

HIV/AIDS School-based Education in Selected Asia-Pacific Countries

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ABSTRACT *This paper describes findings from a recent UNAIDS-funded study of how education systems in selected countries in East Asia, South East Asia and the Pacific are responding to HIV/AIDS-related education. Data were collected by means of postal questionnaire and key informant interviews in Brunei, Cambodia, China, Indonesia, Malaysia, Mongolia, Myanmar, the Philippines, Papua New Guinea, Thailand and Vietnam. Sources of information varied but included ministries, non-governmental organisations and other interested bodies. Findings suggest that the education provided is largely information-based, but with a developing emphasis on life-skills such as assertiveness and negotiation. Specific sexual practices are rarely discussed in the region's schools, except in a somewhat mechanistic way, focusing mainly on human reproduction and anatomy. However, those countries most affected by the epidemic are beginning to re-think their approaches. An increasing openness about sexual and drug injecting practices, and how to communicate these issues with young people, is beginning to become apparent.*

Introduction

Schools have long been identified as appropriate environments in which to undertake activities to promote HIV-related risk reduction among pupils and young people (Kirby, 1992; Kirby *et al.*, 1994; Kirby, 1999; National Commission on AIDS, 1993; Rivers & Aggleton, 1999, 2000; SIECUS, 1999). Given that in the majority of countries young people between the ages of five and thirteen spend relatively large amounts of time in school, school environments can also provide resource-efficient access to large numbers of young people from diverse social backgrounds (UNAIDS, 1997a; Aggleton & Rivers, 1999).

While we know something of the policies and practices governing HIV-prevention education and sex education in the resource-rich countries of the world—particularly those countries where HIV poses a serious threat to the well being of its population—

very little is known about policies and practices in countries where HIV has been a comparatively late arrival, and/or of those countries that are not resource-rich.

In particular, we know virtually nothing about *how* HIV and AIDS-related health promotion actually takes place in such settings, the successes there have been and the actions that need to be scaled up. Of particular interest here are questions concerning where and at what age HIV/AIDS is addressed in the school curriculum; what emphasis is given to different modes of HIV-transmission (e.g. sexual versus drug-related); and in what ways cultural traditions and ideologies govern the manner in which HIV and AIDS-related concerns are discussed.

It was against this background that this study was undertaken. The overall aim was to explore the feasibility of monitoring how selected education systems in East Asia, South East Asia and the Pacific are responding to HIV and AIDS. The choice of region was deliberate in that countries within it vary widely in terms of political structure, the role of government in education planning, and the influence of religion on educational matters. The study's funders were also concerned to assess the feasibility of monitoring education system responses in countries as yet relatively unaffected by the HIV/AIDS epidemic as well as those badly hit.

HIV/AIDS Education in School

There is continuing debate about the content of HIV and AIDS-related education programme and how and in what manner they are delivered to students in school (Aggleton, 2000; SIECUS, 1999; Second International Symposium on HIV Prevention, 1999). It is generally agreed that HIV/AIDS education should include information on: the nature of the virus, its modes of transmission, the consequence of infection, and the steps that can be taken to protect against infection (UNAIDS, 1997a,b; UNESCO, 2001).

More contentious is the inclusion of education relating to interpersonal sexual relations and drug use. In this respect, discussion of the avoidance of disease by the use of condoms or the supply of clean needles and syringes can be particularly problematic. Dominant cultural understandings influence the manner in which HIV/AIDS is positioned and addressed; for example, drugs are most usually positioned as illegal and therefore to be avoided. Sex presents more of an immediate challenge to educators.

Across the world, much HIV-related education takes place within curriculum subjects such as science, biology, and health education. Alternatively, issues relating to HIV and AIDS may be addressed within the context of citizenship and political studies, religious or moral education, or as part of the work linked to personal and social development and/or the acquisition of life-skills.

To the extent that HIV and AIDS is contained within a subject area such as science and biology, the links between it, and broader social concerns, are likely to be left unexplored. On the other hand, where the personal dimensions of HIV-prevention are stressed, interpersonal and social concerns are likely to come to the fore, most usually with respect to prevention, but sometimes in relation to issues such as the experiences of people living with HIV disease, the forms and determinants of HIV- and AIDS-related discrimination, and government responses to the epidemic.

There also exist debates regarding mode of delivery, for example, over whether HIV/AIDS and related issues should be addressed via knowledge-based models or through interactive and skills-based modes of learning. Of particular interest here is discussion over whether HIV/AIDS-related health promotion should be taught didactically as a set of 'facts', or using more student-centred models. In the belief that

HIV-prevention is more effective if linked to the everyday lives of students, some educators have promoted life skills models (UNAIDS 1999, UNICEF, n.d.).

But how are issues such as HIV/AIDS addressed within the context of East Asia, South East Asia and the Pacific, and which of the above models or approaches has proved the most popular? To what extent are strategies and approaches influenced by prevailing politics and the overall social, cultural and religious climate? And what kinds of innovative approaches are arising in circumstances where they might not have been expected? These are but some of the questions to be examined here.

Methods

The countries included in this study were Brunei, Cambodia, China, Indonesia, Malaysia, Mongolia, Myanmar, Papua New Guinea, Philippines, Thailand and Vietnam. These inclusions were made in discussion with UNAIDS and countries were selected for their diversity with respect to the impact of the epidemic, political structures, the role of government in education planning, and the influence of religion on educational matters.

Initial discussion with key international and country-level officers within UNAIDS and its co-sponsoring organisations, suggested that in-country data would need to be collected from a variety of sources, and triangulated to ensure reliability. Likely sources of input and support included national AIDS programmes and councils; government officials, especially those in ministries responsible for curriculum development and teacher training; non governmental organisations (NGOs) working locally on issues relevant to HIV/AIDS and sexual/reproductive health; and relevant international non-governmental organisations.

Over 150 individuals were contacted and asked to complete our questionnaire or to advise us of somebody who could. By far the majority of those contacted responded. Over 40 gave reasonable to good responses either in terms of answering the questionnaire (partially or in full, depending upon the respondent's area of expertise) or in providing us with documents on policy, curriculum and training. Of the in-depth

TABLE I. HIV Prevalence Rates

Country	Adult population with HIV (%)*	Primary mode of transmission
Brunei	0.20	Heterosexual
Cambodia	4.04	Heterosexual
China	0.07	IDU*
Indonesia	0.05	IDU; Heterosexual
Malaysia	0.42	IDU
Mongolia	< 0.01	No significant epidemic
Myanmar	1.99	IDU; Heterosexual
Philippines	0.07	Heterosexual
PNG	0.22	Heterosexual
Thailand	2.15	Heterosexual
Vietnam	0.24	IDU; Heterosexual

[*IDU: injecting drug use]

Source: All figures from the UNAIDS Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Diseases (year 2000 update). Available on the UNAIDS website: http://www.unaids.org/hivaidinfo/statistics/june98/fact_sheets/index.html

responses, most were from international and local NGOs who had strong links with schools and departments of education, or from people who worked within curriculum development units in departments of education. Strong responses were elicited from at least one person in all the countries included.

Data were collected by means of a questionnaire and face to face or telephone key informant interviews, initially through contacts nominated by UNAIDS and/or UN Country Theme Groups on HIV/AIDS. Subsequent respondents were snowballed to include people working in other ministries and organisations. In several instances, additional respondents were contacted via media reports, conferences and the like, and corroborative data were collected face to face during the 5th International Conference on Asia and the Pacific (ICAAP) in Kuala Lumpur (1999). The majority of the interviews were tape recorded with the permission of the informant.

The questionnaire sought to elicit information on the overall policy context, the placement of sexual health-based HIV information, the content of the curriculum, the training of teachers who deliver sex-oriented HIV/AIDS education, the ages and class levels of the students to whom it is offered, and perceived constraints and barriers to undertaking this kind of education. Copies of the questionnaire were distributed to participants by e-mail, mail, and fax in each of the participating countries. E-mail and telephone follow-up occurred at regular intervals following initial distribution to ensure a strong response. Respondents were also asked to forward documents relating to school based HIV/AIDS or sexual health policy, curriculum or training.

Based on the information supplied, an outline of HIV/AIDS and sexual health education was compiled for each country, which was later amended following further comments from research informants [1]. A number of caveats on the accuracy of the data need to be made. First, although most respondents were directly or closely related to policy or curriculum development and implementation, the information given should not be read transparently. Phrases such as 'sexual and reproductive health education' and 'sex education' have different meanings for different people and organisations—both within and between countries. Second, the data were collected throughout 1999. While ongoing contact has been maintained with respondents, policies and curricula continue to change as countries develop their response to HIV.

Third, stated policy does not necessarily translate seamlessly into practice. With the resources available we were only able to gather lesson plans and/or teacher guides from four of the eleven countries participating in the study. This, together with an absence of observational data, makes it impossible to have a thorough understanding of what actually takes place in schools. Follow-up research is needed within schools to test the realities of the situation regarding the delivery and content of HIV education. Fourth, as might be expected in a preliminary study of this kind, the completeness of the data varies from country to country, making comparisons problematic at particular points of the research. Finally, the international nature of the project has inevitably obscured fundamental differences *within* individual countries. These include differences linked to urban/rural location; varying degrees of political stability; differences between public/private, formal/informal and religious/secular school structures.

Findings

In this paper we focus on four main sets of issues: policy development at the national and ministerial level; curriculum development, including the framing of HIV/AIDS education within subjects and the development of teaching resources; modes of HIV/

AIDS education delivery to students; and teacher education and training. We will illustrate our analysis by means of boxed examples taken from individual country profiles.

These four areas represent key aspects of sex education in schools. Policy points toward the extent and content of high-level governmental commitment. Similarly, curriculum and available teaching resources point toward what students are expected to be taught and in what subjects it should take place. Curriculum and teaching resources, unlike policy, offer greater detail in terms of specific content (e.g. diseases, health, ethics, negotiation skills, practice skills, and reproduction) and locate that content in subjects areas. The mode of delivery is important in terms of whether students are being told about the 'facts' of sex in a manner relatively abstracted from their lives, as in traditional information-based approaches, or in terms of how sex and sexuality constitute a part of their lives in broader social contexts. Given the widespread sensitivities of delivering sex education and the uneasiness many experience when talking about sex, it is important that teachers have specific training that sensitises them to the importance of the subject matter and provides them with skills on how to convey such material in a manner that benefits students and educators alike.

Attention to all the above areas is necessary if the proportion of students who receive sex education is to be maximised, and in such a way that helps them to protect their own and their partner's health and well being. Our research is intended to contribute to this greater project by documenting and analysing the extent of attention to sex education in a region that disproportionately bears the global burden of HIV disease.

Policy on HIV/AIDS education

As of late 1999/early 2000, Mongolia, Indonesia, Papua New Guinea, the Philippines, Thailand and China had developed the most comprehensive policies relating to HIV/AIDS education in schools (see Table II). Cambodia and Vietnam both made available draft versions of policies relating to HIV/AIDS and sexual and reproductive health education, which offered some detail in each case. Brunei, Malaysia and Myanmar reported having no specific policies on HIV/AIDS and sexual health in schools, although it should not be assumed that not having a policy means a lack of commitment. For example, Myanmar's lack of policy conceals the fact that a very detailed skills-based curriculum has been developed by UNICEF and the Department of Education, and has received ministerial approval. This suggests that in some circumstances it may be better to have no policy than a bad policy, as good curricula can be developed in the absence of policy, whereas bad policy will almost inevitably lead to a poor curriculum. Having said this, the existence of policy can provide persuasive leverage to introduce or improve existing HIV/AIDS education.

A number of themes recur throughout the policy positions we were able to analyse. First, official policy identifies in which types of school HIV/AIDS and sex education should be provided. Schooling is compulsory for children aged between six or seven years and fifteen years in the majority of countries included in the study. In Myanmar, the Philippines, Cambodia, Vietnam and Papua New Guinea, however, schooling is mandatory for a shorter time period. All countries recognise the importance of informing school students about HIV and sexual health and most propose inputs into both primary and secondary schools, but the major focus by far is the senior years in secondary school.

Beyond this, Government policy throughout the region recognises in-service teacher education and training as important, since in most countries the education teachers have

TABLE II. Existence of Policies by Country as of 2000

Country	Yes	No	Being developed	Comments*
Brunei		X		The Malay Islamic Monarchy was said to govern how HIV/AIDS and sex-related education is delivered in schools
Cambodia	X		X	Some references are made to schools in National AIDS Authority policies. The Ministry of Education Youth and Sport and other ministries have drafted a strategic plan for the years 2000–2005
China	X			Policies on sex-related education have been in place since 1988 and HIV/AIDS-related polices since 1993
Indonesia	X			The Ministry of Education and Culture have had school-based HIV/AIDS policies since 1997
Malaysia		X		Malaysia has no existing or intended HIV/AIDS policies although the Malaysian AIDS Council refers to schools in their <i>Malaysian AIDS Charter</i> (which does not bind the government)
Mongolia	X			HIV/AIDS policy emerged in 1990 in the <i>Medium Term Plan 1</i> . Increasing emphasis has been given in policy since 1994
Myanmar		X		Myanmar has no existing or intended policy though has existing HIV/AIDS and sexual and reproductive health education program in some schools (refer to Country Profile)
Papua New Guinea	X			School-based HIV/AIDS policies have been in place since 1997 (contained in the <i>National AIDS Council Act</i>). Population education policies have also been in existence since 1997
Philippines	X			As early as 1995 the Department of Education Culture and Sport had circulated Memoranda to schools that encourage HIV/AIDS education in schools. In 1998 school-based education was mandated in the <i>Philippine AIDS Prevention and Control Act of 1998</i> . The implementation rules and regulations followed in the same year
Thailand	X			School-based policies have been in place since 1991 and were developed by the National AIDS Committee. The Ministry of Education has subsequently developed its own policies
Vietnam			X	There are currently no formal policies in place in Vietnam. However, the Ministry of Health has a draft policy for reproductive health education, which includes school-based education.

Note: please refer to the individual Country Profiles for greater detail (see footnote 1)

received about HIV/AIDS is very patchy indeed. In particular, policies identify that teachers need to be equipped to deliver skills-based education, so as to effectively conduct work on values clarification, assertiveness and gender roles. The move to life-skills models is an important and relatively recent development in most countries involved in the study and has been championed by international agencies such as UNICEF. Nevertheless, concerns have been expressed about the way in which life-skills models are being delivered in the classroom by teachers who may be inexperienced or badly trained. Policy initiatives to tackle this problem are now being developed in some of the countries surveyed.

Official policy usually locates HIV/AIDS-related knowledge across a number of subject areas, and typically integrates this into existing subjects such as biology, science, and health. The tendency to locate knowledge concerning HIV transmission in science-based areas of the curriculum, where skills-based work tends to be under-developed, reflects the fact that biological and medical knowledge is emphasised in the vast majority of education policy documents. Detail about more skills-focused issues such as harm minimisation or specific sexual risk practices, including the dangers of unprotected penetrative sex, is typically absent. Where policy does stray into consideration of the social, cultural and personal context, abstinence and fidelity are stressed, with official documents frequently talking of 'desirable health values', 'healthy and responsible behaviour' and 'family values'. While most governments seem keen to promote such a moral framework for HIV/AIDS education, in countries where the HIV epidemic is more serious, such as in Thailand and Cambodia, HIV/AIDS and sex education tend to be more detailed and explicit, with reference to (if not an emphasis on) harm minimisation and risk reduction.

Curriculum development

All the countries surveyed would appear to deliver some form of sexual and reproductive health education to students at some stage in their history of schooling. As suggested above, however, the education students receive tends to be focused on the biology of sexual reproduction and not upon sexual *practice* in its social or personal contexts. There is little discussion of the *relative* risks of different sexual practices. Such matters are not mentioned in any official curricula, so far as we were able to determine. Moreover, 'sex' is always presumed to be vaginal intercourse, with there being no mention of anal intercourse or less risky forms of sex such as oral/genital sex or other forms of sexual kissing and touching.

Where sex is discussed in social terms, it is usually framed by reference to 'the family'. This emphasis is reflected in the titles of many HIV/AIDS and sexual and reproductive health education programmes. For example, in Thailand, there is 'Life and Family Education', in Vietnam 'Population Education', and in Indonesia and Mongolia 'Adolescent Reproductive Health'. In Malaysia, 'Family Health Education' (FHE) aims to preserve the family institution, grounding itself in a presupposition that young people will not engage in sexual activity until married, despite evidence to the contrary. That 'sex' is not used in these curricula titles points toward local sensitivities, reflecting a belief that sex is only one aspect of broader social and health concerns. 'Sex education', it might be argued, does *not* describe what most countries currently do. The most obvious example of this comes from Brunei, where the idea that young people should receive broad-based sex education is roundly rejected. As one ministry official made clear:

... sex education (or sexual education or sexuality education) in its liberal sense is *not* taught in any of the topics in the science syllabus developed by the Curriculum Development Department at any level of education in Brunei Darussalam as this is contrary to the teachings of Islam. Sex [education] that explicitly mentioned the [encouragement] use of condoms and other forms of contraceptives including IUDs, sex enhancement devices and drugs including orally taken pills, masturbation, forms of intercourse (oral, anal, vaginal), 'free' sex, multiple partners, exchanging spouses, free intermingle among men and women for pleasure as a pastime, or communal marriage, polyandry, infidelity, the likes of any unnatural forms of sex (including homosexuality and lesbianism) is strongly condemned in Islam. Unlawful and immoral sex practices including premarital sex are all forbidden (*haram*) in Islam.

Thus, while students in Brunei will receive education on reproductive anatomy and physiology, STDs and birth control, this is framed within a biological discourse that excludes reference to personal and social contexts, except where these touch on the religious or the familial. AIDS, syphilis and gonorrhoea education focuses upon their 'causes and harmful consequences', while birth control education is framed within the context of marriage.

Primary level

At primary level, and across the countries participating in the study, HIV/AIDS is not discussed in detail, if at all. Similarly, sexual relations, especially in relation to explicit discussion of sexual practice, are not mentioned in any primary curricula. All sex-related topics focus instead on reproduction, differences in male and female anatomy, and physical changes at puberty. Education in these areas often begins soon after the child enters school. According to our data, primary schools do not discuss condoms in detail, except in Papua New Guinea and perhaps in Cambodia where this is part of pilot projects. Most countries consider explicit sexual talk to primary school students to be inappropriate, arguing that senior secondary school is the appropriate forum to begin to discuss sex in some detail. Whether or not one agrees with this, the fact remains that in many countries the majority of students do not progress to secondary school and even fewer to senior secondary school (see Table III).

This reluctance to introduce HIV education into primary schools may be diminishing, albeit slowly. Pilot work in Cambodia and Papua New Guinea (see Box 1) is beginning to reach primary school children. Success in these initiatives may encourage other countries to develop similar curricula. In order for such an approach to be taken forward, a shared policy between education and health ministries (which often approach the area with different priorities) is important. In China, for example, while a joint ministerial statement entitled *Principle of Health Education STD/HIV/AIDS Prevention* has recommended that primary schools should receive such education, this policy was not supported by the Ministry of Education. However, where there *is* cross ministerial policy support for primary education about HIV/AIDS, and where this is implemented alongside community-based education of adults (thereby generating local support for work in schools), such primary curricula can be introduced successfully at a local level.

TABLE III. Gross Enrolment Ratios by Level of Education by Country*

Country	Year	Gross school enrolment ratios (%)**		
		Primary	Secondary	M/F secondary ratios
Brunei	1996	106	77	72/82
Cambodia	1996	110	29	31/17
China	1997	123	70	74/66
Indonesia	1996	113	56	—
Malaysia	1997	101	64	59/69
Mongolia	1996	88	56	48/65
Myanmar	1994	120	30	29/30
Philippines	1997	117	78	77/78
Papua New Guinea	1995	80	14	18/12
Thailand	1996	87	56	—
Vietnam	1997	113	57	—

*Statistics taken from the UNESCO 1999 Statistical Yearbook.

**Some of the figures are above 100%. This is because Gross Enrolment Ratios are measured by taking the total enrolment of students in primary school, regardless of age, expressed as a percentage of the population corresponding to the school years.

Box 1

PAPUA NEW GUINEA

One pilot programme in Papua New Guinea has acknowledged the problem of children leaving school before they reach secondary level. The Reproductive and Sexual Health Supplementary Text (RSHST) was developed as a response to this problem by the Papua New Guinea Curriculum Development Unit within the Department of Education to supplement existing sexual and reproductive health education. The RSHST is targeted at upper primary school students (grades 5 and 6) and is being integrated into Science and Personal Development. Although positive messages about marriage, abstinence and fidelity are offered by the RSHST, condom use is also promoted. Detailed diagrams with text show how condoms should be used, and situations where condoms might be appropriate are noted.

The RSHST is a central element of a pilot study that is being conducted in 80 primary schools across two provinces. Prior to implementation locally, the community is brought together and educated on matters relating to HIV. In this way, local people are made aware of the need for HIV/AIDS sexual health education in schools. Given the sensitivity of the subject matter, it is considered important that communities be informed and involved about the reproductive and sexual health programmes in schools. Without community support, school programmes might be resisted, and for this reason (as identified in the Secretary's Circular), parallel community awareness programmes are integral to developing school-based work.

Secondary level

In all the countries studied, HIV/AIDS is dealt with in the greatest detail at secondary level. As is the case at primary level, HIV/AIDS and sex-related education in secondary schools is generally integrated into a broad range of subjects. Typically, these subjects include physical health, biology, science, civics and home economics. All secondary level curricula include reference to the following:

- Transmission modes of HIV
 - HIV/AIDS and STD scientific knowledge (e.g. What is HIV? Consequences of HIV infection)
 - Avoiding HIV and STDs, stressing sexual abstinence and fidelity (condoms are mentioned in a small number of countries)
 - Contraception within marriage
 - Human reproduction and anatomy*
 - Puberty—psychological and physiological changes*.
- [* = begun typically at primary level]

Once again, however, secondary school curricula rarely address interpersonal sexual relations. How to cope with sex for the first time, for example, or how to maintain an active yet safe sexual life are issues that typically remain unaddressed even at secondary level. Similarly, discussion of contraceptive methods tend to be abstracted from the lives of students and framed by reference to marriage and ‘family planning’ (as noted above). From the data elicited, China, Vietnam, Cambodia and PNG are the only countries that explicitly mention condoms as a mode of disease prevention within the secondary curriculum. Safer sex as a concept is rarely mentioned within curricula, although reference to the ABC of sex (**A**bstinence, **B**e faithful or use **C**ondoms) is included in the curricula of Mongolia, Thailand, Cambodia, and Papua New Guinea. Importantly, the ABC of sex usually promotes condom use as a last resort, rather than as an option equivalent to abstinence or fidelity. The notion that in high prevalence countries condom use may offer *more effective* protection against HIV infection than fidelity was mentioned in no official statements or curricula seen by the research team.

At secondary level, there have been cautious moves towards broadening sex-related material beyond sexual reproduction and anatomy, although this trend is by no means universal and is so far mainly at pilot stage. Similarly, all countries except Brunei have developed broadly skills-based curricula. All existing pilot projects, for example, incorporate some form of skills-based work. One example of a move towards both a broader and more skills-focused approach is to be found in a Thai programme developed for private schools, but intended for wider distribution and use (see Box 2). Although these kinds of programmes cover much more ground than most traditional curricula (condom use and safer injecting, for example) similar kinds of messages about sexual morality still take centre stage. Equally, all countries with a skills-based curriculum emphasise the skill of ‘saying No (to sex)’ or developing strategies to avoid pre- and extra-marital sex.

Mode of delivery

In all countries surveyed, key informants suggested that prior to the advent of HIV/AIDS, most if not all sexual and reproductive health education in schools used didactic teaching methods. Research data indicate that the didactic approach remains the predominant form of sex-related education, and in many countries HIV/AIDS education has been incorporated into existing curricula. However, the urgency of the AIDS epidemic has provided an impetus for governments to consider new approaches to sex-related education and, consequently, skills-based education is being increasingly introduced, bringing with it an emphasis on interactive learning through role playing, games, debates, small group work and brainstorming. As the Chinese data shows (see Box 3), this approach opens up dialogue between students and teachers, and between the

Box 2

Thailand

A handbook, *Life Skills Activities to Protect and Fight against AIDS*, has been developed by the Office of Private Education Committee together with the Thai Ministry of Education (no date) for use in private schools, although it is intended for a wider audience. The curriculum is life-skills based, and contains a programme of four units, composing of 14 50-minute lesson plans for secondary school students. It is suggested that the programme be integrated into a range of subjects including health education, physical education, counselling and social studies. The plans are intended to be student-centred and participatory, and are premised upon self-teaching and students resolving their own problems.

The programme covers a range of subject matter, and includes some material that would be seen as controversial in most countries surveyed—for example, showing young people how to inject properly and use condoms. Nevertheless, traditional messages about abstinence ('saying No') and 'promiscuity' are heavily promoted, even though this purports to be a 'life-skills' initiative encouraging young people to reach their own decisions. In Lesson Plan 12, for example, a story is read to the students about Yut, a basketball champion, described as intelligent, handsome and tall, who has a great deal of unprotected sex before he marries. Once married, his wife becomes pregnant and both are informed following routine blood screening that they are HIV positive.

Suggested questions and answers are provided for the teacher, although it should be noted that this 'skills-based' work has already decided on the correct answers. Examples include:

Q: Why did Yut have multiple sexual partners? A: The influence of the media on social values; having sexual appeal is valued and is thought to give dignity to men; a misunderstanding that women who are not sex workers are 'safe'; an inability to negotiate to use condoms.

Q: Should men stop such behaviour? How can he stop and why should he? A: He should stop because of AIDS, which is spread though having sex with the opposite sex, losing control and having sex. Be decisive to quit and admire women but don't treat them as sex objects.

Q: How can you reduce sexual desire? A: Avoid sexual arousal and being alone for an extended period of time; do exercise; have hobbies; play sport; masturbate—it is natural to have sexual desire—masturbation doesn't harm health and is safe.

Q: If you can't stop yourself- how do you have safe sex? A: Use a condom every time you have sex, and use it correctly. Have condoms ready. Don't drink before sex so as to avoid loss of control.

Teachers are encouraged to distribute a handout on how to choose and use condoms.

students themselves. The relative fluidity of these learning practices creates a space for sensitive issues to be raised that might otherwise not be feasible in the current climate.

WHO has defined life-skills education as promoting 'adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life'. Life skills work has also been positioned as a model for imparting a balance of values, information, attitudes and skills. The approach was initially developed to prevent young people from using recreational drugs but has been broadened to include a range of other social concerns. WHO, for example, has applied the model to the area of mental health and UNICEF has been heavily involved in promoting life-skills in sex-related education, including gender equity. Within the Asia and Pacific region, life-skills

Box 3

China

In China, reproductive health education has traditionally taken place within the context of biology and population education, and has been didactic in approach. In recent years, however, China has developed a different approach to sexual and reproductive health education and is focused more upon student participation and social skills building. For example, the new education model includes such areas as the formation of relationships, coping with peer pressure, negotiation skills, empowerment, gender roles and game playing. Interactive and skills-based models of learning are slowly replacing more didactic teacher-centred approaches. This skills-based model is applied to a broad range of health related issues, such as smoking, in addition to sex-related topics. The new approach to sexual health and HIV/AIDS education is being incorporated into the new subject of health education. However, health education is a compulsory, non-core subject that is not graded or examined. In consequence, it is frequently not treated as seriously as core curriculum subjects, or in some schools, despite the policy, may not be taught at all.

programmes within schools have typically been developed through partnerships between governments and international organisations such as UNICEF, UNESCO and WHO.

Even in circumstances where life-skills work has been heavily promoted, the mode of delivery varies in accordance with the subject positioning of HIV/AIDS. Where the emphasis is on the biological aspects of disease—as it remains in many of the countries surveyed—the teaching approach is likely to be didactic, and HIV/AIDS is taught in biology or science. Here, as noted above, the interpersonal and social aspects of sex tend to be downplayed if mentioned at all. Education on interpersonal relations, on the other hand, lends itself to more skill-based approaches, but here condom use is most usually addressed as a ‘fall back’ in contexts where abstinence or fidelity have ‘failed’ (the ABC of sex as discussed earlier). Moreover, while life-skills approaches have the potential to deal with interpersonal sexual relations, moral frameworks frequently constrain the ways in which sex can be explicitly discussed.

Some respondents commented that the implementation of skills-based learning was honoured in name rather than in actual practice. They suggested that students were often told what to think rather than learning to think for themselves. Our reading of curriculum documents supports this observation. Most of these promote specific values. For example, in the Thai example referred to above, one unit discussed the misery induced by visiting beer houses. The family is positioned as central to any understanding of sexuality. Fidelity within marriage and sexual abstinence outside of marriage are positioned as harm reduction imperatives. This suggests something of a lip-service approach to life-skills work.

Where the classroom does not lend itself to the exploration of controversial subject matter, peer education may be a more appropriate avenue. It is certainly an approach that has been widely promoted in the Asia-Pacific context. In Indonesia, for example, it is being piloted in and out of school contexts (See Box 4).

Teacher training

Existing forms of teacher training were identified by the great majority of respondents as a fundamental barrier to the delivery of good quality HIV/AIDS and sexual health education in schools. Some countries noted that there was a lack of teacher training in general—not just in relation to sexual and reproductive health. In Cambodia,

Box 4

Indonesia

In Indonesia, peer education has been identified as an important means of disseminating HIV/AIDS and reproductive health because sex-related issues are often difficult to discuss publicly, and there is general resistance to delivering formal reproductive health education in schools. Programmes of peer education have been implemented in 14 Indonesian provinces. The learning model adopted is often one of information, education and communication (IEC).

The primary objectives of peer education training has been to provide trainees with:

- Knowledge, understanding and skills to conduct HIV/AIDS prevention programs among their peers
- Knowledge and awareness about the dangers of HIV/AIDS
- The ability to explain HIV/AIDS prevention through the learning materials provided
- The necessary skills to carry out HIV/AIDS prevention activities
- Motivation skills that can be brought to bear upon their peers.

Students are selected for the peer education training programme based upon the following criteria:

- They are senior secondary school students
- Have an interest in HIV prevention
- Have the ability to become actively involved in HIV prevention
- Have empathy with, and are not prejudiced against, people living with HIV/AIDS
- Are involved in organising student activities
- Are recommended by the Chairman of the school.

for example, wages are so low that teachers need to supplement their incomes with second jobs, such as private tutoring (especially in secondary school education). A similar situation pertains in Myanmar (see Box 5) where many teachers, especially in remote areas, lack formal training. These conditions do not bode well for specialist

Box 5

Myanmar

In Myanmar, an HIV/AIDS and sexual health curriculum developed by the School-based Healthy Living and HIV/AIDS Prevention Education Project (SHAPE) was published in March 2000. However, very soon problems introducing SHAPE activities in local schools became apparent. Difficulties included:

- High rates of teacher attrition, especially at the primary school level, and a shortage of primary teachers in rural areas.
- High levels of teacher absenteeism due to economic hardship.
- Reluctance to introduce new teaching because of existing curriculum overload, especially in middle and high schools.
- Lack of motivation and skills to embrace a participatory approach.
- Unwillingness among teachers to talk about sex in the classroom context (students, on the other hand, showed enthusiasm).
- Poor distribution of SHAPE materials.
- Cost of teaching materials.

Although a lack of resources was identified as contributing to the project's initial lack of success, so too was the teaching culture. SHAPE refresher courses had to be provided to teachers and school principals on the grounds that the course and the participatory teaching methods it promoted were foreign to the classroom and therefore needed regular reinforcement.

TABLE IV. HIV/AIDS- or sex-related teacher training

Country	Pre-service	In-service
Brunei	No	No
Cambodia	?	Yes*
China	No	Yes*
Indonesia	No	Yes*
Malaysia	?	Yes
Mongolia	No	Yes*
Myanmar	No	Yes*
Papua New Guinea	Yes	Yes*
Philippines	?	Yes
Thailand	Yes	Yes
Vietnam	Yes*	Yes*

*Known to be a part of pilot projects

work in the fields of sexual and reproductive health. In addition, most countries highlighted the existence of cultural barriers to discussing sex, and emphasised that many teachers are ill-prepared to deliver such education due to anxiety and/or lack of understanding.

The provision of teacher training on HIV/AIDS (and on drugs, sexual and reproductive health more generally) tends to be short-term and delivered on an in-service basis (see Table IV). All countries except Brunei reported providing some level of specific HIV/AIDS education and training, which, as far as our data shows, are always skill-based and at least partly funded by international organisations. A cascade model is most usually adopted, which involves training a core group of lead trainers who, in turn, train other trainers, who then train teachers. The method is a means of maximising the number of trainers with limited human and financial resources.

Pre-service training on issues relevant to sexual and reproductive health was reported as provided in only three countries—Thailand, Papua New Guinea and Vietnam—but no data on the proportion of teachers trained was available. Pre-service training was not provided in Brunei, China, Indonesia, Mongolia, and Myanmar. No information for the Philippines, Malaysia and Cambodia was available at the time of the survey.

Discussion

Much remains to be done if the schools of countries throughout the Asia-Pacific region are to respond to the challenges that HIV/AIDS poses. Existing provision is both varied and patchy, and there is a marked reticence to addressing the sexual and drug-related transmission of HIV in ways which make clear the varied steps that can be taken to prevent against infection. Lest such an account be seen as unduly critical, it is essential to recognise that similar problems were evident throughout the 1980s and 1990s in many European and Australian schools, and that the USA (among other richer countries) still has considerable difficulty in conducting HIV/AIDS education with young people in an open and explicit manner.

While many of the countries from which data were collected face serious economic and resource shortfalls that are not easily surmountable in the short term, further barriers exist to the implementation of effective programmes of HIV/AIDS education. In

particular, the reluctance of most countries to introduce primary school sex education beyond basic information on biology and puberty is a major concern. This is especially true in countries where many students do not progress to secondary school education, and in countries where fewer girls than boys progress to secondary school level. There is a need to reassess the age at which sexual and reproductive health is provided to students and the content of that education. In the absence of such reforms non-school peer-based sex education is important. Peer-education may also be of value where rigidities in the classroom do not facilitate the exploration of controversial subject matter. This approach has been adopted to a greater and lesser extent in many countries, and is typically skills-based (e.g. Malaysia, Indonesia, China, Thailand and Papua New Guinea are developing such programs).

A further barrier derives from the fact that HIV/AIDS and sex education is rarely compulsory, particularly when offered as a separate unit or teaching block, or is included in non-core curriculum (which is true of most of the curricula discussed here). In contrast, when HIV/AIDS and sex education is integrated into a range of existing subjects, coherence may suffer. In this kind of situation, young people can receive fragmented sexual health information—bits of anatomy, bits about HIV transmission, and still other bits about family values.

A central barrier to the delivery of sex education in schools relates to a number of ‘cultural sensitivities’—sensitivities that pertain to religion, local community and to teacher discomfort. Firstly, religious practices and beliefs were said to limit what could (and could not) be said about sex. One of the most extreme examples of this can be found in Brunei’s response, which is attributed to local religious custom and belief. Here, no policy has been formed about sex education or HIV/AIDS, the curriculum has no skills-based element, and teachers receive no training on the issues. A Brunei respondent stressed that most cases of HIV in the country occurred among foreigners (working or visiting) and that the as yet few reported cases among citizens of the country should be credited to ‘the close adherence [of its citizens] to the teachings of Islam’.

Cambodian respondents similarly suggested that a major difficulty of implementing sexual and reproductive health education in schools derived from ‘traditional Buddhist teachings’, the values of which were seen to contradict the approach and content of sex and HIV education. In Thailand, somewhat paradoxically, Buddhist authorities were reported as being supportive of explicit HIV/AIDS programmes, especially in the North but now also in the North East of the country. Overall, something of a ‘grab bag’ of perspectives would appear to be used to justify or otherwise teaching about sexual health and sex-related matters on religious grounds.

The second sensitivity to effective work derived from teachers’ concerns about discussing sex in the classroom. Even in countries such as Thailand, it was reported that sex and HIV/AIDS education are often considered ‘indecent’. For teachers who strive to be models of modesty, it may be difficult to address such issues directly. Here, as elsewhere within the region, it may be especially inappropriate for a single male teacher to talk to female students, and for a single female teacher to raise the subject of sex. Moreover, married older teachers with children may consider it inappropriate to deliver sex education at all. One respondent noted that there was a wide gulf between required courses and their implementation, and suggested that teachers were ‘almost uniformly uncomfortable with discussions of sexuality’. For this reason the topic is often avoided. Some countries circumvented this problem by inviting speakers from outside the school to provide such education, though such an approach raises a concern about on-going coherence. In some countries, notably Malaysia, a solution was to take students on

camps specifically organised to deliver skills-based sexual and reproductive health education.

The third sensitivity in delivering HIV/AIDS education derives from resistance to particular elements of sex education by local communities. In Indonesia and Malaysia, for example, parents, religious leaders and government officials were reported to have objected strongly to discussions about condoms within classrooms as a means of preventing disease transmission. In Papua New Guinea, Myanmar and Cambodia, countries with large rural and remote populations, it was said a great deal of community consultation was necessary prior to programme implementation. Sexual health education is believed to encourage young people to engage in early sexual intercourse, though recent research in Western countries strongly suggests this is not the case (Grunseit & Aggleton, 1998). Similar research specific to the Asian and Pacific regions needs to be conducted to support this finding. Despite these restrictions, students themselves frequently introduce the topic of condoms. This indicates an important distinction between formal curricular intentions, on the one hand, and what is actually discussed in the classroom, on the other. That students raise the question of condoms suggests widespread prior knowledge of their existence, and their possible use, and in countries such as Thailand and Cambodia condoms have been promoted in public spaces.

The issues faced by many governments—particularly those that operate within cultures with strong and often conservative religious and moral commitments, whether Hindu, Muslim or Christian—are many and varied. So while there is widespread acknowledgement that HIV and AIDS is a problem, and there is a commitment to address the issue at the school level, there is also concern about maintaining cultural traditions and values. Similar issues have of course arisen in relation to the implementation of action following the International Conference on Population and Development held in Cairo in 1994. While the right of people to control their own fertility was acknowledged, plans of action to achieve such rights were interpreted with reference to cultural contexts and the moral values of the countries concerned.

To the extent that successful education must acknowledge and build on the understandings and beliefs of those it seeks to educate, it is also true that education must engage with subordinate as well as dominant discourses. Not only are dominant morals and cultural values important (often those of the adult male world). Equally important are the morals and cultural values of others (often women, the young and those marginalised in other ways). Difference needs somehow to be accommodated.

If we take just one of these—gender difference—and illustrate by reference to Cambodia (Hor, 1998). For women, premarital virginity is required and its loss leads to the kinds of social rejection that can on occasion end in prostitution. Societal norms for men are in almost all aspects contrary to those for women. Men are accorded the right to follow their sexual drive. Now while it is true such societal norms governing male and female sexual behaviour must be taken into account in prevention programmes for HIV, it is also true that educators need to acknowledge the different societal expectations for men and women. Double standards and contradictions must be dealt with. Moreover it is important to recognise that societal values are not static and fixed. Economic liberalisation and the revolution in information technology, for example, have brought many changes.

Tarr and Aggleton (1999) on the basis of their work in Cambodia set out some useful principles with reference to young people and the development of sexual health education. They include:

- Beginning with an analysis of the dominant discourses and understandings about sex and sexuality in the society or community. Recognising them as discourses which may or may not have a direct relationship to present day sexual realities
- Moving beyond such recognitions to inquire into contemporary sexual meanings, beliefs, etc. and developing prevention messages that speak to a sexual life as it is *lived*, not how it is imagined or hoped to be.

With reference to such principles, how does the ABC of HIV/AIDS education fare?

Firstly, promotion of abstinence might work in a country where the young do not have sex ... at least until marriage. Existing behavioural evidence suggests however that the age of sexual initiation is decreasing while the age of marriage is increasing, for example in Malaysia (Huang, 1999) and the Philippines (Gacad, 1998).

The 'abstinence only' sexual health education movement has been propelled by the persistent belief that comprehensive sexual health education leads the young to have sex but there is no reliable evidence to support such a view, as noted above. The casualties therefore are young people themselves, denied information about how to prevent HIV and STDs in the likely event that a proportion of them have sexual intercourse before they are married.

Secondly, fidelity may be a useful strategy but care must be taken that such a strategy is feasible. Data from China, for example, indicate that attitudes are changing with respect to both extra-marital as well as pre-marital sex (Liao, 1998). It is moreover vitally important to acknowledge that serial monogamy does not protect against HIV infection. Furthermore, monogamy does not protect against HIV transmission unless both partners are HIV-negative and neither partner has sex outside the relationship. The very high HIV-prevalence among married women who have had sex with no one but their husbands indicates that fidelity is not the answer in many countries (Piot, 1999).

Finally, condom promotion has been successful in many countries. As well as in rich-resource countries such as Switzerland, they have been effective in Thailand and Uganda. If condom use is positioned as a harm reduction/harm minimisation strategy and not simply as a way to space a family, then it seems to be an extremely effective way of preventing HIV transmission.

Despite these barriers to effective HIV education, there is clear evidence that some countries—particularly those with significant or rapidly growing epidemics—are beginning to adopt policies and curricula that have been shown to be successful elsewhere. For example, the problem of poor quality teacher training is being addressed in Cambodia where the Education Ministry has been encouraged to start new work in teacher training colleges and in school clusters. The ministry together with UNICEF has also established six regional training centres that have a skills-based and student-centred focus. In China, national authorities have also accepted that HIV/AIDS education is more likely to be succeed where teachers have been adequately trained and supported. A National Training Centre for HIV/AIDS Prevention in Schools has been created at the Institute of Child and Adolescent Health of Peking University.

In several countries, the HIV/AIDS and sexual health curricula are being revisited. In Mongolia, following an intensive training course, a pilot sexual and reproductive health curriculum has been developed. Sixty hours of sexual health education lessons were produced and then further adapted and revised. A small team of 'Master Trainers' have tested the lessons at a secondary school in Ulaanbataar and, based on the outcomes, the lessons have been further revised prior to ministerial comment and approval. Similarly, in Thailand, curriculum reform has stemmed from the widespread perception that the

existing curriculum did not adequately meet students' needs, especially in relation to the areas of HIV/AIDS, drug addiction, accidents, inappropriate sexual behaviour and suicide. The focus of recent curriculum reform has been on 'life-skills' and is intended to deal directly with imminent problems students may face. This is to be achieved through eight 'essential' subject areas, one of which is health and physical education.

In Papua New Guinea, a skills-based model of sexual and reproductive health is being promoted in schools. The model incorporates STD/HIV/AIDS knowledge and transmission, self-awareness, social relationships, self-respect, responsible behaviour, decision-making, self-esteem, and values clarification. These 'life skills' are intended to assist youth to make informed decisions when negotiating around or dealing with sexual situations. Personal and interpersonal skills education covers a range of skills relating to decision-making, communication, respecting others, self-control, conflict resolution, assertiveness, negotiation, gender role-plays. These skills specifically encourage equity between the sexes and emphasise resistance to peer-pressure, pressure from one's partner to engage in sex, and learning to control one's own behaviour.

In the course of this relatively small study, it was possible to gain insight into a number of issues relevant to the teaching of HIV/AIDS and sex education throughout East Asia, South East Asia and the Pacific. However, a number of questions remain to be answered. They include the extent to which a skills-based curriculum can be delivered by teachers accustomed to more didactic modes of teaching; the extent to which teachers are willing and able to discuss the content outlined in contemporary HIV/AIDS curricula; the extent to which content that does not appear in curricula (for example, condom use, risk reduction strategies) is nevertheless discussed in class; and the detailed processes of policy/curriculum development that lead to success in this field. Further comparative investigations of the type described here—conducted both between and within countries—hold the potential to illuminate such concerns.

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NOTES

- [1] The country profiles and a summary report can be accessed at: http://www.arts.unsw.edu.au/nchsr/publications_other.html

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