

UNESCO'S RESPONSE TO THE REPORT OF THE COMMISSION ON AIDS IN ASIA

HOW SHOULD EDUCATION SYSTEMS REACT
TO REFOCUS PREVENTION ON
ADOLESCENTS MOST AT RISK FOR HIV?

HIV/AIDS
& EDUCATION



Discussion Paper No. IV

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List of Acronym

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<i>ADB:</i>	<i>Asian Development Bank</i>
<i>UNAIDS:</i>	<i>The Joint United Nations Programme on HIV/AIDS</i>
<i>UNICEF:</i>	<i>United Nations Children's Fund</i>
<i>UNDP:</i>	<i>United Nations Development Programme</i>
<i>UNODC:</i>	<i>United Nations Office on Drugs and Crime</i>
<i>UNESCO:</i>	<i>United Nations Educational, Scientific and Cultural Organization</i>
<i>WHO:</i>	<i>World Health Organization</i>

Background

The independent Commission on AIDS in Asia was set up in June 2006. It was given an 18-month mandate to study the realities and impact of AIDS in Asia and to recommend strategies for a stronger response to HIV and AIDS. The Commission's work was financially supported by UNAIDS, UNICEF, UNDP and ADB. Three dozen research papers were commissioned, and 600 individuals and community organizations were interviewed. Important work based on an adapted version of the Asian Epidemic Model¹ was conducted to project the likely future course of the epidemic.

This concept note aims to explore the implications of the report's main findings and conclusions for education sector responses to HIV and AIDS in Asia.

Key Findings from the Commission on AIDS in Asia Report

1. Although there is considerable variation in the shape and severity of AIDS epidemics across countries in the Asia region, they share important characteristics. Their most profound similarity is that all of them are driven by three key behaviors that are responsible for at least 75% of all HIV infections in the region. These behaviors are:

¹ Brown, T. and Peerapatnapokin, W. (2004) "The Asian Epidemic Model: A Process Model for Exploring HIV Policy and Programme Alternatives in Asia" in *Sex Transm Infect*; 80:i19-24.

- a. unprotected sex in the context of sex work
 - b. unsafe injecting drug use
 - c. unprotected (mainly anal)² sex between men with multiple partners
2. Due to the small per-contact probability of transmission via vaginal sex and the relatively low density of (hetero-) sexual networks, HIV epidemics in Asia are highly unlikely to sustain themselves in the 'general population' independently of commercial sex, drug injecting and sex between men. This means that dramatically expanded and improved prevention efforts focusing on people engaging in these three behaviors will be needed to bring the epidemic under control.
 3. A mixture of a lack of knowledge, moral judgments and fear causes HIV-related stigma and discrimination, which undermine Asia's responses to the epidemic and prevent people from accessing and using a range of services that they need to protect or sustain their current health – including voluntary counseling and testing services (VCT), antiretroviral treatment (ART) and diagnosis and treatment of sexually transmitted infections (STIs).

In terms of responses to the epidemic, the Commission concludes that the response has 'lagged behind or faltered for long periods.'³ In particular:

1. Coverage of interventions focusing on reducing HIV transmission among people engaging in injecting drug use, sex work and male-to-male sex is far too low to contain the epidemic, let alone turn it around. Only 34% of people engaged in sex work, 2% of people who inject drugs and 5% of men who have sex with men were reached with prevention services as of 2005. These levels need to reach 60-80% in order to halt and start to reverse the HIV epidemic.
2. The Commission reports that many resources for prevention are allocated to people at little or no risk of HIV infection; for example, through workplace and education sector interventions. In particular, 90% of HIV prevention funds under the UNAIDS Unified Budget and Workplan scheme are expended on HIV prevention among low-risk youth where less than 5% of HIV infections occur. Adolescents who engage in one or more of the three risk behaviors mentioned above cause up to 95% of all HIV infections in their age group, but they receive less than 10% of these HIV prevention resources.⁴

Similarly, it was calculated that it costs US\$ 2,722 to save one disability-adjusted life year (DALY) by spending funds on HIV prevention among 'mainstream youth', versus US\$3 for a DALY saved in interventions focusing on reducing HIV transmission in the context of sex work, US\$39 for injecting drug use and US\$74 for men who have sex with men.⁵

2 The extent to which anal sex occurs within heterosexual relationships or sexual encounters is unknown in most countries in the region, and should remain high on the research agenda for behavioral researchers. Anal sex may play a much bigger role in the epidemiology of HIV than is currently realized, considering that anal sex is up to ten times more efficient in transmitting HIV than vaginal sex, and anal STIs have a smaller chance of being treated and cured than vaginal and penile STIs (due to unrecognized or untreated symptoms, reluctance by patients to report, and hesitancy by medical staff to ask about anal symptoms).

3 UNAIDS. (2008) *Redefining AIDS in Asia: Crafting an Effective Response. Report of the Commission on AIDS in Asia*. New Delhi: Oxford University Press, p. 121.

4 *Ibid.*, p. 145.

5 *Ibid.*, p. 90.



3. The Commission notes that coordination, collaboration and leadership are lagging behind, with some notable exceptions. In particular, attempts to involve non-health sectors – especially education and social welfare – have generally been unsuccessful.

The Report of the Commission on AIDS in Asia – especially in its evidence of costs per DALY averted – makes clear that from an epidemiological perspective, considerably fewer funds should be specifically earmarked for HIV prevention aimed at the general population. This particularly includes nearly all children and adolescents in schools. Instead, the report calls for targeting interventions towards reducing HIV transmission in settings where most infections occur: i.e., via unsafe injecting drug use, unsafe sex in the context of sex work and unprotected male-to-male sex.

Implications for the Education Sector

While UNESCO sees mobilizing education sector responses as a cost-effective way of increasing knowledge and changing attitudes related to HIV and AIDS, current school-based interventions generally do not focus explicitly on the three risk behaviors that put Asian adolescents most at risk of HIV.⁶ Instead, they are more likely to focus on heterosexual transmission (linked to prevention of pregnancy), on adolescent reproductive health, and on becoming a (responsible) parent in the future. These are important educational objectives too; however, from the perspective of HIV prevention, it is important to put the three risk behaviors firmly on the agenda because they cause 95% of all HIV transmission among adolescents. If education responses miss out on the chance to prevent infections among those adolescents who currently or soon will engage in high risk behaviors, their impact in terms of preventing new HIV infections will likely be small. This is why the AIDS Commission classifies school-based responses to HIV as ‘low cost, low impact’ – their impact on the overall epidemic is likely to be limited due to the small number of infections that occur and can be prevented among low-risk youth.

UNESCO believes that if schools were able to meet the educational needs of adolescents who engage in risky behaviors well before they start engaging in them, the impact of school-based HIV prevention programmes on the course of Asian AIDS epidemics would be dramatically increased. This can be promoted by three distinct (and complementary) strategies:

1. **Improving the quality and scope of current approaches and curricula towards sex, relationships and HIV education to include the phenomena of sexual diversity, male-to-male sex, drug abuse and sex work.** UNESCO believes that, where possible, school-based education about sex, relationships and HIV education should be made more relevant to the HIV epidemic and to specific risks for young people by including information about substance/drug abuse, male-to-male sex (and anal sex, in general), and the phenomenon of sex work. Ideally this would mean the inclusion of these behaviors and contexts of HIV transmission as part of the core curriculum, in an open-minded and non-judgmental manner (e.g. in comprehensive school health programmes or education programmes focusing on sex, relationships and HIV).
2. **Reducing stigma and discrimination of people who engage in these risk behaviors (as well as people living with HIV)** as a means of improving their self-esteem and enhancing their ability to negotiate safer behaviors and access to services. Reducing stigma and discrimination would also enable at least some

6 UNESCO. (2008) *EDUCAIDS Resource Pack*. Paris: UNESCO.



adolescents who engage in risk behaviors to continue in or return to school. An inclusive school environment, tolerant of diversity and fostering a caring attitude, promoting confidentiality and respect for the situation of the adolescent/child involved is an essential first step in achieving this. A fact that may not be sufficiently acknowledged by the AIDS Commission is that schools can play an important role in reducing stigma and discrimination in the community, both by influencing attitudes of students and by helping teachers to provide a role model to the wider community of which the school is part.⁷ If the cost of reducing stigma and discrimination were calculated as part of the projection and costing exercise conducted in the AIDS Commission report, the mobilization of the education sector might well come out as a 'low cost, high impact' response.

3. Where the first option may not be considered currently viable, **extra-curricular activities or linkages to services outside the school setting should be promoted**, and there is a need for schools to play a proactive role in this process. This could be the formation of partnerships between schools and civil society organizations working with people who engage in high-risk behaviors and helping to ensure access to youth-friendly services tailored to their specific needs. Examples could include inviting young MSM or (former) drug users to schools for a group discussion, posting notices for students who are involved in risk behaviors about the availability of anonymous confidential counseling and testing services, or arranging referrals to harm reduction interventions. Active 'case finding' by school authorities is pivotal if this strategy is to succeed.

Related to the third point, a recent review paper suggests that most interventions currently working to provide services to people who engage in risk behaviors implicitly assume that their target audience is adult, whereas in reality significant numbers of people engaging in these behaviors are younger than 18 years old.⁸ Part of the reason for this might be that HIV prevention interventions act from a public health service, not a social welfare/'child rights' paradigm. Often when encountering 'underage' clients, service providers face a dilemma – withholding the service from the client is unethical from the individual's perspective, but providing the service might be seen as condoning the behavior in question for the child. There is, therefore, a need to improve such interventions by making them friendlier and more accessible to children and adolescents, taking both a child-rights and a public health/service provision perspective. Efforts should start with making civil society and health sector programmes for people who engage in high risk behaviors for HIV more prepared to deal with adolescent 'clients'. In some Asian countries, UNICEF and UNFPA have already started working towards this goal.

Schools could play a pivotal role in this process – both by identifying children who may be vulnerable and at acute risk of HIV infection, and by helping to support children who have dropped out of school and are involved in risk behaviors (especially sex work and injecting drug use). In achieving improved access to services for children and adolescents who engage in risky behaviors, public health experts and programme implementers, school staff, child rights/child welfare workers, law enforcement agency officials and representatives of people who engage in the above-mentioned risk behaviors must work closely together.

7 Devine, S. (2002) *A Multi-Sectoral Approach to Planning Services for AIDS Orphans, Sanpatong District, Chiang Mai [Thailand]*, Bangkok: UNICEF.

8 UNICEF/UNFPA/UNESCO. (2007) "Responding to the HIV Prevention Needs of Adolescents and Young People in Asia: Towards (Cost-) Effective Policies and Programmes," paper prepared for discussion within the AIDS Commission in Asia, 9 May 2007.



Conclusions

1. HIV prevention efforts in school should deal with the behaviors that cause 95% of all HIV infections among adolescents. On-going HIV and AIDS prevention and adolescent sexual and reproductive health education programmes in Asia-Pacific schools must incorporate the issues of injecting drug use, male-to-male sex and sex work as part of the core curriculum in order to increase the epidemiological and public health impact of these programmes.
2. Where, for political, religious or other reasons, discussion of these behaviors in the school setting is deemed inappropriate or otherwise currently not possible, schools should design and implement extracurricular responses for adolescents who engage in risk behaviors, or seek linkages to adolescent-friendly services outside of schools.
3. Strong collaboration and coordination among UNESCO, UNDP, WHO, UNICEF, UNFPA, and UNODC is needed to agree on and strengthen a common approach towards meeting the needs of adolescents who are most at risk of HIV, and to strengthen school-based approaches for reducing stigma and discrimination of people who engage in risk behaviors.
4. Schools can also play an important role in reducing stigma and discrimination of people who engage in risk behaviors as well as of people living with HIV and AIDS. This will help school-based adolescents who engage in risk behaviors stay in school and gain access to essential prevention and care services. It can also help the rehabilitation of adolescents who may have dropped out of school and want to return to pursue their education.



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