UNAIDS INTER-AGENCY TASK TEAM (IATT) ON EDUCATION

GUIDANCE ON HIV IN EDUCATION IN EMERGENCIES

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Global Education Cluster

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Cover photograph: Young girls and boys sing about AIDS prevention during a school AIDS club meeting at in the city of Blantyre, Malawi. © UNICEF/NYHQ2009-1912/Giacomo Pirozzi

Contents

Introduction

This *Guidance on HIV in Education in Emergencies* provides information for education practitioners who provide, manage or support education services in emergencies. It provides guidance for mainstreaming HIV and sexual and reproductive health issues into formal and non-formal education responses for adolescents 10-19 years old.

Adolescents make up a large proportion of the population in many countries, but often humanitarian interventions fail to adequately address their particular needs. Adolescence is a period of individual development when important physical, cognitive, emotional and social changes are occurring. It is a period often characterized by increasing sense of identity, autonomy, and progressive independence from adults. While the guidance focuses on more formal education interventions aimed at adolescents, much of the content can be adapted for non-formal interventions and for use with other age groups.

All children have the right to information, education and protection:[1,2]

- the right to access adequate information about HIV prevention and care, through formal channels such as school or child-targeted media, as well as informal channels, such as through their families or peers.

- the right to relevant, appropriate and timely education that recognizes their different levels of understanding; is tailored and appropriate to age, level and capacity; and enables them to deal positively and responsibly with their sexuality, and protect them from HIV infection.

- the right to protection against all forms of physical and mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation (including sexual abuse).

Emergencies often create new threats and vulnerabilities, as families are displaced or faced with disasters or conflict in their communities. Emergencies can also worsen existing vulnerabilities, with particular groups, including people living with HIV, in orphan-headed households, or people with disabilities, disproportionately affected and increasingly isolated or discriminated against during and after an emergency. In such settings, education can provide protection through a safe and stable learning environment. It can also restore a sense of routine, dignity and hope by offering structured, relevant and supportive activities.

During emergencies, adolescents can be more stressed. They may be more likely to face dangers or engage in behaviour that puts them at increased risk of HIV infection as the social structures that normally influence behavior are broken and power disparities between men and women may increase which can lead to adolescents to engage in consensual or coerced sexual activity at earlier ages. And, although more research is needed on this issue, livelihood insecurity may lead adolescents to engage in sex work in order to meet their survival needs. HIV-related risk factors include threats that are present in the environment, for example, high HIV prevalence or a culture of gender-based violence and individual vulnerabilities, such as powerlessness, or being part of a discriminated group.

Access to quality education opportunities in a safe and supportive environment can help address these risks and reduce the number of new HIV infections and mitigate the impact of HIV and AIDS for those infected with and affected by the virus.

1 UN Convention on the Rights of the Child, 1989.
2 UN Committee on the Rights of the Child, General Comment no. 3, 2003, articles 24, 13 and 17.

Contents of this Guidance: A combination approach to HIV and education in emergencies

Multiple approaches are needed to respond to the HIV epidemic. 'Combination prevention' involves a mix of behavioural strategies to reduce HIV transmission, combined with legislative measures for ensuring policies free of discrimination, structural, or contextual measures that impede or facilitate HIV transmission, such as social vulnerabilities (e.g. poverty, gender-based violence, xenophobia and homophobia), and biomedical measures including access to treatment, care and support. Such combined measures help to reduce immediate risk, change underlying social dynamics that make people vulnerable to HIV, and better respond to the needs of people living with HIV.

The education sector has a role to play in all these preventive measures, and this guidance provides information on all four areas. For schools and learning spaces, this means that life skills based HIV education (behavioural measures) is undertaken within a protective and enabling learning environment which has access to services (legislative/structural measures).

Behavioural measures

Parts 1 and 2 of this guide focus on the behavioural measures of combination prevention. Education in emergencies is about more than just providing teaching and learning of literacy and numeracy. It is a way to empower adolescents through cognitive, emotional and social learning, to help them *make informed decisions and act on them*. The guidance on this section can be used to inform curriculum revision or enrichment.

Part 1 **Life skills learning:** focuses on how to develop relevant learning outcomes to help reduce the number of new HIV infections and mitigate the impact of HIV and AIDS for those infected with and affected by the virus.

Part 2 **Life skills teaching:** focuses on ensuring that teacher training covers interactive methodologies, relevant content and adequate psychosocial support to achieve the intended learning.

Legislative, structural and biomedical measures

Life skills based HIV education works best where schools and learning spaces are safe; where steps have been taken to eliminate gender inequality and discrimination, GBV and HIV-related stigma and discrimination; and where learners and staff have access to available services. Parts 3 and 4 of the guide therefore deal with the legislative, structural and biomedical measures of combination prevention that are needed to support the behavioural measures (learning and teaching).

Part 3 **Protective and enabling learning environments:** focuses on school policy to ensure the wellbeing of learners and staff, and on considerations with regard to gender based violence.

Part 4: **Information on – and access and referrals to – HIV-related services:** focuses on services available regarding HIV and sexual and reproductive health. It also includes information on referrals to the available HIV-related services for staff and learners, in particular for those infected with or affected by HIV and/or with high-risk behaviours.

Complementary Tools and Standards

This document is in line with the IASC *(*Inter-Agency Standing Committee) *Guidelines for Addressing HIV in Humanitarian Settings* (2009), which includes an education action sheet stating that an education sector response should:

- focus on knowledge, attitudes and skills learning and teaching
- ensure protective and enabling learning environments
- provide links to essential health, psychosocial and social services.

Table 1: IASC action framework for education responses in humanitarian settings

Preparedness	• Ensure HIV is included in all formal and non-formal education methods. • Train teachers and auxiliary staff on HIV, sexual violence and exploitation, and life skills. • Ensure sufficient stocks of key HIV and life skills educational materials and curricula. • Establish systems to monitor, supervise and respond to violence and abuse, and HIV-related stigma and discrimination. • Facilitate access to education for children affected and infected by HIV.
Minimum initial response	• Promote access to relevant and protective education for all children and young people. • Ensure that young people, including those affected by HIV, participate in the planning, implementation and evaluation of education programmes. • Provide all children and young people with free access to formal and non-formal education. • Provide needs- and outcome-based participatory life skills based HIV education. • Provide enabling and protective learning environments for all children and young people. • Facilitate access to essential HIV health services for learners and staff.
Expanded response	• Refer affected children and young people to specialist services.

This guidance is also based on good practice and standards outlined in the *INEE Minimum Standards for Education: Preparedness, Response, Recovery.*[3] The INEE Minimum Standards cover four domains of educational preparedness, response, and recovery: Community Participation, Analysis, Coordination, Access and Learning Environment, Teaching and Learning, Teachers and Other Education Personnel and Education Policy.

All of these domains of education are important and should be considered when planning HIV mainstreaming, however this particular guidance focuses in detail on two areas of emergency education response:

- Teaching and Learning
- Access and Learning Environment

For the full map outlining all the INEE Minimum Standards, please see the inside back cover of this volume.

[3] The INEE *Minimum Standards for Education: Preparedness, Response, Recovery* (2010) provide good practices and guidance to governments and humanitarian workers for coordinated action to enhance the quality of education preparedness and response; increase access to safe and relevant learning opportunities and ensure accountability in providing these services. They are used in over 80 countries to improve programme and policy planning, assessment, design, implementation, monitoring and evaluation as well as advocacy and preparedness, in order to reach the Education for All goals. The INEE Minimum Standards Handbook is available online at: www.ineesite.org/standards

Box 1: A cluster approach in humanitarian settings

An education humanitarian response will often be coordinated through an established Education Cluster. Where it operates, the Education Cluster is a key coordination mechanism for supporting states in determining educational needs in emergency situations and responding to them jointly in a coordinated manner. At the global level, the cluster is co-lead by UNICEF and Save the Children. At a country level, these agencies also often serve as co-leads, although leadership can vary and often includes the active involvement of the national Ministry of Education. Cluster members are agencies with expertise and a mandate for humanitarian response within the education sector. The INEE Minimum Standards are the foundational tool used by the Global Education Cluster and country-based Education Clusters to provide a framework to ensure quality education response.

The cluster approach is part of a wider reform process aimed at improving the effectiveness of humanitarian response by ensuring greater predictability and accountability, while at the same time strengthening partnerships between responding actors. The principle is that response within a given sector is coordinated by one or more designated cluster lead agencies. Education was included in the cluster approach in 2006. Not included in the cluster approach are refugee settings, where UNHCR is the lead coordinating agency.

'HIV' and 'gender' are two important cross-cutting issues in the cluster approach, and education actors should work with those in other sectors/cluster, such as health and protection to holistically address them.

For more information about the work of the IASC Education Cluster see: http://oneresponse.info/GlobalClusters/Education

A note on cultural sensitivity

During a crisis, education practitioners may be tempted to rush in quickly and introduce programmes without thinking about local cultural context. While HIV education is a life-saving intervention and should be considered without delay, it is important to keep in mind the cultural context, especially as the topics can be sensitive in some cultures. Education practitioners should be aware of local beliefs and customs and promote dialogue and participation of the community, parents, and adolescents in the planning, implementation, monitoring and evaluation of any programmes. This will not only improve the quality of the programmes but will also ensure that sensitive issues are addressed in ways that are culturally acceptable in the local context.

Adapted from: UNFPA and Save the Children, Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings, 2010

Part 1: Life skills learning

All learning programmes, at the start, should consider the needs of the intended learners and their existing skills or experiences (*see Topic 1*). It is important to work with other sectors/clusters, in particular health and protection, and with the learners themselves to find out about the current situation.

Remember, life skills based HIV education has two overall goals:

Goal 1: **reduce the number of new HIV infections**

Goal 2: **mitigate the impact of HIV and AIDS** for those infected with and affected by the virus.

Life skills based HIV education aims to help prevent HIV infection and HIV-related discrimination by reducing risk factors and increasing protective factors:

- **Risk factors** are related to *external threats* such as HIV prevalence, a culture of violence, gender inequality and discrimination, sexual violence; as well as *individual vulnerabilities,* such as poverty, powerlessness, disability, being part of a discriminated group.
- **Protective factors** are related to *opportunities*, for example, ensuring that learners have equal access to livelihoods and are able to establish and maintain healthy relationships.

It is therefore crucial to start by deciding on some measurable learning outcomes –related to knowledge, attitudes and skills – which influence these risk and protective factors (*see Topic 2*). Once you have decided on the learning outcomes, you can develop assessment strategies and learning activities for achieving these outcomes (*see Topic 3*).

Participation of children and adolescents

Life skills based HIV education cannot work without the involvement of adolescents. Their participation in the design, implementation and monitoring and evaluation can help to ensure that:

- the complex social setting in which adolescents live are understood
- the needs and perspectives of groups of adolescents with different levels of risk and vulnerability within a community are identified
- local associations working with children and youth are involved

It is important to ensure that the participation of adolescents is as diverse as possible, ensuring equal gender, religious, ethical representation.

Peer education is one way to increase the participation of adolescents in teaching interventions. Peers speak the same language and share the cultural norms and values of their group/community. Effective design, implementation, evaluation and commitment to results is as important in peer education as in any other HIV intervention. Training for peer educators is a long process, so during the immediate response to an emergency, peer educators who were trained before the emergency need to be used.[4]

4 www.fhi.org/NR/rdonlyres/em7o6gq65ntn3p5cdtq2g3pqut5rxhs7afrnu64vmmva36aydt65naap6vaxyezz42bvaeuoohof6a/YI7.pdf

Planning relevant content

☑ **Know the HIV epidemic in your emergency**	☐ **Use results-based planning**	☐ **Match interventions**
Collect information from relevant health, HIV or protection sectors		

If you know about the HIV epidemic in an emergency, you can create a response that is more comprehensive, specific and relevant. You need to learn about the behavioural and social factors that contribute to new infections and discrimination, and then you will be able to target people who are most at risk. First steps include:

- finding out what general type of epidemic are you are facing (*see Table 2*)
- use this information to plan how to reach those most at risk.

Table 2: What type of epidemic are you facing?

Epidemic scenario		Know your epidemic
Low level	• HIV prevalence among general population is less than 1%. • HIV prevalence has not reached significant levels in any sub-population. • Risk is diffuse (low levels of exchange between partners or of non-sterile injecting equipment), or the virus has only recently been introduced.	You need to gather basic information about the most vulnerable and at-risk populations. You need information on risk behaviours, networks and other factors that could indicate the potential for HIV spread (such as rates of other sexually transmitted infections – STIs) to help you plan prevention activities.
Concentrated	• HIV prevalence is 5% or more in one or more sub-populations, such as men having sex with men, injecting drug users or sex workers and their clients. • The virus is not circulating in the general population, where the prevalence remains less than 1%.	The epidemic is fuelled by key risk behaviours. The future direction for this type of epidemic will depend on: • how many people are in the vulnerable sub-population(s) • how well the needs of these affected and most vulnerable populations are being addressed • how often, and in what ways, people from vulnerable sub-population(s) and the general population interact with each other.
Generalized	• HIV prevalence is between 1% and 15% in pregnant women attending antenatal clinics. This indicates that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic.	HIV is present among the general population and no sexually active person is “low risk”. The spread of the epidemic is affected by social norms that lead people to have multiple sexual partners, and/or by norms and policies that prevent people from protecting themselves (e.g. limited access to education and information for girls). These need to be addressed.
Hyper-endemic	• Virus has spread to more than 15% of the adult population and very large numbers of people are living with HIV.	HIV is spreading because many people are having hetero-sexual relationships with more than one person (concurrent relationships), and they are not always using a condom. There are high levels of HIV-related stigma, GBV (including sexual coercion and violence in marriage), gender inequality, etc. All sexually active persons have a higher risk of HIV infection. The drivers and risk factors are complex and diverse, but may include: people having sex for the first time at a young age; high levels of people having concurrent sexual partnerships over the longer term; inter-generational sex; inconsistent condom use; low levels of male circumcision; and the presence of STIs.

You need to work with teams from different sectors to collect and share information and gather a more accurate picture of the local situation. Information can be collected from:

- health, nutrition and protection cluster assessments
- national AIDS control programmes
- other government ministries, such as health and social affairs
- HIV associations and networks
- community-based organizations (CBOs)
- non-governmental organizations (NGOs)
- teachers, youth groups, etc.

At this stage, it is more important to use the available information than to set up complicated new assessments. However, as far as possible, it is still important to disaggregate information by sex and age.

Key questions to ask when planning the content of life skills based HIV education

- **What is the HIV prevalence in the affected area (disaggregated by sex and age)?**
  → Seek information from the country epidemic profile and national AIDS control programme.
- **What are the known modes of HIV transmission?**
  → Seek information from the country epidemic profile and national AIDS control programme.
- **In which age groups are new HIV infections taking place?**
  → Seek information from the health sector, the health cluster and its assessment, and from HIV associations and networks.
- **What are the most common modes of HIV transmission (sexual tansmission, injecting drug use, etc)?**
  → Seek information from the health sector, the health cluster and its assessment, CBOs, NGOs, and from HIV associations and networks.
- **What are, or could be, the changes in modes of HIV transmission (e.g. increased incidence of sexual violence, changing patterns in substance and drug use, etc) due to the emergency?**
  → Seek information from the health sector, the health and protection clusters and their assessments, CBOs, NGOs, HIV associations and networks, and youth groups.
- **Who is particularly vulnerable, and potentially most at risk of HIV infection?** e.g. young girls; unaccompanied children and adolescent girls and boys; children and adolescents involved in high risk behaviour, etc.
  → Seek information from the health sector, the health and protection clusters and their assessments, CBOs, NGOs, HIV associations and networks, and youth groups.
- **What are the protective factors in the environment, and other factors of risk tolerance/resilience?**
  → Seek information from the protection cluster and its assessment, CBOs, NGOs, teachers, and youth groups.
- **What are the underlying reasons among girls and boys, respectively, for risk behaviours?** e.g. gender inequalities, lack of livelihood, lack of hope, etc.
  → Seek information from the protection and health partners and their assessments, CBOs, NGOs, teachers, and youth groups.
- **What are the perceptions of risks, risk behaviours, and social and peer norms around**

sexual activity?

→ Seek information from the health and protection partners and their assessments, CBOs, NGOs, teachers, and youth groups.

- **What information exists on current knowledge, attitudes, behaviour and practices**?

  → Seek information from the health sector, the health and protection clusters and their assessments, CBOs, NGOs, HIV associations and networks, and youth groups.

Once the situation is more stable, it is good to conduct a multi-sectoral, multi-agency assessment. This will provide a better understanding of the situation, as well as map the existing services and identify gaps and needs for new and revised programming.[5]

5 A good multi-sectoral tool to adapt and use is: UNHCR/UNAIDS, *HIV-related Needs in Internally Displaced Persons and Other Conflict-affected Populations: A Rapid Situation Assessment Tool*, United Nations High Commissioner for Refugees / United Nations Joint Programme on HIV/AIDS, Geneva, 2007.

Topic 2

Defining age appropriate learning outcomes

☑ **Know the HIV epidemic in your emergency**	☑ **Use results-based planning**	☐ **Matching interventions**
Collect information from relevant health, HIV or protection sectors	Decide on behavioural goals and develop measurable knowledge, attitude and skill-related learning outcomes and indicators	

After finding out about the main behaviours and risk and protective factors (*Topic 1*), you need to develop measurable knowledge, attitudes and skills learning outcomes for the targeted age group(s). This should ideally be done in collaboration with the main stakeholders, e.g. teachers and youth and community groups.

Table 3: Examples of potential learning outcomes

Goal 1: Reducing numbers of new HIV infections	
Younger adolescents will…	**Older adolescents will…**
…know and understand… (knowledge and critical thinking)	
• comprehensive and correct facts about HIV prevention • what behaviours put them at risk of HIV infection • reasons for abstaining from or delaying sex • negative effects of gender stereotyping and discrimination • future consequences of present actions • the increased risks of alcohol and substance use • the importance of seeking timely support and care after incidence of rape.	• comprehensive and correct facts about HIV prevention • that intergenerational relationships, multiple and concurrent partnerships, and sexual exploitation all increase the risk of HIV infection • how social norms and power dynamics can make it difficult for adolescents to avoid sex or use condoms • the benefits of choosing not to have sex, or using male or female condoms correctly every time if having sex • the availability and importance of accessing HIV care, treatment and support services (including timely post-rape care). • the increased risks of alcohol and substance use
…be someone who… (personal values and attitudes)	
• is aware of their personal vulnerability to HIV • is empowered to refuse, abstain or delay sex.	• believes in him/herself and has hope for the future • rejects norms that may harm him/herself or others • is empowered to refuse, abstain, delay or negotiate safer sex.
…be able to… (skills and behavioural capacity)	
• identify places where people can get treated for HIV, and/or obtain post-rape care • speak more comfortably about condoms • identify local places to obtain condoms if having sex • live positively with HIV or with people living with HIV (PLHIV) • seek help when needed.	• demonstrate refusal skills, delay tactics, condom negotiation, etc • articulate what forms of gender based violence can increase risks, and in what ways • describe barriers to getting and using condoms, and ways to overcome these barriers • explain the benefits of choosing not to have sex, or of using condoms (male or female) if having sex • be able to seek support for alcohol and substance use problems.

Goal 2: Mitigating the impact of HIV and AIDS for those infected with and affected by the virus	
Younger adolescents will…	**Older adolescents will…**
…know and understand… (knowledge and critical thinking)	
• local myths and misinformation about HIV and AIDS • rights and considerations of PLHIV • how separation and child-headed households can affect vulnerabilities and risks.	• the rights and life choices of people living with HIV • the effects of HIV infection, stigma and discrimination on the individual and on the community • the challenges of coping with grief and loss.
…be someone who… (personal values and attitudes)	
• exhibits positive attitudes towards PLHIV • copes constructively with loss, abuse, trauma, grief and anxiety • rejects stigma and discrimination.	• manages anger and rejects violence • sets, maintains and works towards personal and societal goals • exhibits positive attitudes towards people living with HIV.
…be able to... (skills and behavioural capacity)	
• understand and respect others' needs, circumstances and perspectives • act to prevent bullying and harassment • resist inappropriate peer or social pressure • show compassion for people who are sick, have difficulties, or are being discriminated against.	• handle negotiation and conflict management • use networking and organizational and persuasion skills to promote the health, safety and welfare of self and others • establish and maintain healthy and rewarding relationships.

It is important to check that the chosen learning outcomes comprehensively cover gender-related HIV issues. The following checklist can help with this.

Table 4: Checklist to ensure that gender-related HIV issues are covered in learning content

	YES	NO
Does the learning content address the specific needs, perspectives and experiences of girls and boys regarding HIV and AIDS?		
Does the learning content include comprehensive, gender-sensitive and correct information that challenges existing gender stereotypes in the society and those that arise as a result of the emergency?		
Are the specific needs and rights of boys and girls being considered through meaningful participation in planning, developing and implementing interventions?		
Have all stakeholders been involved in developing culturally appropriate and gender-sensitive messages regarding the prevention of GBV (in its various forms) and the transmission of HIV?		
Does the education provided include both male and female perspectives and roles in prevention?		

Topic 3 Matching learning outcomes, assessment and activities

☑ **Know the HIV epidemic in your emergency**	☑ **Use results-based planning**	☑ **Matching interventions**
Collect information from relevant health, HIV or protection sectors	Establish behavioural goals and develop measurable knowledge, attitude and skill-related learning outcomes and indicators	1. Learning outcomes 2. Assessment strategies ⇄ 3. Learning and teaching activities

The learning outcomes that you have developed form the basis for planning the learning and teaching activities and the assessment strategies. Assessment of individual learning motivates and provides useful feedback to teachers and learners.

Table 5: Assessment of individual learning

Area for assessment	Assessment questions	Measurable learning outcomes
Knowledge and critical thinking	*Through*: Closed questions; open-ended questions; analysis of a case study or fictional scenario; timelines; picture sorting; and role plays and simulations. *Example:* UNAIDS recommends that comprehensive and correct knowledge be measured by the correct responses to five prompted questions, three of which are required and two of which are optional and context-specific, as presented below. **UNAIDS required knowledge assessment** questions[6]: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time he or she has sex? 3. Can a healthy-looking person have HIV? **Examples of two context-specific knowledge assessment questions:** 1. Is there medication that can reduce the risk of HIV infection within 3 days of sexual assault? 2. Does the sharing of injecting equipment lead to higher risk of HIV infection?	*Example:* Learners will have comprehensive and correct knowledge about HIV prevention.
Values and attitudes	*Through*: Closed questions; open-ended questions; analysis of a case study or fictional scenario; role plays and simulations. *Example:* Do learners feel empathy and concern for people living with HIV?	*Example:* Learners will demonstrate care and concern towards persons infected with or affected by HIV.
Skills and behavioural intent	*Through*: Closed questions; analysis of a case study or fictional scenario; role plays and simulations; checklists, diaries and journals; and 'intent to behave' statements. *Example:* If learners are pressured to have sex, can and will they assertively negotiate safer behaviour?	*Example:* Learners intend to – and will be able to – negotiate less risky alternatives to intercourse.

[6] Adopted from UNGASS indicator 13.

Once learning outcomes (and assessment strategies for measuring these) have been established, teachers need to be supported to develop appropriate interactive learning and teaching activities to help them reach the learning outcomes. They may need to hold 12 sessions – or sometimes 20 or more sessions – on topics related to HIV, in order to influence behaviour.

Box 3: Developing a lesson plan

1. **Describe the purpose**: Identify the main idea or goal that the lesson will address, and the expected key learning outcomes: knowledge, attitudes and skills.
2. **Decide how to assess these key learning outcomes**: How will learning be monitored? How will the teacher check for understanding (describe, identify, name, state, demonstrate, produce, select, compare, explain, justify, support, interpret)? How will links be made between this lesson and other lessons before or after? How will the main ideas be reinforced or drawn together, and conclusions drawn?
3. **Choose interactive learning and teaching methods** and processes. Effective interventions balance (i) information with (ii) participatory and active methods (interactive activities, class discussion, brainstorming, role play, group work, games and simulations, situation analysis and case studies, debate, storytelling, etc – *see Topic 4*), and (iii) relevant resource materials needed for the teacher and the learners.
4. **Conclusion**: Assess learning outcomes, and revise or summarize learning.

Examples of activities

Activity 1: Drawing up a code of conduct
Once the learners have knowledge about HIV prevention, care and support, ask them to work in small groups. Their task is to draw up a code of conduct (list of rules) on what they need to know, think and do to promote their own and others' wellbeing and safety. Each group reports back and together they make a list for the whole group. Allow learners to make their own rules – they are more likely to follow rules they have made for themselves.

Activity 2: Research project
Ask learners to find out about attitudes to sex and marriage and HIV or AIDS in their own communities. Here are some questions they could ask:

- At what age do girls get married? At what age do boys get married?
- Do men and women believe sex before marriage is wrong or right? Do they have the same views?
- At what age is it socially acceptable for girls and boys to first have sex?
- How many girls have babies outside marriage? How many boys become fathers outside marriage?
- How many men have more than one wife or partner?
- Are sexually transmitted diseases common in their community? (They could visit the local clinics.)
- Are HIV and AIDS a problem in their community?

Some topics could be sensitive, so give learners some ideas about how to approach people without offending them.

Creating the right environment in which to conduct activities

It is very important to ensure that learning takes place in a supportive setting (*see Topic 6*). The following list of actions will help, and can, if needed, be adapted for specific HIV content.

- Make sure that daily routines in the classroom are structured and predictable. Include relaxing and fun 'rituals' (e.g. a song or movement performed to a rhythm, or an interactive game to open and close the class).
- Provide ample opportunities for all adolescents, including those with additional needs, to succeed.
- Use a flexible curriculum that encourages learners' participation (e.g. frequent use of questions; games that focus on finding the right answers; no long 'lectures').
- Introduce subjects that are relevant to the lives of children and adolescents, and involve them in choosing topics that interest them.
- Use learning activities that involve group work to encourage peer interaction, problem-solving, leadership skills and cooperation.
- Include time for expressive art, such as drawing and singing (with children and adolescents working together to create songs).
- Never judge drawings. Ask simple questions about them that give children and adolescents 'permission' to talk about aspects of their lives (dreams, hopes or worries), if they feel like it.
- Hold regular discussions about the emergency and the difficulties that children and adolescents, their families and their community are facing. Emphasize finding ways to cope.
- Use child- and adolescent-friendly discipline.
- Address gender disparities in learning and teaching practices, and in the assessment of learning.

Part 2: Life skills teaching

Individuals use life skills when they reflect on, analyze, choose and act. It is essential to use active and participatory methods when teaching life skills, to help learners understand better how they could use the skills in real life. If we deliver life skills based HIV education using only passive learning approaches, such as reading or listening to a lecture, there is less chance of changing attitudes and behaviour.

Remember, life skills based HIV education has two overall goals:

Goal 1: **reduce the number of new HIV infections**

Goal 2: **mitigate the impact of HIV and AIDS** for those infected with and affected by the virus.

Effective life skills based HIV education involves:

- learning and teaching activities that are appropriate to the learner's age, gender and experience
- multiple teaching and learning activities that are structured in a logical way, so that learning builds up gradually, and learners are given plenty of chance to practice skills
- telling learners about the intended learning outcomes of every activity
- the use of participatory and skills-building methods.

To achieve this, teachers need to:

- adapt the way they interact with learners (*see Topic 4*)
- understand the impact of HIV (*see Topic 5*)
- include structured psychosocial aspects relating to HIV in the teaching and learning processes (*see Topic 6*).

The topics presented in Part 2 need to be considered in any training that teachers and facilitators already receive in emergency situations. Separate training might only be necessary in a situation where there is a hyper-endemic and where HIV and AIDS are considered to be a top priority.

Topic 4 Participatory teaching methods

Active and participatory teaching methods are essential for successful life skills learning, particularly when dealing with sensitive issues such as HIV and AIDS. Participatory approaches can help learners to understand how changes to norms and community structures can affect the risks and vulnerabilities they face.

Training objective 1: **Teachers are trained to use participatory, experience-based methods which increase the chances of children and adolescents using skills to reduce risk and increase protection.**

Training at any emergency response stage needs to ensure that an equal balance of male and female teachers and educators:

- are trained using interactive methodologies

- are ‘facilitators of learning’. They know how to give learners the time, space and tools to practise a range of skills, and are themselves able to apply knowledge and skills to real-life situations
- are able to interpret the curriculum content, create learning assessments, shape the instruction, and develop lesson plans and activities that are relevant in the emergency context
- tell learners about the expected learning outcomes of each lesson, and ensure active participation in all aspects of their learning
- are able to create safe and protective learning environments
- are able to encourage community participation and support to reduce vulnerabilities and risks.

Table 6: Teaching methods and their benefits

Interactive teaching methodology	Benefits
Class discussion	• learners can learn from each other through solving problems • they personalize and deepen their understanding of the topic • learners develop listening, assertiveness and empathy skills.
Brainstorming	• learners generate ideas quickly and spontaneously • they use their imaginations and practise a different way of responding • offers a good way to get discussions started.
Role play	• provides an excellent way to practise skills • increases empathy for others and their points of view • increases insight into one’s own feelings.
Small group work	• is useful when classes are large and time is limited • maximizes student input • learners get to know each other better, with an increased likelihood that they will consider how another person thinks • learners hear and learn from their peers.
Games and simulations	• promote fun and active learning • learners test out assumptions and abilities in a safe environment.
Situation analysis	• learners explore problems and safely test solutions • they learn that different people can see things differently.
Case studies	• stimulate thought and discussion • can be tied to specific activities to help learners practise positive responses.
Debates	• provide opportunities to address a particular issue in-depth and creatively • allow learners to defend a position that may mean a lot to them • offer a chance to practise more advanced thinking skills.
Storytelling	• learners can think about local problems • they can engage their creative skills by writing and/or telling stories.
Awareness raising	• posters, written and designed by children and adolescents, can be used in schools • songs/poetry can deliver information on HIV and AIDS.

Topic 5 Addressing sensitive issues

As we saw in Part 1, the content of life skills based HIV education is linked to the current context and to learners’ lives. These conditions change and evolve, often rapidly in an emergency situation. Teachers and educators therefore need help to access relevant and new information and materials, and to continue their education and professional development.

Training objective 2: **Teachers are trained in: specific knowledge about HIV and increased risks and vulnerabilities linked to the emergency situation; clarification of their own attitudes regarding HIV; and building their skills for accessing new information and services.**

Teachers need to be trained about HIV to ensure that they:

- understand and have comprehensive and correct knowledge about HIV prevention and protection
- understand how the emergency situation affects the mental, physical, social and emotional development of children and adolescents, and the impact this has on HIV vulnerabilities and risks
- can discuss sensitive issues with people living with HIV, CBOs, NGOs and other teachers. This will raise their self-confidence when talking about these issues with their learners.
- are aware of their own rights, particularly regarding HIV status, and equally respect the rights of all their learners
- are able to deal with their own HIV status
- know about HIV-related services and their current availability (*see Topic 9*)
- understand risks related to GBV and know about post-rape care services and their availability (*see Topic 9*).

Examples of sensitive issues that might need to be discussed during teacher training

Issues related to preventing HIV exposure:

- sexual debut
- number of sexual partners
- concurrent sexual partnerships
- condoms
- intergenerational sex
- sexual exploitation
- alcohol and substance use
- injecting drugs and harm reduction
- rape and post-rape care, including post-exposure prophylaxis
- SRH, including STI prevention and treatment, preventing mother-to-child transmission of HIV, counselling and testing, and HIV and breastfeeding
- young men who have sex with men.

Issues related to mitigating the impact of HIV:

- dealing with emotional trauma
- dealing with coercion
- living with HIV infection (oneself, family or friends)
- coping positively with separation, orphanhood and bereavement
- involving (young) people living with HIV
- stigma and discrimination
- child-headed households and poverty
- socio-economic vulnerabilities
- GBV
- disclosing one's status without fear of prejudice.

Topic 6

Training issues for supporting the protection and psychosocial well-being of learners and teachers

Background

The provision of psychosocial support contributes to coping and learning. The strategies and content used in this support will vary depending on a learners' sex, culture and experience during the crisis, and on the current protection and psychosocial threats facing all learners. Adolescents' knowledge and understanding and emotional and social wellbeing can be supported if teachers receive appropriate training, and if the children are encouraged to engage with their peers and younger children.

Mental health and psychosocial problems can cause and be caused by sexual and reproductive health problems among adolescents. Mental health and psychosocial issues can affect a person's ability to make decisions and increase their high-risk behaviors, such as unprotected sexual intercourse. This, in turn, leads to the risk (and the associated distress) of unwanted pregnancies and to acquiring or transmitting HIV and other STIs.

People living with HIV, their partners and their families may suffer from mental health and psychosocial problems due to fear, stigma and other stress factors. HIV and AIDS can also biologically induce mental health problems such as depression, psychosis and dementia. Mental health and psychosocial problems can also lead to people not maintaining their treatment plans.

What do we mean by psychosocial support?
The "psychological" component refers to our thoughts, emotions, attitudes and behaviour, and the "social" component to our relationships, traditions, spirituality and culture. The term psychosocial therefore emphasizes the close and dynamic interaction and relationship between these two areas and how they influence each other. Psychosocial support can be a range of local or external support that promotes psychosocial well-being and prevent or treat mental disorder.

Teacher's role

There are two different ways in which teachers can provide psychosocial support and build resilience in all learners thereby reducing high-risk behaviours.

1. **Day-to-day psychosocial support in the classroom.** Teachers use the normal curriculum to deliver learner-centred, emotionally supportive classes. These help children maintain their wellbeing and develop resilience. Teachers can:
   - include in their teaching activities some key skills for dealing with stressful experiences, e.g:
     - cognitive life skills (such as reasoning, critical and creative thinking, and perception of vulnerability and risk)
     - emotional life skills (such as self-esteem, self-confidence, self-control, informed decision-making, and looking to the future not the past)
     - social life skills (such as communication skills, a sense of structure, and meaning in community life)

- build self-esteem and self-worth by helping children to achieve success in specific tasks, skills or sports.

2. **Specific psychosocial interventions and activities.** These can benefit learners of all ages and increase their ability to survive, cope and thrive following an emergency. Teachers can try to:
   - strengthen the learners' sense of belonging with his or her peers and community
   - work with parents, other family members and the community to help reduce vulnerabilities
   - be aware of unaccompanied/separated children and alert appropriate sectors
   - be aware of learners who are behaving violently or aggressively, abusing alcohol or using drugs, and provide additional support and care
   - refer learners to existing psychosocial services.

All education staff should be trained to recognize signs of distress – in themselves, their learners and co-workers – and know how to act: listening, providing support or referring to existing psychosocial, mental health or social services when appropriate *(see Training objective 3 below)*. To create a supportive environment for learners, teachers need to be:

- empathic
- non-judgmental and accepting
- calm and able to handle conflict peacefully
- able to express caring: listen actively and show interest, giving learners full attention when they speak
- patience: understanding that psychological and social difficulty or distress can make concentration and studying difficult for some children
- encouraging, recognising and praising learners
- open communicators helping learners feel free to talk about their ideas, hopes and worries.

Training objective 3: **Teachers are trained to identify learners with additional needs, provide basic psychosocial support, and refer them to specialized services.**

Teachers need to be trained to:

- cope effectively with their own stress, fears, loss, grief, stigma and discrimination, so that they can deal with similar needs in their learners
- understand the effects of difficult experiences and situations on the psychosocial wellbeing and resilience of learners
- deal with learners' additional issues (e.g. anger, fear, and grief), and understand the links with problem behaviour, and the potential impacts on vulnerabilities and risks
- understand and support each other – including learners – regarding stress, fears, grief, stigma and discrimination

- know where get psychosocial support for themselves, and how to use referral mechanisms to support learners with additional needs.

Remember: Teachers should not try to counsel, or conduct therapy themselves as part of their psychosocial support response – support from dedicated psychosocial support services should be sought.

Box 4: Suggested strategies for providing psychosocial support to learners

- Begin education activities as soon as possible to reduce the psychosocial impact of the emergency.
- Establish programmes that focus on longer-term concepts of justice, peace, freedom and democracy.
- Support good teaching and learning practices that build cognitive, emotional and social skills.
- Incorporate psychosocial impact of the emergency situation into teacher training on skills-building and content matter *(see Topics 3 and 4).*
- Train teachers to monitor learners and identify those who may be experiencing special difficulties in school.
- Provide peer-to-peer psychosocial support activities to help learners deal with the effects of the emergency and cope positively with any additional stress.
- Support the physical and psychosocial needs of educators and learners.
- In longer-term emergencies, support parents, families and communities with activities to address stress.
- Provide necessary service referrals and support to teachers so that they can support distressed learners.
- Work with health and protection actors to put a referral system in place for mental health and other services where available *(see Topic 10).*

Part 3: Protective and enabling learning environments

During emergencies, children and adolescents can be more stressed. They may be more likely to face dangers or engage in behaviour that puts them at increased risk of HIV infection. Appropriate policies (*see Topic 7*) at the school or learning-space level can ensure a safe and supportive environment – both physical and psychosocial – that helps you to achieve your two overarching goals.

Remember, life skills based HIV education has two overall goals:

Goal 1:	**reduce the number of new HIV infections**
Goal 2:	**mitigate the impact of HIV and AIDS** for those infected with and affected by the virus.

In non-emergency settings, HIV risk increases among people with a history of GBV, and there are higher rates of GBV in its various forms among those who are HIV-positive.[7] In emergency situations, if HIV is prevalent, sexual violence may lead to HIV infection, so integrating issues around GBV into education is important (*see Topic 8*).

Topic 7 Policies for schools and learning spaces to ensure the wellbeing of learners

In emergency settings, teachers and support staff are not always well trained. They may lack understanding of child rights, positive discipline and participatory methods. Schools and learning spaces therefore need a code of conduct for teachers and other education staff. This code needs to address confidentiality, sexual harassment, abuse and exploitation, and stigma and discrimination. No violation of the rules should be tolerated.

Codes of conduct should exist before the emergency, but should be highlighted again during the crisis to ensure that all new staff and educators are informed.

Violations of the code of conduct should be documented in a formal monitoring system, and rules for addressing violations should be written and enforced.

7 Andersson and Cockcroft, *Gender-based violence, young women and girls, and HIV in southern Africa*, Policy and Programme Action Brief, UNAIDS Technical Meeting on Young Women in HIV Hyper-endemic countries of Southern Africa, UNAIDS/RHRU, Johannesburg, 2008. See: www.unaidsrstesa.org/userfiles/file/womengirls_GBV.pdf

Table 7: Steps for planning and implementing a code of conduct

Involve as many key stakeholders as possible in the development of the code, particularly learners, teachers and other education staff.	
Make sure the code of conduct rejects all forms of stigma and discrimination in the learning environment, and ensures equal access to and participation in education for:	• **all learners regardless of sex** • **pregnant learners** • **young mothers** • **children of sex workers** • **targets of sexual violence and other forms of GBV** • **learners who are sexually exploited** • **learners affected by HIV** • **HIV-positive learners** • **separated children and unaccompanied minors** • **learners in child-headed households** • **learners with disabilities**
Set up and implement a system in schools and learning spaces to prevent exploitation and violence.	
Develop a confidential reporting system for allegations of sexual exploitation and abuse.	
Implement a confidential monitoring system for allegations of sexual exploitation and abuse.	
Maintain a confidential process for investigating allegations of violations of the code.	
Ensure the existence of penalties for violations.	
Provide all teachers and other education staff, learners, and the community with access to the code of conduct, and inform them of:	• **the systems for preventing, monitoring and reporting violations of the code** • **the process for investigating allegations of violations, and the system for redress.**

Topic 8 Considerations regarding gender-based violence

Gender-based violence occurs in many forms and can get worse during an emergency. In the early stages of an emergency – when communities are first disrupted, populations are moving, and systems for protection are not fully in place – most reported GBV incidents involve sexual violence. During ongoing armed conflict and displacement, sexual violence – including exploitation, abuse and rape – is a well-known and high-risk problem. It is often used as a weapon of war.

> "Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females."
>
> http://www.humanitarianinfo.org/IASC/documents/subsidi/tf_gender/GBV/GBV%20Guidelines%20Definitions.pdf

Later, as things stabilize and rehabilitation and recovery starts, other forms of GBV occur and/or are reported more frequently. These include, among others, harmful practices (female genital mutilation/cutting, forced early marriage, honour killings, etc) and domestic violence.

Education can promote gender equitable relationships and reduce GBV, both within the educational setting and beyond. This in turn can lead to: improved educational outcomes (enrollment, retention, and completion); improved sexual, physical and emotional health; and reduced vulnerability to HIV and other SRH issues.

Stigma and discrimination can affect a learner's ability to attend school. The education sector needs to make sure that young mothers, those affected by GBV, children of sex workers, and

pregnant girls have access to education.

Box 5: HIV-related GBV interventions to consider

- Contact the GBV working group that should be established as part of the emergency response. Nominate someone from the education sector to participate. They can help ensure education-sector involvement in the multi-sectoral assessment and response, and in the sexual violence situational analysis. These lead to an understanding of who in the community is potentially at greater risk of the various forms of GBV *(see also Topic 1)*.
- Ensure that you understand the nature, extent and context of GBV, particularly when and where it is most likely to occur in the community. If it is in the school or learning space, you must work with other sectors to combat violence and ensure protection.
- Understand how boys as well as girls can become involved in the prevention of sexual violence *(see Topic 2)*.
- Understand the stigma and discrimination experienced by HIV-infected and affected learners and staff, and those who are targets of GBV. Address this:
  - within school and the teacher training curriculum *(see Topics 2 and 5)*
  - within the protective and enabling learning environment.
- Understand why it is important that teachers and other education staff are:
  - informed about issues related to GBV in the community, prevention strategies and potential after-effects for learners, and how to access services in the community (*see Topic 6*)
  - aware that both boys and girls can be targets of sexual violence and that all should be provided with referrals to relevant and accessible psychosocial support and health services (including post-rape care) *(see Topic 10)*.
- Ensure that teachers and other education staff know about the link between risky behaviours, GBV and HIV, and about the need for them to behave responsibly and accountably *(see Topics 5 and 6)*.
- Use participatory methods to involve children, adolescents and the community in gathering information which can be used to develop solutions that reduce the risk of GBV and to determine the needs of the targets of sexual violence.
- Provide a forum for teachers to share their experiences *(see Topic 6)*.

Case Study – Emergency response in Mozambique: A multi-sector effort

Mozambique experiences natural disasters such as drought, cyclones or floods on a regular basis, and also has one of the highest HIV prevalence levels in the world. More than half of the country's youth are out of school and young people aged 15-24 account for half of new HIV infections. In the 2008 flooding of the Zambezi valley, UNAIDS and UNFPA worked together to mainstream HIV and gender into both preparedness and response activities being coordinated by the cluster system in Mozambique.

As part of the Education Sector response, UNFPA worked with a local programme Geração Biz, a collaborative initiative between Mozambique's Ministry of Youth and Sports, Ministry of Health and Ministry of Education which focuses on ensuring young people have access to reproductive health and HIV-related services. Geração Biz carried out HIV awareness-raising in resettlement centres, working with activists to carry out HIV education and condom promotion. Concern had included HIV and gender in its emergency preparedness plan and had mainstreamed HIV into its education programme by training peer educators, school committees and teachers on HIV and gender. HIV prevention was also integrated into other activities, for example Save the Children included HIV prevention and life skills education to children in its Child Friendly Spaces.

Working with existing local partnerships to develop responses to HIV in emergencies meant the response was quicker, utilized local knowledge, and in some cases helped to build emergency response and reconstruction activities into ongoing programme work. A key lesson learned from this response in Mozambique is the importance of including HIV in emergency preparedness and contingency planning processes and documents. This was facilitated through a system whereby focal points for HIV and AIDS participated in all of the humanitarian clusters, ensuring more effective mainstreaming for this critical cross-cutting area.

Case Study adapted from *Evaluation of the Integration of the Cross-cutting issues of HIV and Gender in the 2008 Floods in Mozambique* (October 2008) by UNFPA and UNAIDS.

Part 4: Access to HIV-related services

The education sector should facilitate access to essential HIV, health and social services for learners and staff during emergencies. Multi-sectoral collaboration is essential, and the education sector should ensure that it is represented in HIV coordination meetings.

Remember, life skills based HIV education has two overall goals:

Goal 1: **reduce the number of new HIV infections**

Goal 2: **mitigate the impact of HIV and AIDS** for those infected with and affected by the virus.

The education sector will need to work with the health and protection sector to understand:

- *what* HIV-related services are offered, including treatment for other STIs and SRH issues
- *where* the services are offered in their specific context
- *how* to provide referrals to the services offered.

The education sector will need to work with local communities and health and protection personnel to ensure that learners and education staff – infected with and affected by HIV and AIDS – have access to essential health and nutritional services and psychosocial support. This also means identifying adolescents at increased risk of contracting HIV (e.g. those involved in alcohol and substance use, sexual exploitation and same-sex relationships), and referring them to appropriate services.

In generalized and hyper-endemic situations

The education sector needs to facilitate access for learners and staff to specialized services:

- HIV and sexual and reproductive health services (including access to condoms and sexually transmitted infection diagnosis and treatment)
- antenatal, delivery and postnatal care for pregnant girls including services for the prevention of mother-to-child transmission
- post-rape care (including prevention of HIV, sexually transmitted infections and pregnancies), and psychosocial support for boys and girls who have been sexually abused
- mobilized community members who can provide assistance with domestic and school work.

In all scenarios

The education sector needs to:

- facilitate access to essential HIV, health and social services for learners and staff
- work with local communities, health and protection personnel to ensure learners and staff affected by HIV and AIDS have access to basic psychosocial support and essential health and nutrition services.

Topic 9

What health and support services for HIV are offered, and where?

During an emergency, health and communication systems that provide essential HIV-related services are often disrupted. The extent to which HIV and sexual and reproductive health services are available will vary depending on the local context.

Anyone (including learners, teachers and other education personnel) who was previously on treatment needs help to get back on their medication as soon as possible. In emergencies, the education sector can and should help facilitate this access. It should also provide information to the community on what services are available and where.

The education practitioners, therefore, need to know which services are offered, to whom, and where (clinic-based, community-based and school-based). This requires communication and coordination with the health and protection sectors.

HIV testing

Aadolescents' best interests must be protected and they must not be forced to have HIV tests. The Committee on the Rights of the Child has explicitly stated that States must not impose mandatory HIV testing of children and adolescents under any circumstances, and must ensure protection against this.

In an emergency, counselling and testing services will not always be available. Where they are available, such services should consider the capacity adolescents, and their right to be involved in all decisions affecting them.

Table 8: HIV and sexual and reproductive health services that should be available in humanitarian situations

Service	Description	Available?	Where?
Voluntary counselling and testing (VCT)	VCT is provided in non-emergency settings for community members to find out their HIV status. Counselling is provided to the individual before and after testing, when results are provided. HIV counselling should be adapted to the age and maturity of the child.		
Antiretroviral therapy (ART)	Antiretrovirals (ARV) are medications that reduce the HIV viral load in a person's body, making the person healthier (but it does not cure HIV). In some countries, ART is provided to patients who are HIV-positive and who have a CD4 count (number of cells in the body which help to fight infection which are attacked by the HIV virus) below a specific level (number varies by country).		
Prevention of mother-to-child transmission (PMTCT)	A mother can take a short course of ART (if not already on it because of her advanced HIV) during her third trimester to prevent transmission to the child. The newborn is given a short course of ARV to prevent transmission. Pregnant HIV-positive mothers who were on PMTCT prior to the emergency should continue to receive their treatment. If a teacher has a student who gets pregnant, it is important to refer them to adequate maternal and child health services, including PMTCT where it is available.		
Post-rape care (including post-exposure prophylaxis - PEP)	Post-rape care should be provided to boys, girls and women who are survivors of sexual violence. Post-rape care consists of a medical examination and medical treatment: • PEP to prevent HIV infection – must be provided within 72 hours of the rape in order to be effective, and continues for 28 days • antibiotics to prevent the transmission of STIs • a pregnancy test • emergency contraception (to prevent pregnancy). Emergency contraceptives can be provided up to five days and prevention of sexually transmitted infections up to two weeks after the assault. All children and adolescents should be made aware of these services. Even after 72 hours, referral to the health facility should take place.		
Treatment for opportunistic infections	Treatment can be provided for opportunistic (HIV-related) infections in HIV-positive people, including children and adolescents. This is a daily dose of the antibiotic cotrimoxozole, which will prevent secondary infections.		
Treatment for tuberculosis	Treatment for tuberculosis can be provided using antibiotics.		

Treatment for Sexually Transmitted Infections (STIs)	Management of STI symptoms is provided using antibiotics.		
Access to condoms	Male and female condoms should be available in health centres. It is important that instructions are provided on how to use them. Condoms should also be made available in youth and community centres. Studies have shown that the availability of condoms will not increase promiscuity among young people or their risk behaviour.		
Sexual and Reproductive Health services	Clean delivery kits, midwife delivery kits and basic emergency obstetric care should be available in order to prevent excess neonatal and maternal morbidity and mortality. Facility-based delivery should be encouraged. Counselling on breastfeeding to prevent transmission of HIV should be available for women and adolescents.		
Contraception	Modern family planning methods should be available, including intra-uterine devices and injectable contraceptives. Ensure coordination with health services to determine when and where learners, teachers and staff can be referred for services.		
Mental health and psychosocial programmes	A wide range of psychosocial programmes could be initiated in the minimum response phase to the emergency. In an emergency, education in a protective environment is itself is considered a psychosocial intervention. This includes peer education. These services are offered through the education sector, as well as other sectors working in the community.		
Supplementary feeding	Supplementary feeding programmes for children and adolescents can be provided in the school setting, and nutrition programmes can be important for all learners, particularly those with HIV and AIDS. Supplementary feeding programmes can help to ensure school attendance.		
Refer young children for growth, weight gain	Children who are noticeably underweight should be referred for health-related services.		
Others, e.g. • universal precaution • access to safe blood • planning post-disaster response	Universal precautions to prevent occupation-related transmission of HIV should be available (this includes latex gloves, gowns, goggles, etc). Ensure a safe blood supply for transfusions, etc. Post-disaster plans include expanded response to HIV and AIDS, STIs and SRH issues.		

Table 9: Self-assessment tool to ensure that learners and staff have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a non-discriminatory basis

Access to health facility-based services	***Yes or No***	***Comment (e.g. not available, unsure)***
Do you know what HIV-related services are offered to the emergency-affected population with which you are working?		
Do you know where to refer learners, teachers and staff for post-rape care,		

including post-exposure prophylaxis?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff who are in need of mental health and psychosocial support programmes?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff who were *previously* on ART for continuation of services?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff for cotrimoxazole prophylaxis for HIV-related infections?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff who were *previously* on PMTCT for continuation of services?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff for services to treat malnutrition?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff for access to condoms?		
Do you know where to refer learners, teachers and staff for contraceptives (when available)?		
Has a referral system been developed?		
Do you know where to refer learners, teachers and staff for STI treatment?		
Has a referral system been developed?		
Do you know where to refer pregnant learners, teachers and staff for safe delivery?		
Has a referral system been developed?		
Do you know where to refer injecting drug users for clean needles and syringes, and for information on HIV?		
If VCT is available, do you know where to refer learners, teachers and staff?		
If ART is available for everyone, not only those who had previous access, do you know where to refer learners, teachers and staff?		
Services in schools and learning spaces		
Is supplementary feeding or school feeding provided for learners?		
Are SRH sessions, led by health outreach staff, provided for learners?		
Are teachers trained to help identify and refer vulnerable learners to the health sector for SRH programmes?		

Topic 10 Referral to services for staff and learners

It is important for the education sector to work with the health, nutrition and protection sectors to develop a comprehensive system for referrals and service provision in emergency settings. These sectors should also work together to develop a monitoring system for the referrals provided.

Coordination between the education and health sectors is critical. This includes participation in planning, service supervision, evaluation, and information system development. It is important to discuss and determine the role the education sector (including schools and learning spaces) plays in the response to HIV, sexually transmitted infections and sexual and reproductive health during emergencies, and how to strengthen coordination with the other sectors and service providers.

In humanitarian crises, adolescents are at increased risk of poverty, separation from family and community, and physical and sexual violence and exploitation. This in turn leads to increased risk of sexually transmitted infections, including HIV, unwanted pregnancy, pregnancy-related health risks, stigma and discrimination. Within communities, social and physical barriers can prevent adolescents from accessing SRH services. Schools and learning spaces can help provide an opportunity for:

- peer educators to offer age-appropriate SRH education sessions
- reproductive outreach staff to provide SRH information sessions in classrooms
- teacher training to identify children and adolescents with high-risk behaviours and develop a system to link them to SRH services.

Table 10: Links between schools and locally available health, social and psychosocial support services

Schools or learning spaces	Networking between sectors and services	Health, social and psychosocial support services
Prevention of HIV: • know students individually and screen for high-risk behaviours • promotion activities (in classroom and among peers) • invite health staff to the school or learning space to hold awareness sessions on these topics Helping process • help those especially vulnerable and with high-risk behaviours • internal referrals (to counsellors) • case conference • external referral • basic services provided through schools (such as school feeding) • network with community.	Participation in planning, coordination, service supervision, evaluation and information-system development.	Provide technical support on promotion and prevention, treatment plan, case conference, and clinical service for referral.

Key Terms

AIDS stands for acquired immunodeficiency syndrome, which is a fatal disease caused by HIV, the human immunodeficiency virus.

ART stands for antiretroviral therapy or antiretroviral treatment, which is a treatment that slows down replication of HIV and can greatly enhance quality of life, but does not eliminate HIV infection.

GBV stands for gender-based violence, and is a term that covers not just sexual violence but also forced/early marriage and pregnancy, female genital mutilation/cutting, sexual exploitation and abuse (including exchanging sex for good grades, 'survival sex', exchanging sex for benefits or privileges, etc), preferential nutrition and health care for boys, etc. These are all factors that can contribute to HIV prevalence and exposure.

HIV stands for human immunodeficiency virus, which is the virus that causes AIDS.

Life skills are psychosocial abilities for adaptive and positive behaviour. They enable individuals to deal effectively with the demands and challenges of everyday life.

Life skills education is a structured programme of needs- and outcomes-based participatory learning. It aims to increase positive and adaptive behaviour by helping individuals to develop and practise psychosocial skills that minimize risk factors and maximize protective factors.

Life skills learning outcomes are measured in the form of knowledge, attitudes, skills, behavioural intent and capacity.

PEP stands for post exposure prophylaxis, and refers to preventative medications given within 72 hours after an HIV or suspected HIV exposure in hopes of decreasing the likelihood of HIV infection from the exposure.

PMTCT stands for prevention of mother to child transmission.

SRH stands for sexual and reproductive health which refers to the reproductive processes, functions and systems at all stages of life.

STD or STI stand for sexually transmitted disease or sexually transmitted infection, which are infections acquired by sexual contact.

VCT stands for voluntary counselling and testing, which is provided in non-emergency settings for community members to find out their HIV status.

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INEE
Inter-Agency Network for Education in Emergencies
Réseau Inter-Agences pour l'Éducation en Situations d'Urgence
La Red Interagencial para la Educación en Situaciones de Emergencia
Rede Inter-Institucional para a Educação em Situação de Emergência
الشبكة المشتركة لوكالات التعليم في حالات الطوارئ

Minimum Standards for Education:
Preparedness, Response, Recovery

Foundational Standards

Community Participation Standards: Participation and Resources – **Coordination Standard**: Coordination – **Analysis Standards**: Assessment, Response Strategy, Monitoring and Evaluation

Access and Learning Environment

- **Standard 1: Equal Access** – All individuals have access to quality and relevant education opportunities.
- **Standard 2: Protection and Well-being** – Learning environments are secure and safe, and promote the protection and the psychosocial well-being of learners, teachers and other education personnel.
- **Standard 3: Facilities and Services** – Education facilities promote the safety and well-being of learners, teachers and other education personnel and are linked to health, nutrition, psychosocial and protection services.

Teaching and Learning

- **Standard 1: Curricula** – Culturally, socially and linguistically relevant curricula are used to provide formal and non-formal education, appropriate to the particular context and needs of learners.
- **Standard 2: Training, Professional Development and Support** – Teachers and other education personnel receive periodic, relevant and structured training according to needs and circumstances.
- **Standard 3: Instruction and Learning Processes** – Instruction and learning processes are learner-centred, participatory and inclusive.
- **Standard 4: Assessment of Learning Outcomes** – Appropriate methods are used to evaluate and validate learning outcomes.

Teachers and Other Education Personnel

- **Standard 1: Recruitment and Selection** – A sufficient number of appropriately qualified teachers and other education personnel are recruited through a participatory and transparent process, based on selection criteria reflecting diversity and equity.
- **Standard 2: Conditions of Work** – Teachers and other education personnel have clearly defined conditions of work and are appropriately compensated.
- **Standard 3: Support and Supervision** – Support and supervision mechanisms for teachers and other education personnel function effectively.

Education Policy

- **Standard 1: Law and Policy Formulation** – Education authorities prioritise continuity and recovery of quality education, including free and inclusive access to schooling.
- **Standard 2: Planning and Implementation** – Education activities take into account international and national educational policies, laws, standards and plans and the learning needs of affected populations.

Key Thematic Issues: Conflict Mitigation, Disaster Risk Reduction, Early Childhood Development, Gender, HIV and AIDS, Human Rights, Inclusive Education, Inter-sectoral Linkages, Protection, Psychosocial Support and Youth