill among HPS with regard to workshop skills such as presenting and facilitating. There is an issue about follow-up visits to schools and how this is managed with a small staff with limited resources at hand. Performance at the regional level therefore will need to be monitored carefully to ensure programme consistency and to prevent the emergence of inequalities.

A number of measures are proposed for consideration within a strategic planning exercise:

1. **Recommendation 18: *To better support the work of the HPS and HPF, it is recommended an assessment of resources needs be made and the consideration be given to setting up small-scale resource centres on HIV and AIDS at regional education office level. These would include key reference materials and support materials for MOEYC staff working on HIV and AIDS.***

2. **Recommendation 19: *Given the identified variation in HPS skills, it is recommended that a costed training programme should be developed based on a training needs analysis, preferably conducted through an external provider with the provision of follow up support to ensure ongoing professional development.***

3. Thirdly, email connectivity would greatly enhance efficiency and access to resources. Access to ICT has been identified as a programme constraint (Chambers. op. cit.). This was confirmed in interviews with some HRT staff.

Recommendation 20: *It is recommended that an assessment be made of ICT needs for the HRT including internet access and that resources be allocated to meeting these.*

4. The current funding has been identified as inadequate for HPS functioning (Chambers. 2005) and the provision of a decentralised budget for HIV and AIDS activities would likely help the regional offices in developing and managing more effective and efficient programme responses.

Recommendation 21: *It is recommended that costings for regional activities be included as decentralised budgets in the education strategic plan on HIV and AIDS.*

5. **Recommendation 22: *It is recommended that attention be paid to developing monitoring and evaluation capacity for HIV and AIDS interventions.***

HPS duties do not currently include monitoring and evaluation, although there is a requirement to prepare programme and status reports and the HRT currently possesses minimal M&E capacity.

6. Recommendation 23: *It is recommended that attention needs to be paid to developing capacity for improving the quality of workshop sessions and to achieving greater consistency in approach.*

This could be achieved in part through the development of good quality workshop training teaching and learning materials. These could also support school-level training activities. Attention has already been drawn to the limited resource materials that are available for presentations and for distribution. Some presentations have apparently included sensationalised or incorrect information. (Chambers. op. cit).

7. The difficulties in developing effective coordination between the HPS and the Guidance Officer at the Regional Education Office level have been described in terms of differing schedules, areas of residence and long travel distances (Chambers. Op cit). Combined school visiting appears not to have worked or to be workable. The lack of success in coordinating activities needs to be considered as an important challenge for MOEYC in implementing its HIV and AIDS policy. A factor that needs to be considered is the wide range of functions that a Guidance Officer is responsible for which militates against close cooperation with the HPS. Specific attention needs to be paid to developing better team working between the HPS and the Guidance Officer that takes into account the differing job responsibilities.

8. The support and active involvement of Regional Directors has been described as variable and at times 'challenging' (Chambers. op. cit.). The wide range of critical regional activities and the consequent time limitations have restricted the potential for collaboration with HPSs.

Recommendation 24: *It is recommended that efforts be made to bring the Regional Directors together to discuss their roles in the implementation of MOEYC HIV and AIDS policy and experience to date.*

9. The sustainability of almost the entire HRT is in question as only one position is currently being met from MOEYC funds.

Recommendation 25: *It is recommended that consideration be given to assessing the medium to long term needs of the MOEYC in relation to the HRT and to plan for the sustainability of the institutional set up.*

Third, **how can JOCV volunteers most optimally support Jamaican HPSs?** JOCV and JICA have played a key role in establishing the capacity of the HRT. This approach has potential for replication in other countries in the Caribbean region. They have provided valuable support to the HPS in a number of areas including computing skills, materials development, workshop presentations and on school

visits. Constraints such as language and cultural barriers have been identified. The importance of professional direction from the HPS is also recognised. It was mentioned that it would be helpful if the Japanese volunteers could bring with them knowledge of Asian responses to HIV and AIDS. This would be particularly useful in the cases of lifeskills education and stigma prevention.

Recommendation 26: It is recommended that consideration be paid within a strategic planning framework for optimising the way in which JOCV volunteers are deployed to make the most of their individual and collective strengths.

They could play an important role in materials development and in setting up M&E systems. By drawing on Asian experiences (Thailand, Lao PDR, Cambodia) in education sector HIV and AIDS policies and programmes, they could enrich the Jamaican response.

3.1.11 The School-level Response

It appears that HIV and AIDS capacity at school level will be developed through the HACs. Among school staff it is the Guidance Counsellors (GC) who will have the front line role in both HIV prevention including the teaching of HFLE as well as responding to the psychosocial needs of children infected and affected by HIV and AIDS. The responsibilities for HIV and AIDS are additional to those already being undertaken by GCs who are responsible for implementing the National Guidance Curriculum (MOEYC, 2003) in grades 7-9. This curriculum comprises three components:

- The curriculum;
- Responsive services; and
- Community service

The National Guidance Curriculum (NGC) was published in 2003. Its content is organised in thirteen units in what could be categorised as a life skills approach including topics such as communication, critical thinking, decision making and problem solving, relationships, self-empowerment, goal setting, life preservation, ethical issues and etiquette. Units on management of personal resources and study skills are also included. It contains however, no reference to HIV and AIDS. The NGC is supported by the Supplementary Content Book. It has not been possible to obtain this and it may contain HIV and AIDS material. The content of much of the NGC is relevant to addressing some of the personal skills building for HIV prevention and living in a world with AIDS.

Responsive services entail 'prevention, intervention and support strategies' in response to expressed or perceived needs to facilitate the holistic development of students. This is expected to include individual and group counselling, career advising, home visits and consultations with teachers and parents. The group work that is intended would appear to provide a favourable context for the introduction of peer education facilitated by the GCs.

Community service is intended to give students structured opportunities to become involved with the school and the wider community. Some thirty hours of community service are expected of students. This is developed with the form teacher and coordinated by the GC. There is opportunity here for students to work on HIV prevention activities in the community.

The NGC and the role of GCs in its delivery raise a number of critical issues:

- First, the GCs are the most appropriately trained staff at school to handle issues of personal vulnerability and risk that students face. Their ability to deal comfortably with sensitive issues of sexuality and sexual health are less well tested, but it is probable again that GCs will have some comparative advantage over other staff given their general mandate and skills. An issue however that has been identified (Chambers. Op cit) is that some GCs have been unable to recognise that HIV and AIDS are relevant to their school contexts.
- Secondly, GCs already have a significant workload and responsibilities. HIV and AIDS activities will add to these. It may be that these can be successfully integrated within existing duties and work arrangements. While there is a reasonably close fit, this cannot be safely assumed and will need to be monitored.
- Thirdly, new HIV and AIDS responsibilities will require a professional response in terms of teaching and counselling work. This will need attention to both in-service and pre-service preparation for GCs. It will also require the development of support materials specifically for GCs to assist both teaching and counselling roles. The potential for GCs to benefit from a structured approach has already been identified (Chambers. op. cit) including 'frequently asked questions' in CD or DVD format.
- Fourthly, the NGC is in need of review from an HIV and AIDS perspective in order to ensure it can provide optimal and explicit support for the delivery of the HFLE curriculum.
- Fifthly, the majority of pre-primary and primary schools do not have GCs. Statistics on GC deployment are unavailable, but it seems likely that the delivery of HFLE is likely to be the responsibility of classroom teachers in grades 1-6. Their preparation is a key issue as they will be in general likely to be less comfortable in dealing with sensitive personal issues. As with GCs, they will require both in-service and pre-service preparation, together with teacher resource materials.
- Sixthly, the critical role of school principals for effective school responses to HIV and AIDS cannot be overstated. Their leadership, commitment and support are likely to be fundamental to success. A programme of activities and support materials are required to ensure that principals are professionally

equipped to implement MOEYC policy. They need to be specifically targeted, including through the Principals' Associations.

- Seventhly, the need to ensure that there is a robust monitoring and evaluation framework in place to assess implementation processes and outcomes of HIV and AIDS interventions. This is important for problem identification and solving and longer term programme development. It is currently not in place. MOEYC has a division responsible for Planning and Development which includes a section concerned with research, EMIS, policy analysis and another covering educational planning, programme monitoring and evaluation. It is important that the Planning and Development Division is strongly engaged in developing an M&E framework for implementing the HIV and AIDS policy.

Recommendation 27: *It is recommended that particular attention be paid to identifying the needs of front line staff, (the Guidance Counsellors, teachers and school principals) responsible for implementing the MOEYC Policy at school level and to developing a medium term planning framework to meeting these.*

3.1.12 Higher Education

Policy in Place

Higher education institutions are not appear included within the umbrella of MOEYC Policy. In the case of the University of the West Indies (UWI), which is a Caribbean regional multi-site institution, and the University of Technology, Jamaica they have developed their own policy frameworks.

Policy Content

The University of the West Indies (UWI) developed its first policy on HIV and AIDS in 1995. This was a product of its time and not comprehensive. It was redrafted in 2004 to address a greater range of issues (Crewe. 2005). The revised policy (University of the West Indies Policy HIV/AIDS) has the aims of preventing the spread of HIV through its community through the provision of appropriate education and counselling and ensuring easy access to condoms. It also aims to encourage people who may be infected to be diagnosed and get attention at the earliest opportunity. Education will be the primary response of UWI. The policy covers the following areas:

- Rights of affected persons (testing, non-discrimination);
- Confidentiality;
- Managing HIV and AIDS within the university with regard to treatment of affected persons. This includes provision for staff and student welfare, ART and access to PEP;
- Education and counselling: access to comprehensive information about HIV and AIDS. The University's Health Services are responsible for organising and conducting AIDS Education programmes which will aim to equip staff and

students to live and function in societies with significant rates of HIV and AIDS. Counselling and VTC will be available to all students and staff.

- Employee guidelines; non-discrimination, sick leave, sexual exploitation of staff and students,
- Medical/laboratory environments: universal precautions;
- Accidental exposure to HIV: PEP;
- Staff and student responsibilities: individual responsibilities to minimize personal risk and to challenge prejudice and discrimination.
- Gender related issues: gender equality; gender sensitive HIV programmes; medical and other therapy for those who are subject to sexual violence;
- Research: medical, social and economic research to expand knowledge on the impact of the epidemic and mitigate its effects; research into stigma, discrimination and homophobia.
- The community: participation in the medical, education, social and economic sectors in the community it serves; the university will also make available to the community its serves appropriate courses related to the control and amelioration of the impact of HIV and AIDS.

A separate policy on sexual harassment and assault exists, but is not linked formally to the HIV and AIDS policy (Crewe, 2005). The UWI policy is quite closely aligned to the workplace policy content advocated by the ILO. It covers the key 10 principles at varying levels of specificity. It shares much in common with the MOEYC policy. A number of gaps were identified by Crewe (op. cit.).

Gaps

The policy does not cover issues relating to the financial management of HIV and AIDS in the university such as employee benefits, inability to repay student loans, human resource/skills replacement and training costs. The policy does not address HIV prevention, especially prevention education, in the university in any detail in terms of the content of programmes and how they will be implemented, although responsibility is assigned to the University Health Services.

A significant concern should lie in the lack of specificity concerning roles and responsibilities for the implementation of the policy. The policy states that *the policy must be updated and renewed periodically by the body responsible for the UWI's response to HIV and AIDS*. There is no guidance as to how this would be undertaken. There is no mention of the responsibilities of specific University bodies or positions in implementing the policy apart from the University Health Services. There is also no mention of the need to include policy implementation in the Universities Strategic Plan and other corporate planning documents.

University of Technology, Jamaica.

The University of Technology, Jamaica, has an HIV and AIDS policy which was approved by the Academic Board in September 2003. It specifies that the university will integrate HIV and AIDS related initiatives into the core functions of teaching, research and service. The policy has the following stated priorities:

- Education, research and advocacy for PLHAs;
- HIV and AIDS partnerships with other tertiary institutions, NGOs, government and the private sector, managed by an HIV and AIDS Steering Committee;
- Research as a priority for all faculties;
- Prohibition of discrimination against PLHAS;
- Advocacy for PLHAs.

Gaps

This is a much briefer policy document than that prepared for UWI. It is much less comprehensive in coverage of issues. A major gap is HIV prevention among the student body and staff. Other gaps include Managing HIV and AIDS within the university with regard to treatment of affected persons. This includes provision for staff and student welfare, ART and access to PEP; employee guidelines and gender related issues. A Workplace Policy on HIV and AIDS is currently before the University council and it is likely that this will address some of the significant gaps.

An issue is comparability in higher education policy across institutions in Jamaica and throughout the Caribbean.

Recommendation 28: *It is recommended that a review of higher education policies on HIV and AIDS be undertaken at the regional level to ensure to foster learning across institutions and the adoption of comparable standards of policy entitlement. EDUCAIDS could provide evidence-based guidance on policy making on HIV and AIDS in universities/higher education institutions.*

Policy Process

Neither the UWI HIV/AIDS Policy nor the University of Technology, Jamaica, HIV/AIDS policy provides any information on the policy process in terms of formulation and both are vague with regard to implementation and review.

The original UWI policy was reviewed by the West Indies Group of Conformed University Teachers (WIGUT), but it is unclear if there was any student input. The policy has been reviewed once and stakeholders are committed to keeping it up to date and relevant to the challenges of HIV and AIDS (Crewe. op cit)

Policy Power

Neither the UWI Policy on HIV/AIDS nor the HIV/AIDS Policies of the University of Technology, Jamaica, provides any reference to any legal framework, national or institutional. Crewe (op cit) mentions that there was no record of the policy ever being enforced with regard to safeguarding an individual's rights. As with the MOEYC policy, the UWI policy does not mention international agreements on HIV and AIDS. Neither does it mention regional agreements. There is, for example, no mention of the UNICA Commitment (Port of Spain. 2003) an outcome of a conference,

HIV/AIDS. The Power of Education held by UNESCO, UWI and the Association of Caribbean Universities and Research Institutes (UNICA). Vice-Chancellors, Rectors and Presidents of the institutions represented undertook to set up a UNICA task force on HIV and AIDS and Education, to take immediate action in their respective institutions and strengthen regional cooperation.

Policy Dissemination

At UWI, there does not appear to be any dissemination strategy to ensure that all stakeholders aware of the HIV and AIDS policy. In the policy document itself, it is unclear whose responsibility this would be. Crewe (op. cit.) states that there is a general feeling that the policy is not well enough known amongst staff and students.

At University of Technology, Jamaica, dissemination takes place through the University presidents; office. This work requires a full time dedicated post to be established and funded

Strategic Planning

HIV and AIDS do not appear significantly in university strategic plans. This should be addressed.

Capacity Building

At UWI, the institutional response to HIV and AIDS is UWI HIV/AIDS Response Programme (UWI HARP). UWI HARP is a multi-disciplinary response to HIV and AIDS across the entire university (in Barbados, Jamaica, Trinidad and Tobago). UWI HARP is receiving financial support through the European Union Commission for strengthening the institutional response through the SIRHASC project. This has allowed UWI to hire new teachers, research and administrative staff and to carry out significant curriculum review and development in areas relevant to HIV and AIDS. (Areas include Health Economics, Communication, Behavioural Sciences, Medicine, Nursing and Public Health). A 14-point proposal for priority curriculum and programming responses by UWI was submitted by Bain and Morrissey. (2002).

UWI HARP was established in 2001 to ensure a more organised response to HIV and AIDS within the university and to develop and monitor policies. It was therefore a precursor of policy development. The **Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean** (SIRHASC) initiative provided the resources to get UWI HARP operational from 2002.

The mission of UWI HARP is to support capacity building in the University in order to promote a multi-disciplinary understanding of HIV and AIDS to contribute to HIV prevention and care of PLHAs and to mitigate the impact of the epidemic. It has the following aims:

- To accelerate action by UWI to HIV and AIDS through research, education, training and strategic engagement with the wider society;

- Development and monitoring of policies;
- To generate, attract and manage resources to sustain the response to HIV and AIDS; and
- To serve as a clearinghouse for HIV and AIDS information, working in collaboration with and complementing national, regional and international agencies.

UWI- HARP is located within the Medical Faculty with a mandate to look after the entire university response. This location has encouraged the perception of a bio-medical bias which needs to be seriously addressed (Crewe. op cit). UWI HARP is the current capacity building entity within the university. It represents a programme rather than a permanent institutional structure and therefore there are concerns about the long-term sustainability of this initiative.

UWI HARP is largely donor funded. This needs to be considered in the context of insufficient funding generally for the university; senior management feel that few departments at present are adequately funded (Crewe. op cit). Sustaining current levels of funding for HIV and AIDS is likely to be a challenging priority for the university.

UWI HARP is considered to be quite successful in generating project funding, but whether such fund raising should be the responsibility of UWI HARP or the university itself is another key strategic question. Which ever fund raising modality is pursued, it seem appropriate to include HIV and AIDS activities and policy implementation in particular within the next UWI Strategic Plan.

The establishment of the UNESCO Chair in the field of Education and HIV and AIDS at UWI is a step towards the institutionalisation of the response in higher education. The objectives of the new Chair will be

- Guide the response in higher education in prevention, care/support and impact mitigation;
- Ensure that UWI will have a prominent and sustained role in advocacy in the education sector at national and regional levels;
- Strengthen regional planning for HIV and AIDS in education;
- Ensure that HIV and AIDS-related policies, procedures and programmes in higher education are guided by a human right approach.

Specific objectives include:

- Curriculum development for teaching HIV and AIDS at UWI and tertiary level;
- Conduct and supervise research;
- Training of key persons in UWI;
- Co-ordination of HIV and AIDS policies throughout UWI and to develop a system for the monitoring and evaluation of implementation;
- Generate funds;
- Document HIV and AIDS information;

- Organise seminars, workshops and conferences on Education and HIV and AIDS

The core challenge for the Chair will be to develop initiatives that respond effectively to the priority needs of national education sector responses to HIV and AIDS.

3.1.13 Regional Capacity Building Initiatives

The Caribbean HIV/AIDS Training Initiative (CHART) was set up at the request of CARICOM in June 2001. CHART is located in UWI. Its overall goals are to:

- Establish training centres for the Caribbean that utilise cost effective mechanisms, institutions and concepts for the ongoing training and development of healthcare workers;
- Ensure that transfer of knowledge and technologies support the building of indigenous Caribbean capacity to sustain training competence with regional and local institutions; and
- Serve as a coordinating body and focal point for promoting the unique needs and resources of the region.

CHART has been engaged in training of trainers (ToT) for healthcare professionals. There is arguably a need for a CHART-like arrangement to support capacity building in the education sector.

UNESCO has funded the development of a strategic resource for the region, Education and HIV/AIDS in the Caribbean (Kelly and Bain, 2003). UNESCO's Education and HIV/AIDS Strategy.

Recommendation 29: *It is recommended that EDUCAIDS investigate how regional capacity building resources can be established in the Caribbean Region for supporting national capacity development in key skill areas.*

3.2 Prevention

3.2.1 The Knowledge Base

There is a good deal of research evidence on the vulnerability of young people and their risk behaviours including sex. Information about young people comes from a number of sources and concerns a number of thematic areas. The policy usefulness of this information is variable. In general, there are issues about accessibility and dissemination. Some studies present interesting preliminary findings, but these have not always been followed up. There is currently no synthesis of available knowledge on the vulnerability and risk contexts of young people which would be useful for multi-sectoral policy and education programme development.

One of the most pertinent studies for HIV prevention policy and programme development is the National Knowledge, Attitudes, Behaviour and Practices (KABP)

Survey (Hope Enterprises, 2004). This was carried out within the remit of JHANSP monitoring and evaluation activities. It tracks changes, disaggregated by age and gender for the period 2000-2004 in relation to indicators on:

- Risky sex;
- Partnership status;
- Stigma and discrimination;
- Median age at first sex;
- Knowledge of HIV prevention methods.

From the perspective of the education system, the data on the 15-24 age group are the most significant since this is the population that will be most involved in the education system, although data on the 25-49 year old population are relevant to adult education. Unfortunately, children below the age of 15 are not included in the survey and very little is known about their knowledge, attitudes, behaviour and practices regarding sex, sexual health and HIV and AIDS. This constitutes a major gap area for policy and programming.

The KABP data present some positive trends among the 15-24 age group in increases in knowledge about HIV and AIDS, reductions in myths, declines in risky sexual behaviour and more consistent use of condoms. Some data are selected to illustrate issues in HIV prevention:

- Males are more likely to endorse myths about HIV transmission;
- 56% of both sexes perceive themselves not to be at risk on infection - 8% incorrectly;
- 18% and 34% of males and females respectively are reporting delaying the start of sexual activity;
- Multiple partner relationships are reported by 56% and 16% by males and females respectively;
- 39% of females are having sex with males 5 years older than they are and 14% with men 10 years older;
- 15% of females report being forced to have sex within the last 12 months;
- One-night stands are common among males;
- 30.5% and 31% among males and females respectively report unprotected sex with a non-marital non cohabiting partner in the last months;
- Use of commercial sex among males increased reflecting a growth in the sector and protective behaviour is not universally practised;

Despite the positive trends, there are still vulnerabilities and risk behaviour that need to be addressed among young people. The issues include perception of self-risk, delaying sexual activity, multiple partner relationships, forced sex, unprotected sex including with commercial sex workers. The data illustrate gender differences in sexual behaviour which would need to be reflected in HIV prevention education. Male attitudes and sexual behaviour stand out. They provide a rich source of data for HFLE planning and materials. How the MOEYC use KABP data is a issue for capacity building, including for the HRT itself.

Recommendation 30: *It is recommended that consideration be given to building capacity to mainstream gender within the education sector response to HIV and AIDS within the HRT.*

A similar survey was undertaken among young people with disabilities to determine their knowledge, values, attitudes and practice (KVAP) towards sexual and reproductive health by the Jamaican Association on Mental retardation (JAMR) with support from the EC and UNFPA. The main findings indicated that:

- Adolescents with disability (blind, deaf, mental retardation and physical disabilities) expect to have a sex life, marriage and parenthood;
- They are vulnerable to sexual abuse;
- They have significant knowledge gaps including basic information on anatomy, STIs, how pregnancies occur and what constitutes sexual abuse.

These findings indicate strongly the need for HFLE in Special Education and for appropriate learning materials to be developed for adolescents with disabilities.

Recommendation 31: *It is recommended that a rapid participatory assessment of the current situation of HIV and AIDS and children in special education be undertaken in relation to implementing the MOEYC policy.*

A number of qualitative studies illustrate the contexts of vulnerability and risk that affect poor children and young adults. Understanding these will be of fundamental importance in developing effective HIV prevention programmes. The studies tend to focus on urban rather than rural contexts. Rural poverty in relation to the lives of children is not well covered in the research literature.

Urban poverty creates its own crises. In a study of the lives of adolescents in urban St Catherine, Gayle et al (2004) identify a constellation of challenges that need to be faced by policy makers. These include hunger, fear of violence, exploitation of working children, physical abuse by parents, teachers and others, sexual abuse of girls by boys, but also by family and community members. Access to condoms and guidance are hindered by prejudices on the part of adolescent service providers. All of which provide a social ecology that is favourable to HIV transmission.

Commercial sex work includes children but the scale of this is not currently known. A rapid qualitative assessment of children in prostitution undertaken with ILO support (Dunn, 2002) found that they were to be found in a wide range of locations including school gates. Girls predominated, but some 30% of those identified as sex workers were boys. Some were connected to the tourism, others to domestic transactional sex. Some causes of children entering sex work were identified. These included poverty, poor education, learning disabilities, sexual abuse in the family, peer pressure and fear of violence in inner city areas. The research was a preliminary scoping study which identified significant vulnerabilities to HIV, but unfortunately

there has been no follow up. There remains a lack of public awareness of the problem.

A study of sexual violence and exploitation of children in Jamaica (Williams, 1999) found that child abuse is pervasive at all levels of society. The majority of the girls in the survey reported sexual abuse (76%); boys were also subject to abuse (16% representing probable under-reporting due to risk of stigmatisation). The perpetrators were males and known to their victims, but not related. The schools Guidance and Counselling Service reported a lack of data on sexual abuse including a lack of feedback from GCs. Some GCs have reported that principals take no action and therefore there is little point in reporting. Sex is perceived as a lesser threat than gun violence. 89% of students surveyed in 11 urban secondary schools were worried about violence at school (Meeks-Gardiner et al. 2003).

A qualitative study on the sexual risk taking and HIV knowledge of street boys in Kingston (Robinson et al, 2001) found an early age of sexual initiation, multiple sex partners, physical abuse of girls, negative attitudes to condom use and drug and alcohol use. Many had misconceptions about HIV and AIDS and were intolerant of men who have sex with men (MSM).

A study on HIV and AIDS issues in the early childhood age group (Ramsay et al, 2004) was undertaken in the Montego Bay area. This found that there was a general consensus that HIV was a problem. There was fear about associating with PLHAs due to perceived risks of contracting HIV and also because of stigmatisation. Teachers in day care centres and preschools requested training on HIV and AIDS including on how to transfer knowledge to small children. A commonly held view among teachers and principals was that all children should be tested for HIV. There were instances of children being excluded from school because of their HIV status.

Recommendations for interventions included:

- Extension of PATH assistance to households affected by HIV and AIDS to enable young children access to early learning, health and social support;
- An assessment of the quality of the settings providing care and education using the Early Childhood Environment Rating Scale;
- Develop a plan for programme improvements based on the needs assessment to include: training of teachers and care givers, provision of a safe environment, participation of children and parents in health promotion, development of an appropriate learning environment, in-service support for teachers and care givers, participation of the responsible Early Childhood Education Officer in M&E, material assistance to implement the plan direct grants to centres to reduce or waive fees for OVCs, a community participation plan, design and implementation of training modules to develop teaching and counselling skills.

Some conclusions:

- There is scope for further research into the vulnerability and risk behaviour of young people;
- Addressing sexuality in Jamaica is particularly sensitive because of homophobia, child abuse, gender-based violence and child prostitution;
- There research evidence on vulnerability and risk should inform HIV prevention education curriculum content;
- Gender analysis should be fundamental to HIV education programme development;
- Peer education is going to be important to address peer pressure and norms.

Recommendation 32: *It is recommended that an assessment be made of research needs to implement the MOEYC strategy over the next 5 years. This should include an assessment of key issues where more knowledge is required and capacity building within MOEYC/HRT to use it effectively. A strategy for research needs to be developed.*

Gender

No comprehensive gender analysis of the education sector exists. There appears to be no institutional arrangements for gender analysis, policy development or gender mainstreaming in MOEYC. Technical assistance in this field appears to be very limited.

In Jamaica there are virtually equal enrolment of males and females in preschool (at 4-5 enrolment stands at near 90%). Enrolment and attendance and completion are different. On school cohorts who have completed their secondary education, there is consistently higher attrition of males (Brown. 2001). Male school attendance is uniformly lower than girls in rural and urban schools. This is a phenomenon of male under-participation in education resulting in under-performance. More females complete secondary education, sit final examinations for tertiary admission and complete tertiary education (Brown, op. cit).

Evans (2001) suggests that boys are treated differently through their education by teachers. They are disciplined more harshly and meet differential examination expectations. There is gender stereotyping of subjects with 11 subjects of the 18 at school being perceived as 'female' including English (Chevannes 2001 in Brown. Op cit).

Chevannes (op cit) found that boys and girls are socialised differently in terms of household chores, degree of parental supervision, severity of disciplining and punishment and expectations in relation to sexuality and its expressions. Evans (op cit) hypothesises that such 'male privilege' contributes to poorer compliance than girls with school behavioural expectations, but there has been no qualitative research to investigate this as yet. She reports that both boys and girls believed that boys were treated unfairly at school.

Some **recommendations** fall from this:

Recommendation 33: *More research is urgently needed into how masculinity in Jamaican affects learning, how it is constructed by classroom education and how it affects HFLE delivery.*

Recommendation 34: *Institutional capacity is needed to undertake gender analysis in HIV and AIDS programmes in education in Jamaica;*

Recommendation 35: *Gender sensitisation of teachers, including in relation to HIV and AIDS, needs to be included within teacher training;*

Recommendation 36: *HFLE presents an opportunity to challenge traditional gender roles. Peer education processes are likely to be of value in addressing peer norms and pressures and should be piloted;*

Recommendation 37: *HFLE implementation should be monitored from a gender perspective.*

3.2.2 Vulnerability of Education Staff to HIV

No efforts are currently being made to address vulnerability of education personnel through human resource policies as education personnel are not perceived to be particularly vulnerable or at risk from HIV and AIDS.

Recommendation 38: *It is recommended that issues around vulnerability of education staff to HIV in their own lives should be addressed within pre-service training and workplace policy implementation.*

3.2.3 School Health and Safety

MOEYC lacks a comprehensive school health policy framework which covers all issues of health and health promotion in the school setting such as recommended in the FRESH approach. This would include nutrition, sanitation, hygiene, and health-seeking behaviours. Gender-based harassment is not included in the MOEYC Policy on HIV and AIDS.

Violence in schools is being addressed through a number of initiatives including:

- The Programme for Alternative Student Support (PASS). A behavioural intervention strategy being implemented by MOEYC to provide help to secondary schools to cope with students who display chronic problematic behaviours;
- An Inter-agency task force for Reduction of School Violence which will generate recommendations and provide guidelines on inter-agency collaboration and contributions to the reduction of violence in schools;
- Pathways to Peace Programme which is aimed at addressing social, cultural and environmental risk factors within schools.

Violence at school is not included in MOEYC Policy on HIV and AIDS.

The Task Force on Educational Reform recommends as a response to anti-social behaviour at school the following:

- Including co-curricular activity in all schools;
- Introducing mentoring, homework assistance and peer counselling programme in all schools;
- Hiring social workers and deploy throughout the system as needed;
- Reintroducing Guidance Counselling as a mandatory course in Teachers' Colleges;
- Hold summer camps, for boys in particular, that are geared toward esteem building, values, attitudes and sports.

Recommendation 39: *It is recommended that school health and safety be more comprehensively linked with HIV and AIDS in HFLE and in MOEYC policy.*

3.2.4 Out of School Youth

Second chance education opportunities are being offered, but HIV and AIDS education is currently not included within these programmes.

There is no strategic plan of action to reach out of school children and youth and provide them with HIV and AIDS Education. This area of response is currently being taken up by NGOs and CSOs. There has been no comprehensive mapping of interventions.

A national strategic plan for out of HIV prevention among out of school youth may be useful in focusing attention on this vulnerable population. Currently, their HIV prevention needs are best catered for within the Behaviour Change Communication Strategy which provides the framework for the development, implementation, monitoring and evaluation of interventions conducted by the Behaviour Change Communication (BCC) component of the **National HIV/AIDS/STI Programme**. The BCC programme has been informed by a review of studies regarding the sexual behaviours of adolescents, the National KABP Survey and previous evaluations and programme reviews. The BCC Strategy has focussed on:

- Developing interventions to address persistent risk behaviours such as inconsistent condom use and early sexual debut;
- Capacity building of health care providers and NGOs to develop, monitor and evaluate BCC interventions;
- Creating a supportive environment for targeting groups to practice safer sex behaviours;
- Building of alliances with critical opinion leaders to assist in creating or reinforcing social norms which promote behaviours conducive to HIV prevention;
- Maintaining HIV and AIDS issues on the public agenda.

BCC activities have reached high risk populations through targeted community interventions supported by the work of community peer educators. These activities have been linked to access to services which has stimulated demand for VCT, condoms, prevention information and treatment and care. Key messages have been articulated by national, regional and parish level staff (USAID. 2005).

A key component of the BCC strategy has been the mass media campaign. At least one major media campaign is carried out each year focused on a key message and a particular target population. For adolescent boys, the campaign '**Get it, Carry it, Use it**' was designed to promote condom use. Media activities are also used to support the national World AIDS Day effort. Advertisements are regularly placed on the radio and there have been programmes which have been used for open HIV discussions and information sharing.

Other components have been training of a wide range of stakeholders facilitated by MoH including of teachers, parents, youth, CSW, community peer educators. Training has been conducted in areas such as HIV and AIDS education, VCT, communication skills, anti-discrimination, risk assessment and counselling.

Community Peer Educators (CPEs) are largely responsible for outreach education at community level. Currently there are approximately 5 trained CPEs in each parish. They are generally women and aged between 19-35. They include sex workers and men who have sex with men (MSM). CPE activities include:

- Work with commercial sex workers;
- Work with prisoners;
- Reaching and serving men who have sex with men;
- Conducting 'walk and talks;'
- Informing and educating parents.

CPE conduct parenting workshops to help parents improve communications with their children on issues concerning sex and sexuality. Training has included parenting skills, discipline versus corporal punishment, preaching versus communication. It is reported (UNAIDS. op. cit.) that many parents are open to learning more about sexuality and HIV and AIDS.

Recommendation 40: *It is recommended that efforts be made to link Community Peer Educators with schools to support community outreach for HIV prevention involving out of school youth and parents.*

In Jamaica, there appears to be no HIV and AIDS curriculum for out of school children. Attention needs to be paid to developing an appropriate HIV and AIDS curriculum for out of school children/youth and capacity built to implement it. Capacity needs to be developed for NFE curriculum development and resources allocated for materials printing and programme implementation. In addition, there needs to be an M&E framework.

Peer education materials have been developed by UWI with UNFPA support. It is unclear to what extent these are being used, by whom and in what settings. The Jamaican Red Cross has also developed a Peer Education approach. Community Peer Educators may be able to assist schools in developing peer education programmes.

UNESCO is supporting the piloting of combined literacy/HIV/AIDS instructional materials for upper primary/lower secondary students in demonstration schools linked to selected teachers colleges and for highly vulnerable out of school youth in urban literacy centres. It is unclear how their use is being assessed.

Recommendation 41: *It is recommended that an assessment be made of the use of and the learning outcomes achieved from the UNESCO supported literacy materials in Jamaica.*

3.2.5 The Curriculum for HIV Prevention

HFLE has been identified as the main vehicle for HIV prevention education in all Jamaican schools (MOEYC. 2001). HIV and AIDS constitute one of 4 themes. It is also considered as a way to reduce demand for drugs, a means of promoting well being and addressing violence. It is a regionally developed curriculum, originating from an initiative supported by PAHO/WHO, UNICEF and the CARICOM Secretariat in the early 1980's and targeted at lower secondary grades 7-9 (Morrissey. 2005).

HFLE is defined as a comprehensive life skills programme (Whitman. 2004. CARICOM and UNICEF, 2001). It is based on research undertaken on the social and health profile of Caribbean children and youth (PAHO. 1998, UWI-Cave Hill. 1998, UNICEF and CARICOM 1997 and the Commonwealth Youth project. 1997).

HFLE is a CARICOM multi-agency programme but the HFLE curriculum has been slow to be translated into classroom practice (Morrissey. 2005). The implementation problems identified in 2001 (CAROM and UNICEF. 2001) highlight the problems encountered and to be addressed. In summary these, these include:

- Poor vision and strategic planning;
- Multiple and overloaded curricula;
- Focus on content not behavioural change
- The benefits not forcibly presented;
- Lack of broad-based stakeholder involvement and ownership;
- Inadequate teacher training, materials development, monitoring and evaluation;
- No sustained political will;
- Inadequate collaboration among support agencies.

This adds up to a comprehensive list of shortcomings to be addressed. To these could be added that HFLE is not part of the core and examinable curriculum.

Despite these, in 2002, there was a renewal of commitment to HFLE by the regional CARICOM Council for Human and Social Development (COHSD) which resulted in the development of a new curriculum framework and prototype lessons for the four HFLE themes (Morrissey. op cit). The revised detailed curriculum was completed in early 2005.

An important regional programme is the CARICOM/IDB/UNESCO **Caribbean Education Sector HIV/AIDS Response Capacity Building Programme**. The IDB and UNESCO have supported the development of the *Caribbean HIV/AIDS Training Package for Teachers: Advocacy and Instructional Materials for Teacher Training institutions* (UNESCO. 2004a). The Joint Programme Identification Study (JPIS) for the above-mentioned project undertaken in 2003 identified a number of critical weaknesses in the HFLE programme. These include:

- **Content.** HFLE is broad in content; HIV and AIDS do not appear to be sufficiently prominent; sexuality is not discussed openly enough;
- **Curriculum status.** The subject has low priority because it is not an examination/qualification subject
- **Teaching skills.** Life skills requires skills in participatory teaching and learning; teacher preparation has been inadequate; teachers are not comfortable with teaching some of the content
- **Stakeholder support.** There is some opposition from the church and parents;
- **Young people.** Youth have not been directly involved in the content, planning;
- **Delivery of HIV and AIDS and sexuality components;** Many would like teachers from outside the school;

These shortcomings are significant and will need to be addressed if HFLE is to be an effective means of HIV prevention. There is widespread perception that behaviour change is not taking place.

Recommendation 42: *It is recommended that Implementation of the HFLE curriculum needs to take place with active consideration of and reference to the UNAIDS benchmarks (UNAIDS IATT. 2003) and other evidence of characteristics of effective HIV and AIDS education. MOEYC capacity in this field needs to be strengthened.*

In Jamaica, the HFLE curriculum scope and sequences for grades 1-6 and 7-9 were both published in 1998 with support from USAID (Ministry of Education and Culture. 1998a and 1998b). A review of these during this analysis, found that HIV and AIDS were explicitly mentioned in the curricula for grades 5 and 6 only. Here the curriculum specifies teaching on prevention and protection from HIV/AIDS, but provides no guidance on how this will be delivered in the classroom. The approach appears to emphasise the learning of messages rather than skills-building. This is also true of the curriculum for grades 7-9 which address the teaching of sexuality through 'the control of sexual urges,' addressing 'sexual deviance' and STIs, but does not explicitly mention HIV and AIDS. This curriculum in its present form would provide a

very weak basis for providing effective skills-based HIV and AIDS education in the classroom.

The shortcomings in the 1998 HFLE curriculum have been recognised by MOEYC and will be addressed through the CARICOM/UNICEF HFLE project, '**Life Skills-Based HIV/AIDS, Health and Family life Education in Jamaican Schools.**' This will be based at the Guidance and Counselling Unit, MOEYC and have a 2 year duration from January 2005 to December 2006. Collaborating partners include UNESCO, GFATM, the World Bank, UWI-HARP, JBTE and Regional health and education authorities.

Recommendation 43: *While the CARICOM/UNICEF project has a two-year duration and planning cycle, it is recommended that MOEYC develop a 5-year implementation strategy for HFLE.*

The goal of the project is to achieve improved HIV/AIDS/STI and violence-related skills and knowledge of 200,000 children in 200 schools by December 2006. It has the following specific objectives:

- To equip 80 teaching and counselling staff and administrators in 24 pilot schools in grades 5-8 in 4 regions in the use of the HFLE regional framework to inform its delivery and their role in the pilot process (by March 2005);
- To develop an overall performance framework with baseline mid and end of programme performance indicators that can be used to effectively monitor and evaluate the progress and impact of the MOEYC programmatic response;
- To increase awareness of the need to support implementation of HIV/AIDS Schools policy for 700,000 children in 1,000 schools (by December 2006);
- By 2006, to scale up the delivery of the revised HFLE regional framework to reaching 200,000 children in 200 schools across the regions of the MOEYC with the assistance of a designated local technical assistant.

The existing scope and sequence of the grades 1-6 and 7-9 curricula is in the process of being revised using a life-skills based approach aligned to the CARICOM Regional Framework. The revised curricula will emphasise the four themes of the CARICOM regional framework:

- **Sex and sexual health.** This theme seeks to increase children's competence in assertiveness, healthy self-management and coping skills among others as relates to the prevention of HIV;
- **Self and interpersonal relations.** This will attempt to develop children's understanding of the different forms of violence at home, school and community. It will seek to build their conflict resolution, mediation and anger management skills;
- **Eating and fitness.** This will promote healthy lifestyle skills and practices among children;

- **Managing the environment.** This will seek to equip children with critical thinking and problem solving skills to respond to natural or man made disasters.

Final drafts have already been presented on primary (1-6) and secondary levels for review. Age appropriate instructional teaching and learning materials will be prepared. The new HFLE curriculum has yet to be approved for piloting. It is therefore too early to assess whether it is likely to be effective. A key issue will be overcoming community and school barriers to the introduction of sex education and the sexual and reproductive health content of the HFLE programme as intended and as delivered in the classroom. The programme will need to be effectively monitored to see how the programme coheres and whether sufficient time is given to addressing HIV and AIDS and sexual health education.

The initial pilot in 24 schools needs to be rigorously monitored and evaluated. The lessons from the pilot exercise should inform subsequent roll out of HFLE to 200 schools.

Recommendation 44: *It is recommended that a detailed costed monitoring, evaluation and research plan be developed for the HFLE pilot which should include both qualitative and quantitative research. There should also be a good quality baseline study.*

Currently it is planned that a strategy and tools for the monitoring and evaluation of HFLE delivery will be developed. An HFLE co-ordinator has been identified to coordinate the activities of the CARICOM/UNICEF HFLE project with consultants and stakeholders. UNICEF is to provide technical and financial support to strengthen MOEYC capacity to monitor and evaluate. (UNESCO 2005a). To support this the following steps will be taken:

- A policy environment survey based on the National Policy for the Management of HIV/AIDS in Schools within 6 months of policy dissemination. This should give better data on the extent of HFLE implementation in schools;
- A rapid assessment of HFLE and existing M&E structures and mechanisms at all levels in the education system. This will recommend strategies for strengthening M&E of the delivery of HFLE in schools.
- Development of an overall performance framework for M&E of process and impact of MOEYC's programmatic response.

Outside of the HFLE project, a curriculum scope and sequence for the early childhood level is to be developed aligned to the CARICOM regional framework. This has already been drafted and is in the process of being reviewed for approval.

Recommendation 45: *It is recommended that an implementation plan for piloting the early childhood curriculum on HFLE be drawn up once the curriculum has been formally approved.*

As an adjunct to MOEYC policy implementation and as a means of developing support for HFLE, UNICEF is providing training and materials through its **Lessons for Life Programme**. 38 schools have participated to date. There is a strong focus on preparing for World AIDS Day (WAD). The 2005 Lesson for Life campaign in Jamaica aims to give children, in schools and groups, an opportunity to discuss the prevention of HIV and the impact of AIDS and to look at ways they can take action in their own communities to help HIV prevention and to support those who are affected. (MOEYC, 2005). MOEYC is partnering the NAC to lead the initiative. It is recommended by MOEYC that the 2005 Lesson for Life should take place before the middle of November as part of the schools or groups' preparation for World AIDS Day on 1 December. It is envisaged that children and young people be actively involved in the planning, preparation and teaching of the Lesson for Life.

The Lesson for Life campaign offers an opportunity to raise demand at the school level for HIV prevention education. It also presents a means of building capacity especially in terms of teacher skills to implement participatory education in the classroom in a relatively low-risk approach. There are also risks in a campaign approach in the education sector. A significant amount of effort is involved in planning for a single lesson. A **Lesson for Life Activity Pack** has been developed. This may distract from the longer run and what should be a higher priority goal of integrating HIV and AIDS through the HFLE curriculum and if not effectively communicated to stakeholders at school level it may cause confusion.

Recommendation 46: It is therefore extremely important and it is recommended that a monitoring and evaluation framework be put in place to identify the strengths and weaknesses of the lessons for Life Campaign at school level so that the lessons can inform the development of the HFLE curriculum.

The Jamaican Red Cross (JRC) is to launch an initiative called **Power Peers** in 20 schools. This will involve 5 students in each school being trained in life skills to address problems within their schools. How this relates to the HFLE pilot is unclear. Any initiative like this needs a monitoring and evaluation framework and the involvement of the HRT. Given the small scale of the HRT the absorptive capacity for initiatives is limited and these should be selected on the basis on MOEYC policy. However, if the JRC programme is piloting a peer education approach as the title implies this is important and should be carefully monitored for potential to scale up activities.

3.2.6 Stakeholder Participation

Effective programmes include appropriate stakeholder participation in curriculum development (planning, implementation, evaluation and redesign). This may feature an orientation process for parents and community leaders. Ideally, young people and PLHA should be directly and consistently involved in the curriculum development process. Partnerships should be developed between the school and the community.

In the case of Jamaica, it appears that very limited stakeholder participation has been involved in the revision of the HFLE curricula. These seem to have been developed by consultants. UNICEF (2004) has developed a *Participatory Action Research* (PAR) approach, within the Right to Know initiative, for promoting the participation, learning and action of young people and for those seeking to work with them. It is unclear how useful this approach and the accompanying materials have been in the education sector.

The CARICOM/UNICEF HFLE project will sensitise principals, teachers and counsellors regarding the piloting of the new curriculum. There appear to be no explicit plans at present for community and parental involvement or funding for this to take place aside from more general community sensitisation to MOEYC HIV and AIDS policy.

Recommendation 47: A comprehensive plan for piloting the revised HFLE curriculum in 24 schools needs to be developed to ensure that adequate attention is given to stakeholder participation which will be necessary for effective implementation.

3.2.7 Edutainment

Effective HIV education programmes are likely to be multi-faceted. Ministries of Education can promote the use of edutainment for HIV and AIDS education. Perhaps the best known example of such an approach is *Soul City* from South Africa, programmes of which are also being implemented in countries across Southern Africa. The use of media including theatre for development can usefully feature in curricular and co-curricular activities.

Good quality resources exist in Jamaica for edutainment to contribute to the education sector response to HIV and AIDS. Radio and television services are well developed.

There is considerable talent in the performing arts. The ASHE Caribbean Performing Arts Foundation is considered by UNESCO to be the leading professional company in the English-speaking Caribbean. (UNESCO, 2004). It entertains and educates through song, dance, drama and drumming. ASHE has developed its own methodology which is called the EIC Transformational Model. This consists of Excitement (E), Involvement (I) and Commitment (C). ASHE has also developed in collaboration with MOEYC and supported by USAID, 2 major programmes with teaching and learning materials for schools: *Vibes in the World of Sexuality* and *Parenting Vibes In the World of Sexuality*. It is unclear if these have been piloted and evaluated. These materials are a potential, but seemingly unused, resource for teachers and students.

ASHE has worked well with MOEYC at school level and the group have considerable potential to work in partnership with schools and regional education offices to help

deliver the HIV and AIDS Policy. ASHE could also support the training of performing arts teachers.

Portland AIDS Committee, a Parish AIDS Committee (PAC) has published a booklet with support from UNICEF setting out the lessons learned through its Youth Edutainment programme. It developed a youth group that uses art, music, socialising, games, drama, dancing with teaching and service relevant to AIDS. It is suggested that this helps young people see HIV and AIDS as significant in their own lives. The booklet (*Lights, Camera, Action on AIDS*) is a useful resource for groups that would like to harness the arts for HIV and AIDS education. It could be of value in supporting school AIDS Clubs.

There is tremendous potential for edutainment at school to make HIV and AIDS issues real for principals, teachers, students and parents/the community. There is scope through these approaches for innovation and for connecting with the interests and lives of young people. However, the current MOEYC Policy offers no explicit guidance as to how this might be achieved. The main priority should be the development and implementation of the HFLE curriculum in all schools and currently there is no provision for edutainment. The way forward probably lies in MOEYC developing comprehensive guidelines for co-curricular activities with regard to HIV and AIDS which can be promoted by the HACs.

Recommendation 48: It would be helpful if a scoping study could be commissioned by MOEYC on how edutainment might be most effectively harnessed in the fight against HIV and AIDS and also in addressing other related issues such as gender-based violence, substance abuse, and masculine behaviours in and out of school. This could provide options for the development in the medium term of edutainment programmes in school settings.

3.2.8 Co-curricular Activities and HIV

It is good practice to ensure that HIV and AIDS are integrated into co-curricular activities. Co-curricular activities such as sports can be used for HIV and AIDS education including prevention and stigma prevention. Promising examples have been identified for HIV prevention in sport, recreation and play in Honduras, Ghana and Zambia (UNICEF, 2004). School clubs can include HIV and AIDS related activities including peer education. Some countries are experimenting with 'Anti AIDS Clubs' at school.

The MOEYC Policy provides explicit support for prevention measures to be adopted in relation to play and sport. Staff members acting as sports administrators, managers and coaches are singled out as having '*special opportunities for meaningful education for sports participants with respect to HIV/AIDS including education re safe sex and should encourage participants to seek medical and other counselling where appropriate*' (7.4. p17). This is a good first step.

Recommendation 49: It should be recognised that *staff involved in sport, recreation and play will need some professional training (in-service and pre-service) and learning materials if they are to be effective and consistent with good practice in HIV prevention.*

They will also need professional support from principals and school inspectors. There is scope for partnerships with NGOs including with National and local sports associations.

The MOEYC policy lacks attention to other areas of co-curricular activity. This is an area for further exploration. There is considerable room for innovation in this field and opportunities to develop peer education and other young people-led participatory approaches with the involvement of CBOs and NGOs.

Recommendation 50: *It is recommended that a position paper be commissioned by MOEYC exploring the potential for co-curricular activities in the school setting for HIV prevention.*

3.2.9 Teaching and Learning Materials

An effective HIV education programme requires good quality teaching and learning materials to have been developed and in use at all levels in the education system. Such materials should be professionally developed and piloted before their final adoption. Provision needs to be made so that sufficient quantities of materials are distributed to all institutions and their use is monitored. Every teacher and learner should have access to appropriate teaching and learning materials.

Browne (2005) in reporting on a UNESCO-funded evaluation of HIV and AIDS textbooks that as yet no instructional materials have been out by MOEYC. This represents a major impediment to effective teaching and learning about HIV and AIDS. How HFLE can be implemented consistently without there being accompanying teaching and learning materials is difficult to imagine. The absence of materials puts an additional preparation burden on the teacher which often results in a didactic approach in the classroom. Materials are needed to support participatory activities.

The development of teaching and learning materials for HFLE can be built into the current pilot project and its successor. Currently, it is unclear what HFLE materials are to be developed for students in schools or university and how these would be funded.

Another option is to encourage a response from the publishing industry.

Recommendation 51: *Developing good quality teaching and learning materials on HIV and AIDS within HFLE should be a high priority area for MOEYC action.*

Browne (op. cit.) suggests that one intervention that could be tried is to use supplementary readers to support HIV and AIDS education. In a review of African published readers, she reports that some could be used in Jamaica, at primary, secondary levels and in teachers' colleges although there will be some cultural challenges. A longer term project would be to adapt or develop Jamaican/Caribbean readers. This recommendation has been accepted by MOEYC and HIV and AIDS readers mainly of African origin will be piloted by the Jamaica Library Service Mobile Library (bus) Unit to be financed through World Bank support. This is a promising initiative which will need to be carefully monitored from a gender perspective given the reading problems encountered with boys.

Recommendation 52: *It will be important to have a robust monitoring and evaluation framework in place to assess the outcomes of the piloting of HIV and AIDS readers by Jamaica Library Service for future programme planning purposes.*

HIV and AIDS IEC materials have already been supplied to this Unit (65,000 reprints of '101 ways to say 'No' to sex' and 'My Life, My Choice'. These have been distributed to both in and out of school youth especially in rural areas. IEC materials used in an ad hoc or scatter-shot approach are unlikely to be very effective, unless designed to be used in this way. The use of IEC needs to be aligned with HFLE in schools and used as adjuncts for this.

3.2.10 Teacher Preparation

Effective HIV and AIDS education programmes require that educators are being professionally developed. Teacher educators need to be professionally trained in HIV/AIDS issues and curriculum implementation. School teachers need to be adequately prepared through pre-service and in-service training to teach a skills-based approach to HIV prevention.

To date, teacher education has been a neglected area in the education response to HIV and AIDS. This needs to be set in the context of the Jamaican education system in which the majority of teachers (63%) have a teaching diploma but no subject specific qualification. Only 20% of teachers in the public system are graduate trained. There is no requirement for teachers to continue to improve their professional learning once they have received their teaching qualifications. Where there are specific projects, however the MOEYC offers professional development throughout the year (Task Force Report, 2004).

The challenge is two fold:

- First, to ensure that that all teachers who take a professional teaching qualification receive appropriate training on HIV and AIDS for working in schools in a world with HIV and AIDS;
- Second, to develop a comprehensive project to establish continuous professional teaching skills development especially in relation to the

implementation of HFLE. The MOEYC Policy is silent on what is intended for teacher preparation on HIV and AIDS.

It is particularly important that HIV and AIDS are being given appropriate priority in initial teacher education. HIV and AIDS and life-skills should be integral components in the curriculum for the professional preparation of all new teachers. Materials for teacher education need to be developed. It is worth considering the setting up of small resource centres for HIV and AIDS education for staff and student use in Teacher Training Colleges.

The Joint Board of Teacher Education (JBTE) is embarking on a project, funded by GFATM, to pilot in 4 Teachers Colleges, for the period 2005-2008, the implementation and institutionalisation of an HFLE/HIV and AIDS curriculum. JBTE is under the aegis of the Institute of Education (IOE) at UWI which will be the source of professional direction of the project. The project will train lecturers in behaviour change, education values and other strategies.

The project will deliver the following outputs:

- A 2 credit HFLE / HIV and AIDS 30 hour curriculum in 4 teacher's colleges for all student teachers as part of their personal development programme;
- Handbooks and other teaching and learning resources;
- Networks within colleges and the community;
- Research on HFLE;
- Graduate level HFLE/HIV and AIDS course at UWI;
- HFLE/HIV and AIDS for teacher training.

Recommendation 53: *It is important that the piloting of the HFLE curriculum in 4 teachers' colleges be adequately monitored and evaluated so that the programme can eventually rolled out to all such colleges.*

Recommendation 54: *It is recommended that consideration be given to developing professional post-graduate qualifications for teacher educators and senior education staff on HIV and Education. Resource centres for HIV and AIDS education should be established in all Teachers' Colleges. Planning needs to be undertaken to take this project to scale.*

Recommendation 55: *There also needs to be a programme for delivering quality in-service training and support to serving HFLE teachers and a strategy developed to institutionalise it across the country (currently included in CARICOM/UNICEF HFLE pilot project).*

Teaching Guidelines (e.g. A Teachers' Manual) for teachers on HFLE have not been developed to date. No resources are yet available for teachers at school for the implementation of MOEYC Policy.

Recommendation 56: A Teachers' Manual for HFLE needs to be developed and piloted to support the implementation of the HFLE curriculum

As a direct outcome of the UNESCO/CAPNET Conference, Macmillan Caribbean is to publish in early 2006 a Caribbean version of its textbook for teachers: Teaching about HIV and AIDS. This edition is expected to comprise 6 sections:

- What every teacher needs to know about HIV and AIDS;
- Laying the foundations – understanding our attitudes to HIV and AIDS;
- Preventing the spread of HIV;
- Sex and sexuality
- Teaching about HIV in all areas of the curriculum;
- Teaching children affected by HIV and AIDS.

Recommendation 57: It is recommended that funding be provided to ensure that all Jamaican Training Colleges and Regional Education offices have a stock of HIV and AIDS books including reference materials for training purposes and for self-access.

Teacher performance in implementation needs to be supported within the school and by the inspectorate and school principals. Performance should be monitored and quality assured. There is no system at present of providing ongoing professional support for classroom teachers who are implementing HFLE. Performance in delivering HFLE is not monitored or quality assured.

Recommendation 58: A strategy should be prepared for providing ongoing professional support to HFLE teachers.

3.2.11 Access to Health Services

The Ministry of Education needs to be supported by other partners in government such as the Ministry of Health. This includes access to 'youth-friendly' health services including for the treatment of sexually transmitted infections (STIs).

Collaboration between MOEYC and MoH is ongoing. There is no Memorandum of Understanding between the two line ministries setting out their respective roles regarding the implementation of HIV and AIDS policy for the education sector.

Capacity has been built in the provision of VCT and STI control through the MoH National HIV/AIDS/STI Prevention and Control Programme. The VCT programme has been expanded. Counsellors and trainers have been trained in all regions and work as integrated units. Seven youth friendly clinics have been established, three with NGO partners, four in MoH facilities. All sites offer a comprehensive package of services related to adolescent reproductive health, including education, HIV

prevention counselling, distribution of condoms and other contraceptives and referrals. Standards for certifying services and programmes as 'youth friendly' with key criteria under each standard have been developed and pilot tested. VCT sites have been established in all major health centres.

The STI surveillance and control programme is achieving results. The incidence of curable STIs has declined (USAID, 2005). The role of the *contact investigator* (CI) is credited with this success and the maintenance of low HIV prevalence. CIs play multiple roles including contact tracing for HIV and syphilis, serving as community HIV and AIDS educators, perform clinical work, assist with surveillance and perform data entry and record keeping. CIs are often nurses, nurse midwives or other health professionals. They serve as the major point of contact for many Jamaicans to enter the health system. They are trusted members of the community and very knowledgeable. CIs often work at great risk to themselves in contexts of violence and have worked out their own unique strategies for operating in difficult circumstances.

Support from USAID from 2001-2004 was judged to be critical for the success of the programme contributing to training of physicians and contact investigators. Community peer educators were trained in understanding and addressing behavioural factors that drive STI transmission. The reporting system has been computerised down to the parish level. It is the conclusion of the USAID evaluation (op. cit.) that the MoH approach can serve as a model of good practice, although there remain significant human resource capacity deficits which constrain scaling up of activities, especially in the technical areas. A greater emphasis needs to be placed on monitoring and evaluation. Additional human resources are required and a structured approach to training would be beneficial. Attention needs to be given to addressing the sustainability of HIV and AIDS response initiatives beyond donor financing.

Recommendation 59: It is of critical importance that schools facilitate access of students to the youth friendly services described above. This is not as yet included in MOEYC policy, but it is becoming part of Guidance Counselling practice. Guidance needs to be given to school principals of how to link most effectively with youth friendly clinics and CIs who may be able to provide support to school-based prevention efforts.

3.2.12 Higher Education

A curriculum committee was set up by UWI-HARP to address HIV and AIDS in the formal curriculum at UWI. It identified courses across disciplines which showed opportunity for infusion and those which already had HIV and AIDS content (Crewe, 2005). A needs assessment was undertaken and a matrix of courses completed accordingly.

The SIRHASC initiative facilitated two 2 day training of trainers (ToT) workshops in 2003. In 2003/4 at Mona campus, 40 courses were targeted of which 23 were existing courses with infused HIV content. 30 courses were delivered and 973

students were exposed to the courses. SIRHASC has also enabled UWI to recruit 6 new lecturers to strengthen its HIV and AIDS teaching capacity: 2 at each of the three campuses (Mona: a health communication specialist and a health promotion specialist; St Augustine: 2 health economists and Cave Hill: a health economist and a health planning/behavioural sciences specialist).

UWI HARP has supported the teaching and development of HIV and AIDS curricula on an ongoing basis and has developed the University of the West Indies HIV/AIDS Manual: A Caribbean Perspective (UWI-HARP. 2004). This manual has been piloted, updated and made available in CD-Rom format. It has been produced for academic staff at the UWI to provide support in the process of curriculum review and development for HIV and AIDS.

The manual is divided into sections each addressing a key area of HIV and AIDS. These are:

- The Basic Facts about HIV and AIDS;
- Aetiology and Epidemiology of HIV and AIDS;
- Transmission and Infection Control;
- Testing and Counselling;
- Clinical Manifestations and Treatment;
- Legal and Ethical Issues;
- Psychosocial Issues;
- Sexually Transmitted Infections;
- Prevention Issues;
- Adolescent Sexuality
- Life skills for adolescents;
- Interactive learning in the Classroom;
- Teaching Tools for HIV and AIDS in the Classroom

Interactive teaching methodologies include brain storming, case studies, story telling and quizzes. Transparencies and power points are included in manual and electronic formats.

It was not possible to undertake an-depth participatory review of the materials in the setting for which they were developed. However some initial observations are recorded below:

1. The opportunity to present HIV and AIDS as a development issue is not taken.
2. The materials do not readily support peer education.
3. The materials do not seem to relate to campus life. Case studies involve 'others' with HIV and AIDS.
4. The content is largely fact based.

5. No assessment of learning outcomes appears to have taken place.
6. There seems to be a risk that the infused curriculum for HIV and AIDS will lead to academic learning rather than knowledge and skills building related to the students own context of vulnerability and risk. There is a risk that students will not have much of a sense of ownership of the UWI-HARP programme and worth investigating.

There appear to be no HIV and AIDS education materials specifically developed for higher education students. Stickers, mouse pads and student folders have been developed carrying the message 'Are you at Risk of HIV/AIDS?'

Crewe (op.cit) reports that peer education has been established at Mona campus (and the other 2 UWI campuses with some 100 peer educators) funded by SIRHASC and facing sustainability questions with funding coming to a close in September 2005. It is unclear which peer education materials have been used to support these programmes, how they are managed and monitored as there is no peer education co-ordinator. The different campuses have implemented different models of peer education, including more than one model in each campus. Peer educators have been used to deliver the formal curriculum in the role of assistant lecturer in a module on health and safety. This is not what is normally understood to be 'peer education.'

Recommendation 60: *There needs to be a review of peer education practices, including assessments of their quality, coverage and effectiveness at UWI.*

Crewe (op.cit) that UWI has faced difficulties in justifying peer education to donors.

Recommendation 61: *It would be useful to have an independent assessment of the effectiveness of HIV prevention approaches at UWI.*

No KABP survey among students has been conducted at UWI to date. Neither has there been any qualitative research into student sexuality. The national KABP is being used as a reference point.

Distance education represents an under-utilised medium for HIV and AIDS education. How this could be exploited in Jamaica and beyond needs to be explored. Specific HIV and AIDS professional courses could be developed, for example a Master's course in Education and HIV and AIDS, perhaps delivered by open and distance learning (ODL). This development could usefully support the professionalisation of HIV and AIDS education and assist in legitimising it as an innovative field of education.

There has been a number of IEC activities organised by the Health Service and Campus Counselling. These have been run on a campaign footing generally in relation to WAD and various university events. They have therefore been ad hoc and

sporadic in nature. Most IEC materials have been supplied by the Ministry of Health. UWI focussed materials do not seem to have been produced.

Male condoms are freely available on campus and distributed to Halls of Residence and to the Campus Health Centre. Additional condoms are distributed in 'condom week' and on Valentine's Day. Attempts to introduce the female condom have not been successful to date. STIs are diagnosed at the campus health Centre and treatment is available to students and staff. HIV testing is available but there are currently no VCT services on campus at UWI. PEP is available to both students and staff in the event of sexual assault, needle stick injuries and to those exposed to blood in the University Hospital and laboratories.

3.2.13 Technical and Vocational Education and Training (TVET) and Lifelong Learning

The provision of basic education and vocational skills training outside the formal school system is provided by the Human Employment and Resource Training (HEART) Trust/National Training Agency (NTA). Programmes are available to the 17-29 year old group. Pre-vocational and continuing education programmes are also provided at Vocational Training Centres (VTCs) for those who do not satisfy matriculation requirements for HEART Trust/NTA level1 training programmes.

There is no evidence that TVET currently includes any teaching and learning about HIV and AIDS.

3.3 Mitigating the Impact of AIDS on the Education Sector.

3.3.1 Impact Assessment and Response

In many contexts it has become standard practice for the Ministry of Education to commission an AIDS impact study. In addition to assessing the current impact of AIDS, projections can be made of the impact of AIDS on likely enrolments and teacher requirements at various levels of the system over the next 5-10 years. The study may be widely disseminated and used to inform sector policy development and strategic planning in relation to managing the supply and ensuring the quality of education on offer.

In Jamaica, no comprehensive assessment of the current or future impact of HIV and AIDS on the demand for and the supply of education has yet been undertaken. A study investigating the impact of AIDS on the supply of educators and the demand for education (Bailey and McCaw-Binns, 2004a), funded by UNESCO, found no evidence of significant mortality among teachers due to AIDS. It was hypothesised that Jamaica teachers may be a relatively low risk group as they are not very mobile, many are married and many are female. In the same study, discriminatory attitudes and practices towards children affected by HIV and AIDS were evident, including negative attitudes of some school personnel. It is therefore not altogether surprising that actions are not being taken to mitigate the impact of AIDS on the education system. Steps have not been taken to improve and accelerate teacher recruitment;

review teacher education and training; develop teacher substitution policies or ensure access to treatment and care.

Recommendation 62: *It is likely that the major impacts of HIV and AIDS in the short to medium term will be experienced in terms of children affected by AIDS and infected with HIV. Nevertheless it is recommended that the attrition rate of teachers be monitored from an HIV and AIDS perspective.*

There has been no review of teacher education and training to respond to the new policy on HIV and AIDS. Action is being taken to address stigma and discrimination through the implementation of the MOEYC Policy of HIV and AIDS.

3.3.2 Children Infected with HIV and Affected by AIDS. Orphans and vulnerable children

The situation of orphans and vulnerable children does not appear to be monitored by MOEYC. A comprehensive situational assessment has not been conducted on orphans and vulnerable children including their access to education.

A rapid assessment of the situation of orphans and other children living in households affected by HIV and AIDS was undertaken in 2002 (National AIDS Committee. 2003). In education was expressed about irregular attendance, particularly among children from poor families. About a third of all secondary school children were reported as taking advantage of government school fees, while two thirds of children participate in school feeding programmes. Impediments to accessing financial relief were reported as in need of study and action.

Recommendation 63: *It is worth considering undertaking a follow up situational assessment of orphans and vulnerable children adapting or adopting assessment tools which have more recently been developed in sub-Saharan Africa.*

Ramsey et al (2004) report that children known to be affected by the virus are greatly disadvantaged as a result of stigma, increasing poverty and social disruption. A study on the barriers to the integration of HIV and AIDS infected and affected children into the school, system (Bailey and Bailey. 2004b), identified the following issues:

- Negative effects of disclosure due to strong stigmatisation;
- Decline in school performance;
- Increased financial burden of the disease leading to poor diets and irregular attendance at school;
- Orphans being taken into institutional care where there is no provision of education;
- Fears of teachers who were unwilling to share space with affected children;
- Basic school teachers were sometimes poorly informed about HIV and AIDS;

- Majority view that children living with HIV should be not be taught with the healthy.

There is a lack of a national policy framework to respond to the special needs of increasing numbers of orphaned and other vulnerable children. There is a National Plan for Orphans and Vulnerable Children. The **National Plan of Action for Orphans and Other Children Made Vulnerable by HIV and AIDS** was developed for the period 2003-2006 (Child Development Agency, MoH). A national Steering Committee on orphans and other children made vulnerable by HIV and AIDS has been established. There is a national OVC focal point within the Child Development Agency, but there is no OVC focal point within MOEYC. It is not clear if there has been a mid-term review of this plan.

The **strategies** in the National Plan of Action which involve the education sector include

- Building awareness, user-friendliness, confidentiality for PLHA (education is seen as a key sector in output 2: information on existing services disseminated and services accessed);
- The imparting of counselling/support skills to existing professionals such as teachers (output 3: psycho-social support to care givers, orphans and other children made vulnerable by HIV and AIDS);
- Conducting BCC campaign against to reduce stigma against PLHA, OVCS and their caregivers and involve children, young people and PLHA more actively in stigma reduction, (output 4: stigma against PLHA and those associated with them reduced).

Activities for the education sector include:

- Include appropriate information and skills on HIV and AIDS in training and certification curricula in post secondary institutions and for any groups who may work with OVCs;
- Develop a continuing education system for these groups;
- Recruit education personnel to attend training and sensitisation sessions on HIV and AIDS including the impacts of HIV and AIDS on families and OVCs as part of MOEYC policy process;
- Include HIV and AIDS sensitisation in all orientation programmes;
- Assess, on a case by case basis, levels of psycho-social distress among OVCs and their caregivers and ensure they receive appropriate support;
- Through school teachers, identify voluntary counsellors for sensitisation and training in care and support of OVC, PLHA and caregivers

These strategies and activities predate the introduction of the MOEYC Policy on HIV and AIDS and will now need revisiting. This would be best accomplished in a comprehensive strategic planning exercise.

Recommendation 64: *Policies and programmes need to be put in place to ensure there is access to education for all, including orphans and vulnerable children.*

Cost barriers, direct and indirect, to education need to be removed. The education system can help maintain attendance at school through cash/food transfers and school health programmes. The track record of PATH will need to be monitored in this regard.

Recommendation 65: *The performance of the PATH programme and NGO programmes of support in meeting the needs of OVCs from an educational perspective needs to be fully assessed.*

Recommendation 66: *The role of schools to provide care and support to orphans and vulnerable children needs to be expanded.*

Ideally, children who are affected and infected are being provided with a caring environment/culture of care. Learners who are affected by AIDS should find help/counselling from their teachers or from persons other than teachers. Teachers who are dealing with the trauma of children affected by AIDS should receive training and support to cope.

A caring environment and a culture of care are some way from being a reality in Jamaican schools where children living with and affected by HIV and AIDS face strong stigmatisation and discrimination.

Recommendation 67: *MOEYC Policy at present mentions only HIV-infected children MOEYC needs to adopt policies and practice to protect orphans and other children made vulnerable by HIV and AIDS. In particular, an intensive effort needs to be implemented to prevent stigma and discrimination in all schools and educational institutions.*

3.4 Strong Leadership and Commitment to Action

An effective national response to HIV and AIDS requires that there is visible political and professional leadership at all levels to support the education sector response to HIV/AIDS. Leaders at all levels should be knowledgeable and committed to action.

Involvement of political leaders and senior official in the education sector response to HIV and AIDS appears generally to be at a low level and could easily be strengthened. There appears to be little visible high-level support for the education response to HIV and AIDS. The UNESCO/EDC Advocacy and Leadership Programme, involving participants from Trinidad and Tobago, Jamaica and St Lucia, will provide an opportunity to support the mobilisation of high-level educational leadership in Jamaica.

Progress is being made at school level. Principals are significant gatekeepers to the implementation of the HFLE curriculum and seem to have considerable discretionary powers in running schools. They have been involved in the MOEYC Policy dissemination process, but it is advisable to tailor specific interventions to meet their needs. PTAs are being sensitised by the Policy dissemination workshop programme being rolled out by the HRT. HAC formation potentially provides a means of mobilising local leadership for addressing HIV and AIDS in the school. The process of developing School Action Plans under the aegis of the HACs offers opportunities to consolidate this.

Recommendation 68: The Ministry of Education needs to show ongoing committed leadership at all levels and actively communicate that addressing HIV and AIDS is a part of its core business.

Ministry publications carry articles on HIV and AIDS. The Ministry/University websites should have an appropriate HIV and AIDS webpage. All policy documents should include HIV and AIDS. Currently, there is no reference to HIV and AIDS on the MOEYC website.

It is recommended that MOEYC

Recommendation 69: Include a web page on its response to HIV and AIDS which would showcase its policy and provide information on implementation.

Recommendation 70: Develop a newsletter for schools on HIV and AIDS (for principals and teachers)

4 Conclusion

The education sector response to HIV and AIDS in Jamaica is on track though at an early stage of development. The next few years will be critical to putting in place planned initiatives such as the HFLE pilot and HACs. The first priority should be on developing a strategic plan for the sector as a whole with an emphasis on policy implementation at all levels in order to bring together all the different ongoing initiatives within one framework and ensure that all key activities are being developed appropriately.

4.1 Summary of Key Findings.

What is working and should be continued or expanded?

a) Policy. MOEYC has put in place the National Policy for HIV/AIDS Management in Schools (2004). Key points include:

- It is the first comprehensive education sector policy in the Caribbean;
- It provides a platform for strategic planning and capacity building;
- It covers the entire education sector with exception of higher education;
- The policy needs to be expanded to include access to treatment and care for students and staff;
- The workplace elements of the MOEYC policy could be made more specific and comprehensive through alignment with the National Workplace Policy on HIV/AIDS and the ILO and UNESCO guidance on workplace policies for the education sector;
- The policy needs to be accompanied by a handbook containing guidelines for implementation at school level;
- Consistency and clear linkages need to be ensured between MOEYC Policy on HIV and AIDS and other national policies;

b) Policy Dissemination.

- A decentralised approach is being taken with policy dissemination;
- All junior high schools have been covered and many primary schools amounting to almost 50% of the country's schools;
- Attention needs to be paid to monitoring the quality and consistency of the dissemination process and to facilitating school-based dissemination;

c) Establishment of the HIV and AIDS Response Team (HRT) to operationalise policies and plans.

- Establishment of HIV and AIDS coordination and communication capacity at MOEYC headquarters;
- Health promotion outreach capacity established in all regional education offices;

- Attention need to be paid to consolidating the work of the HRT at all levels through additional resources, training and ICT connectivity;
- HRT Capacity in monitoring and evaluation needs building;
- Attention to be paid to the sustainability of the HRT in the medium to long term;

d) University Policy on HIV and AIDS

- Policies on HIV and AIDS are in place for UWI and University of Technology, Jamaica;
- Policies need to expand on prevention education for students and coverage of workplace issues;

e) Capacity building on HIV and AIDS in Higher Education

- UWI-HARP has supported the building of multi-sectoral capacity;
- UWI HARP is largely donor funded and there are questions of sustainability;
- UNESCO Chair in Education and HIV and AIDS established and filled at UWI in 2005;

f) Research. A good knowledge base of research evidence exists on the vulnerability and risk behaviour of young people;

- Knowledge gaps exist in relation to masculinity and education, stigma and discrimination at school and HFLE;
- A research strategy is required for the education response to HIV and AIDS;

What is not yet working, but should be continued ?

a) HFLE. The main vehicle identified in policy for school-based HIV prevention education.

- MOEYC Policy needs to be more explicit in relation to HFLE and timetabling, teacher preparation, assessment of learning outcomes, peer education and its linkages with youth friendly services;
- Clear and practical guidelines need to be developed for HFLE implementation at school for principals and teachers;
- Peer education needs to be developed;
- Capacity needs to be built in MOEYC in the field of skills-based health education and behavioural change;
- HFLE needs to be developed with reference to UNAIDS Benchmarks on Skills-based health education and evidence of the characteristics of effective HIV and AIDS education
- HFLE is to be piloted in 24 schools at first, then scaling up to 200 schools;
- HFLE pilot needs a detailed costed monitoring, evaluation and research framework;

- An implementation plan is needed for HFLE piloting in early childhood education;
 - Teaching and learning materials need to be developed to support HFLE at all levels;
 - The piloting of supplementary readers on HIV and AIDS with the Jamaica library Service Mobile Bus needs to be professionally monitored and evaluated and linked with HFLE implementation;
 - Teachers need to be professionally trained to teach HFLE. The piloting of HFLE in 4 teachers colleges needs to be appropriately monitored and evaluated before being taken to scale, a strategy needs to be developed for in-service training and support;
- b) HACs.** The establishment of Health Advisory Committees (HACs) in schools as recommended by MOEYC policy;
- Guidance is needed on how to set up HACs and what particular functions they should have for HIV and AIDS response at schools, also what financial resources they will have at their disposal;
- c) HIV Prevention in co-curricular education.** Mention is made of HIV education in MOEYC policy in relation to sports only.
- Attention needs to be given to exploring how co-curricular activities can best support HIV and AIDS education activities;
- d) HIV Prevention in Special Education.** HIV prevention education for special needs students;
- KVAP carried out among adolescents with disabilities indicating need for HIV prevention education;

What is not working and needs a new strategic approach?

- a) Leadership.** A more concerted and focused approach is needed from educational leadership at all levels. This includes:
- Endorsement of policy documents on HIV and AIDS by senior officials in the foreword to the document;
 - Targeted intervention for Regional Directors of Education regarding implementation of MOEYC Policy on HIV and AIDS;
 - MOEYC website and communications need to include HIV and AIDS policy and implementation details;
- b) Addressing stigma and discrimination.**
- A more comprehensive rights-based approach to stigma prevention and mitigation is needed;

- c) Impact mitigation.** Mitigating the impact of HIV and AIDS on the demand for education and its supply.
- MOEYC Policy needs to consider impact and its mitigation. Currently there is no mention of orphans and vulnerable children;
 - Attrition rates of teachers should be monitored;
 - A new situation assessment of OVCs should be considered using recently developed tools;
 - Attention needs to be paid to ensuring all OVCs are able to continue to access education and to expanding the role of the school to provide care and support;
- d) Gender.**
- MOEYC Policy on HIV and AIDS does not mention gender issues;
 - Capacity needs to be built to mainstream gender throughout the education sector response to HIV and AIDS.
- e) Monitoring and Evaluation.**
- SMART performance indicators need to be developed to monitor the dissemination and implementation of MOEYC policy;
 - Monitoring from a gender perspective needs to be developed.
- f) Strategic planning.**
- The Work plan for MOEYC in the JHANSP can be considered as a precursor for a more detailed costed strategic plan for HIV and AIDS in the education sector which should be developed for the period 2006-2010.

What is not relevant to current needs and should be dropped?

No evidence was found of programmes that were not relevant to current needs.