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Barriers to HIV and sexuality education in Asia

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Abstract

Purpose – The purpose of this paper is to identify the key barriers to the delivery of school-based HIV and sexuality education in selected countries in Asia.

Design/methodology/approach – A review of published literature on barriers to school-based HIV and sexuality in countries in Asia was conducted, with a focus on research carried out after 1990. The paper also draws on recently undertaken national situation analyses of HIV and sexuality education conducted by the second author with support from UNESCO, as well as more general Asia-Pacific regional assessments undertaken by others.

Findings – Four key barriers to the delivery of good quality, school-based HIV and sexuality education are identified: cultural and contextual factors, policy factors, resource constraints and school-level factors.

Originality/value – The paper maps these four barriers as key areas in which action needs to occur in order to improve the delivery of school-based HIV and sexuality education. Potential levers for success are highlighted.

Keywords – Barriers, Asia, HIV/AIDS, Sexuality education

Paper type – Research paper

Introduction

Globally, there continues to be debate about how best to undertake HIV prevention, particularly in parts of the world severely impacted upon by the epidemic. Across much of Asia, the major means of HIV transmission is through unprotected sex, although the sharing of injecting needles and equipment plays an important role in some countries within the region (UNAIDS, 2012a). Because of the close links between education about HIV and education about sex, sexual relations and sexuality, UNESCO (in cooperation with UNAIDS, UNFPA and UNICEF) developed guidance on the most effective approaches to take with respect to HIV and sexuality education. HIV and sexuality are considered together in this guidance due to the importance of addressing sexual transmission (UNESCO, 2007, 2008, 2009, 2010).

After at least 20 years' experience, there is a very substantial body of evidence to show that well-designed and executed "comprehensive" programmes [1] of school-based

HIV and sexuality education have the potential to bring about beneficial sexual and reproductive health (SRH) outcomes for young people. These include delaying the initiation of sex, reducing the frequency of sex, reducing the number of sexual partners and increasing condom or contraceptive use among those who are sexually active (Kirby et al., 2006). Comprehensive programmes have also been shown to have a positive impact on one or more key factors affecting sexual behaviour, including knowledge about risks and consequences of pregnancy and STIs, values and attitudes about having sex and using condoms or contraception, and confidence in the ability to say “no” to unwanted sex, to insist on using condoms or contraception, or to actually use condoms or contraception (UNESCO, 2007, 2009). On the other hand, more narrowly focused efforts such as programmes that focus exclusively on sexual abstinence have shown no such effects (Kirby and Laris, 2009).

Reviews by Kirby et al. (2006) and Aggleton et al. (2012), together with the advice contained in the UNESCO International Technical Guidance on Sexuality Education (UNESCO, 2009), concur that the most effective forms of school-based HIV and sexuality education use some form of social learning theory as the foundation for programme development. In general terms, social learning theory suggests that new behaviours are learned either by modelling the behaviour of others, or by direct experience. Self-efficacy and outcome expectancies are key tenets of most social learning theory approaches. In the context of HIV and sexuality education, “I know I can insist on condom use with my partner” is an example of self-efficacy, while a belief that using condoms correctly will prevent HIV infection is an example of an outcome expectancy (UNAIDS, 1999).

Effective programmes also provide accurate information about the risks of unprotected intercourse and methods of avoiding unprotected sex, often through experiential activities which aim to personalise the information provided. Such programmes include activities addressing social or media influences on sexual practices, reinforce clear and appropriate values to strengthen individual values and group norms against unprotected sex, and provide modelling and practice in communication and negotiation skills. An approach similar to this, sometimes termed “life skills-based HIV education”, has until recently been widely promoted in developing countries, and appears in United Nations General Assembly Special Session (UNGASS) core indicators for national reporting on HIV and AIDS (United Nations, 2001) [2].

However, major barriers exist to the implementation of effective HIV and sexuality education in schools in Asia. Despite international and national efforts, progress in institutionalising a life skills-based approach to HIV education in school systems appears to be limited. Data from national UNGASS HIV and AIDS reports in 2010 show that relatively few countries have managed to achieve 100 per cent coverage of life skills-based HIV education in schools (Indicator 11 – as cited in Clarke and Aggleton, 2012). The following countries provided no data at all: Brunei Darussalam, China, Fiji, Indonesia, Kyrgyzstan, Maldives, Marshall Islands, Micronesia (FSM), Mongolia, Myanmar, Pakistan, Palau, Philippines, Samoa and Sri Lanka (Clarke and

Aggleton, 2012). The available coverage data are shown in Table I.

Table I. Asia-Pacific UNGASS reporting 2010, Indicator 11: coverage rates of life-skills-based HIV education in schools

Coverage range	100%	99-75%	74-50%	49-25%	24-0%
Countries	Papua New Guinea, Singapore, Tuvalu, Uzbekistan	Kazakhstan	-	Cambodia, India (secondary), Lao, PDR, Vietnam	Afghanistan, Bangladesh, Malaysia, Nauru, Nepal, Tajikistan, Thailand, Tonga, Vanuatu

In addition, data on comprehensive knowledge about HIV among young people [3] are also disappointing. According to UNAIDS, less than 50 per cent of young people had comprehensive knowledge in most countries that submitted UNGASS country reports, suggesting that the quality of much of the HIV and sexuality education on offer is questionable (Clarke and Aggleton, 2012). These trends are especially pronounced in countries in Asia, with only three countries reporting more than 50 per cent school coverage of life-skills-based HIV education: Kazakhstan, Singapore and Uzbekistan (Clarke and Aggleton, 2012). Within this context, the present paper reviews some of the barriers to programme development and implementation, drawing both on the published literature and country-level analyses developed by the authors as part of ongoing reviews for national authorities and international agencies in countries in Asia. Our goal here – albeit it in a preliminary way – is to map out some of the different areas in which action needs to occur, as well as potential levers for success.

Methods

A review of existing literature on barriers to school-based HIV and sexuality education in Asian countries was carried out by searching electronic bibliographic database including ASSIA (Applied Social Sciences Index and Abstracts), SAGE Journals, Web of Knowledge, ERIC and SciVerse Scopus. Online search engines such as Google Scholar were used to locate further literature on the topic. Inclusion criteria guiding the review stated that studies must: focus on school-based sexuality and/or HIV education; discuss barriers to the provision of sexuality and/or HIV education in one or more Asian countries and be based on research carried out after 1990 (in order to consider the response from early on in the HIV epidemic, but also remain recent enough so as to be relevant to the current context). The paper also draws on findings from recently undertaken national situation analyses of HIV and sexuality education (carried out with the involvement of the second author in Brunei Darussalam, Indonesia, Malaysia, the

Philippines and Timor Leste with support from UNESCO, 2012a, b, c, d, e), as well as more general Asia-Pacific regional assessments undertaken by Plan International (2010) and UNESCO (2012a). To the authors' knowledge, together these constitute the most up-to-date and comprehensive sources of data available on the region at the time of writing.

The context in Asia The diversity of people, cultures and histories that make up the different regions and countries of Asia should not be under-emphasised; the countries of Asia are in fact extraordinarily heterogeneous. Perhaps as a consequence, and given the wide variations in sexual and drug-related practices, earlier speculations concerning the severity in scale and intensity of HIV epidemics in Asia have not been borne out.

Nevertheless, an estimated 4.9 million people are living with HIV in Asia and the adjacent Pacific, roughly the same as in 2005 (UNAIDS, 2011). Local HIV epidemics are driven by the behaviours and practices of key populations at higher risk: people who buy and sell sex; people who inject drugs; men who have sex with men and transgender people. The vast majority of people living with HIV in Asia live in 11 countries (Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea, Thailand and Vietnam). Data suggest that a significant proportion of new HIV infections within the abovementioned key populations occur among young people below the age of 25 (UNAIDS, 2011) [4].

The recent Commission on AIDS in Asia (2008) has exerted a strong influence on the response to HIV in the region. Its report contained a set of recommendations on HIV prevention, treatment and care with a strong focus on key populations. The provision of sex education was recommended in schools and colleges to equip young people with the information that can help them avoid or reduce risky behaviours such as unprotected sexual activity, which can lead to early pregnancies and sexually transmitted infections including HIV. The report also advised that sex education should be incorporated into relevant sectoral programmes to ensure long-term sustainability.

UNESCO (2008) has recommended that schools in Asia should include discussion of injecting drug use, male-to-male sex and sex work as part of the core curriculum in order to increase the epidemiological and public health impact of HIV programmes. Where discussion of these behaviours is deemed inappropriate or is otherwise currently not possible (for political, religious or other reasons), it is recommended that schools design and implement extra-curricular responses for young people who engage in risk practices, or seek to establish links to youth-friendly services outside of schools. Significantly, these recommendations are somewhat at odds with those given by WHO (Ferguson et al., 2006), which recognises the effectiveness of HIV and sexuality education for all children and recommends widespread implementation at large scale of curriculum-based interventions with characteristics that have been found to be effective in developing countries.

UNESCO, along with other international agencies, has also recognised that schools can play an important role in reducing stigma and discrimination towards people who

engage in risk practices as well as of people living with HIV (UNESCO, 2009). Stigma reduction efforts are likely to help school-based adolescents who engage in risk practices to stay in school and gain access to essential prevention and care services (UNICEF, 2012).

Findings

The literature identifies four different kinds of barriers to the delivery of good quality school-based HIV and sexuality education: cultural and contextual factors, policy factors, resource constraints and school-level factors.

Cultural and contextual factors

Socio-cultural norms surrounding the discussion of sex are among the most commonly cited barriers to school-based HIV and sexuality education, and young people's access to information on HIV prevention and SRH more generally (Shaw, 2009). The belief that talking to young people about sex will encourage earlier sexual activity forms the basis of much of this resistance (Acharya et al., 2010; Shaw, 2009; UNESCO, 2007; Ingham, 2005; Gubhaju, 2002; Schenker, 2001), although extensive research suggests that good quality HIV and sexuality education does in fact delay the age of sexual debut and reduce young people's sexual risk behaviours (Aggleton et al., 2012; UNESCO, 2009; Bearinger et al., 2007).

Numerous studies have explored the ways in which conservative socio-cultural norms offer significant barriers to the delivery of effective school-based HIV and sexuality education in Asia. Nath (2009), Lal et al. (2000) and Barnett et al. (1995) are among those who have detailed the "cultural sensitivities" which inhibit the open discussion of sexual matters in schools in "predominantly conservative" Indian society. Nath (2009) notes that since sex-related issues are widely considered a taboo for discussion in India, young people have limited opportunities to gain this knowledge formally within schools. Chamsanit (1999) has identified the presence of similar socio-cultural norms in Thailand. Although HIV and sexuality education is regarded as important for young people's health on a national level, the fact that open discussions about sex are largely "unacceptable" in Thai society inhibits the implementation of such programmes in schools (Thaweessit and Boonmongkon, 2009). In the Philippines, education sector stakeholders also report having difficulty in discussing sexual health with their children and students (UNESCO, 2012d).

Religious and political beliefs have a strong influence on the content and approach of HIV and sexuality education in many Asian countries. They can inhibit discussion of sex, both within schools and in wider social contexts. Upadhyay et al. (2006, p. 117) have described the way in which views expressed by senior leaders within the Catholic church contribute to strong disapproval of the use of contraception in the Philippines, with resistance from the church also negatively affecting the availability of SRH

information and services for young people (see also Smith et al., 2003). In Malaysia, issues relating to sexuality and youth are often contentious, and linked to notions of public morality. For the majority of Malaysians, barriers to implementing HIV prevention education appear to stem more from cultural and religious values than from limited resources or capacity (UNESCO, 2012c). In Brunei Darussalam, religious education and nurturing “praiseworthy moral conduct” in citizens are believed to be central to HIV prevention and sexuality education, which constrains potential curriculum content (UNESCO, 2012b).

Beyond specifically religious beliefs, stigma and social ostracism can form barriers to the discussion of HIV in particular. Nath (2009), Kodandapani and Alpert (2007), Piot and Seck (2001), Wolffers (1997) and Lyttleton (1994) have all discussed perceptions of HIV as a “disease of shame” due to its associations with sex, which further inhibit attempts to open up discussion about HIV in schools. The stigmatisation of sex workers, people who inject drugs and men who have sex with men also militates against mention of such groups in schools, even though sex work, drug injection and sex between men are important drivers of HIV regionally (UNICEF, 2007).

Socio-cultural norms inhibiting the discussion of sex are strongly gendered in most Asian countries (Yankah and Aggleton, 2008; Ricardo et al., 2006). Young women and men’s vulnerability to HIV and other SRH risks is increased by social norms which associate femininity with ignorance and passivity when it comes to sex, and masculinity with risk-taking behaviours and promiscuous sexual activity (Shaw, 2009, p. 134). The notion that “good” women should not know about sex means that young women in countries such as India can be reluctant to participate in school-based HIV and sexuality education, or to seek SRH information elsewhere (Weiss et al., 2000). Adults may also be unwilling to provide this information to young women within a school context, and the fear that talking about sex leads to sexual activity is notably gendered in contexts where young women’s pre-marital activity is prohibited to a greater degree than young men’s (Weiss et al., 2000; Chakraborty, 2010; Jaya and Hindin, 2009; Abraham, 2002). Conservative norms dictating that women should be modest, chaste and should refrain from expressing (or gaining) knowledge about sex before marriage contribute to similar limitations on HIV and sexuality education in the Philippines (Gipson et al., 2012) and Thailand (Thianthai, 2004).

Absence of supportive enabling environment

A supportive context for HIV and sexuality education is important for effective implementation, but what constitutes an enabling environment may vary from context to context, depending on local laws, policies and implementing arrangements. The presence of a policy shows that a government has a position on HIV and sexuality education; what the policy actually mandates in terms of action at the school level and in the classroom is obviously of great significance. Policies need to be disseminated to all implementing bodies and stakeholders and formal mechanisms established to

oversee implementation. Also of great importance is a detailed strategy to implement policy throughout the school system, backed up by adequate financial resources.

UNESCO (2012a) has undertaken a mapping of laws, policies and strategies for sexuality education in the Asia-Pacific region. Unsurprisingly, this found considerable variation between countries. At the time of the study, 20 countries had national HIV laws or policies, of which 13 explicitly mentioned the role of education. However, only six countries offered a detailed description of sexuality education in their policy frameworks: Cambodia, China, Indonesia, Nepal, Papua New Guinea and Vietnam. These countries had specific education sector policies on HIV or health.

In general, education policies and laws were less likely to include content on sexuality education than for population, reproductive health or HIV. This signals a continuing lack of ownership by the education sector, and appears to support the idea that assuming HIV is a “health sector issue” has hampered the education response to the epidemic in many countries, with ministries of education being slow to formulate appropriate policies (Schenker, 2001, p. 423).

Lack of detailed sectoral policy on HIV and sexuality education is mirrored by a lack of strategy for implementation. UNESCO (2012a) found that only nine out of 27 countries in the Asia-Pacific region had specific education sector strategies to address HIV and SRH. As with policy, the content of these varies in detail and specificity. Very few Ministries of Education have developed detailed, costed medium-term strategies (i.e. for three to five years) for HIV and sexuality education. Cambodia was the first country in the region to do this (Plan International, 2010), and stands out for its integration of HIV and sexuality in its education planning documents, along with Papua New Guinea (UNESCO, 2012a). However, on the ground implementation in both countries is highly variable.

The formal curriculum is arguably the most important vehicle for school-based HIV and sexuality education, although co- and extra-curricular activities have an important and complementary role to play. Across the countries of Asia, policy and strategy generally concern the development and implementation of formal curricula. In a recent review, UNESCO (2012a) found that important progress has been made in including sexuality education in the formal curriculum, mainly at secondary school level. There are notable differences across countries within the region in terms of approach, content and sequence. Life skills education emerges as a common thread, but there is considerable variation in the way this is implemented at country and classroom level. The integration of HIV and sexuality into the existing curriculum is a common strategy, particularly in subject areas such as biology, health, physical education and personal development. Integration may also take place across several different subjects such as mathematics and geography, especially when life skills are being integrated or “mainstreamed” across the curriculum (e.g. in the Maldives and Vietnam). Some countries include HIV and sexuality education in non-compulsory subjects, which means that coverage may be inconsistent and sporadic. Overall, it is far from clear that countries in the region are

developing curricula in line with characteristics of effective programmes that have been identified through research (Kirby et al., 2006).

As Obare et al. (2011, p. 152) have noted, national policies must be implemented within the context of “local realities”, which include the political and socio-cultural norms discussed above. Under the impact of advocacy and support by external agencies and development partners, policies concerning school-based HIV and sexuality education may therefore be comprehensive and supportive at a national level, but may have a limited impact in schools themselves when confronted with norms prohibiting frank and open discussion of sex. Additionally, poorly formulated policies can lead to a lack of clarity concerning stakeholder responsibilities for the implementation of school-based HIV education (Schenker, 2001).

As indicated, an absence of political will (largely due to cultural or religious assumptions surrounding HIV and sexuality) also forms a key barrier to HIV and sexuality education, and active political opposition to the implementation of policies relating to HIV and sexuality education has been a significant barrier in countries such as India. In 2007, following the Government of India’s attempt to introduce a comprehensive HIV and sexuality education curriculum for secondary schools, a conservative backlash against “indecent” and “explicit” materials led to 12 Indian states banning school-based sex education completely (Chakraborty, 2010). Although HIV and sexuality education curricula are now re-emerging in various forms across India (Katyayal et al., 2012), the complete absence of national policies and guidelines for schools constitutes a significant barrier to the implementation of good quality and consistent forms of HIV and sexuality education.

Resource constraints

Schools are viewed as key locations in which large numbers of young people can potentially be provided with HIV and sexuality education in “ways that are replicable and sustainable in resource-poor settings” (UNESCO, 2007, p. 7). However, Kirby et al. (2006) are among those who have argued that within resource-poor settings, the implementation of school-based programmes are likely to be constrained precisely by the lack of access to necessary financial, material and technical resources. Education systems in a number of Asian countries face financial and other constraints, which affect the provision of primary and secondary education in general. This lack of financial and human resources within the education system can have serious implications for HIV and sexuality education in terms of both coverage and quality of implementation.

For example, limited budgets can mean that the development of curricular materials and teacher education on HIV and sexuality-related issues are not prioritised (Birdthistle and Vince-Whitman, 1997; UNESCO, 2007, 2009). In terms of human resources, lack of qualified and experienced staff to develop curricula and to adequately train teachers may further impede the delivery of good quality work in schools (Smith et al., 2003).

Combined with the socio-cultural barriers discussed above, resource constraints can therefore severely impact the implementation of HIV and sexuality education. The lack of a costed education sector strategy to implement HIV and sexuality education is likely to be a significant constraining factor concerning the mobilisation of resources, both domestic and international, in many Asian countries.

Resource constraints beyond the education system may also present a barrier to effective HIV and sexuality education; lack of provisions such as condoms or other forms of contraception can limit young people's ability put into action what they have learned (Yankah and Aggleton, 2008). Similarly, even where SRH services are accessible, financial constraints may mean that young people are unable to afford condoms and other forms of contraception, and so are still unable to act upon advice provided in the HIV and sexuality education they receive (Gubhaju, 2002).

School-level factors

Effective HIV and sexuality education in school requires attention to sound learning activities and teaching methods involving multiple activities in which students can participate. Teachers need to be well-selected, trained, supervised and supported (Kirby et al., 2006). In practice, this is generally not happening.

Bott and Jejeebhoy (2003) and Nath (2009) have noted that HIV and sexuality education usually takes place within Science and Biology curricula in Asian countries. Following research in 11 countries including Thailand and the Philippines, Smith et al. (2003) found that HIV was dealt with in the greatest detail at secondary level, and topics frequently covered included transmission modes of HIV, STIs, sexual abstinence and fidelity, contraception within marriage, human reproduction and anatomy, and psychological and physiological changes during puberty. In many cases, this focus on biological and scientific aspects of HIV and SRH means that broader social concerns, such as the interpersonal dimensions of HIV prevention, the experiences of people living with HIV, and HIV- and AIDS-related discrimination, are largely unexplored (Smith et al., 2003).

Epstein and Johnson (1998, p. 190) have argued that HIV and sexuality education couched exclusively or largely in terms of biological reproduction "cannot fail to be heterosexist in nature", and the topics noted by Smith et al. (2003) also fail to address interpersonal sexual relations including first sexual experiences, and how to maintain an active and safe sexual life. Issues such as contraception are often presented in contexts that are disconnected from young people's lives, and framed by reference to marriage and family planning which may not be the immediate goals of all young people (Smith et al., 2003; Schenker, 2001). Moreover, HIV and sexuality curricula are very seldom informed by young people's own priorities and interests (Allen, 2005). They tend to have been developed by adults, who may be out of touch with (or even antagonistic towards) the needs and interests of diverse groups of young people.

Ingham (2005), Allen (2005) and Cornwall et al. (2008) are among those who have critiqued the lack of attention in HIV and sexuality education to the more positive aspects of sex, including questions of pleasure, reciprocity and rights. The problem-focused, “medico-moral” approach adopted by most school-based HIV and sexuality education curricula has been critiqued for presenting sex-related issues as problems, and in an almost exclusively negative light. While “risk reduction” approaches are viewed as more effective than “abstinence-only” approaches (UNESCO, 2007, p. 15; Jones, 2011), both approaches fail to address the wider social implications of HIV and SRH, and so act as a barrier to providing young people with comprehensive HIV and sexuality education (Smith et al., 2003; UNESCO, 2007).

The teacher is central to the success of education about HIV and sexuality in schools. Teachers can act as barriers to implementation in the classroom if they are not motivated, well-trained and supported (Clarke, 2008). With respect to pedagogy, teaching HIV and sexuality education can be a “tough job” (Schenker, 2001, p. 425). For example, HIV and sexuality education often has to compete in a crowded curriculum for teachers’ attention (UNESCO, 2007, p. 22). Teachers may feel under pressure from parental and community attitudes towards HIV and sexuality education, and while parents can view schools as responsible for HIV and sexuality education, they may want teachers to present information in way that promotes particular (often conservative) messages (Nath, 2009; Lal et al., 2000; Chamsanit, 1999).

In order to teach the subject, teachers need a good understanding of the scientific and social dimensions of SRH, including HIV prevention, and should ideally consider the ways in which their own beliefs, attitudes, (mis)conceptions and experiences affect their teaching (Schenker, 2001; Smith et al., 2003). However, lack of specific training which, for example, sensitises teachers on the importance of HIV and sexuality education and provides them with skills to teach the subject to students, constitutes a significant barrier to effective implementation in many Asian countries (Schenker, 2001; Smith et al., 2003; Ross et al., 2006; UNESCO, 2007, 2009).

UNESCO (2012a) notes that available documentation on HIV and sexuality education in Asia and the Pacific gives only limited attention to teacher training. This is an area where more research is needed. Considerable challenges are observed in providing teacher training on the scale that is required for effective national implementation (i.e. 100 per cent coverage). Other teacher training issues that have been identified include:

- the scope, quality and focus of existing teacher training on HIV and sexuality education;
- lack of availability of resources for pre-service training including time and materials (e.g. Timor Leste – UNESCO, 2012e); and
- guidelines for HIV and sexuality education which may be of very limited use to the teacher (e.g. Indonesia – UNESCO, 2010).

Lack of initial training crucially means that teachers’ embarrassment and anxieties remain unaddressed, which can in turn may mean that the subject is not taught at all

(Ross et al., 2006; UNESCO, 2007; Barnett et al., 1995). In Sri Lanka, teachers were reported as being uncomfortable in carrying out the work, and in Papua New Guinea as many as 30 per cent of teachers have been reported as skipping parts of the curriculum that contain sexually explicit or sensitive content (UNESCO, 2012a). Even where teacher training does exist, it often fails adequately to address socio-cultural norms that promote double standards and gender inequality, and which discriminate against sexual minorities including lesbian, gay and trans people.

A cascade model has been adopted for in-service training in both the Philippines and Thailand, as a means of maximising the number of trainers with limited human and financial resources (Smith et al., 2003) and reaching a large number of teachers in a short time (Schwille et al., 2007). However, this model of teacher training has been much-criticised for its limited success in changing teachers' practices and behaviour through an initial one-off "workshop" format, and the subsequent dependence on a small group of teachers to both understand and pass on new information to their colleagues (Schwille et al., 2007). Unsurprisingly, this approach frequently fails to address teachers' anxieties relating to HIV and sexuality education, or the material constraints within which teaching and learning take place. As indicated earlier, despite several decades' advance in Thailand, teaching about sex is still widely perceived as "indecent" by teachers, who are therefore "almost uniformly uncomfortable with discussions of sexuality" in schools (Smith et al., 2003, p. 17). Similarly, in-service training on HIV and sexuality education in the Philippines has not addressed anxieties and lack of understanding among many teachers (Smith et al., 2003, p. 17).

When HIV and sexuality education is implemented in schools, curricula are commonly taught using authoritarian and formally didactic teaching methods (Smith et al., 2003; UNESCO, 2007; Ross et al., 2006). These methods may be used to limit the discussion of "embarrassing" topics, and are also consistent with teaching methods adopted elsewhere on the school curriculum. This focus on simply providing information means that students are neither able to explore different values and attitudes, nor to gain practical skills which are relevant to their lived experiences (Ferguson et al., 2006). The combination of narrow curricula and didactic approaches to teaching are therefore further barriers to implementation.

A key issue affecting the implementation of HIV and sexuality education in schools is that of assessment. To date, there has been limited monitoring of the learning outcomes associated with these forms of education (UNESCO, 2012a). Indeed, little is known about the most appropriate assessment methods and how evidence from these might best be aggregated at a national level. Lack of focus on assessment when sex, sexuality and HIV are addressed within the school curriculum means that the status of knowledge about HIV and sexuality remains low status, compared with other more formally assessed subjects.

One final school-level factor that needs to be considered concerns sexual relationships between students and teachers. While well-documented across a variety of African

contexts (e.g. Leach et al., 2003; Dunne et al., 2006), rather less is known about such practices in schools in Asia. Leach and Sitaram (2007) suggest that, due to the strict policing of girls' behaviour after puberty in India, sexual relationships between girls and male teachers may be "extremely rare" (Leach and Sitaram, 2007, p. 270). However, Patel and Andrew's (2001) study with secondary school students in Goa, India found incidents of teachers sexually abusing students, while Choo et al. (2011) similarly report physical, emotional and sexual abuse by both male and female teachers in Malaysian secondary schools. The current lack of information means that it is unclear how widespread such practices are across the region. However, where these exploitative relationships do occur, young people are exposed to SRH risks. Additionally, the existence of such practices clearly undermines teachers' authority when delivering messages concerning responsible sexual practices within an HIV and sexuality education curriculum.

Conclusions

The four barriers to implementing HIV and sexuality education identified in this paper are strongly inter-related. Each needs to be addressed by national and local authorities, as well as by individual schools, if 100 per cent coverage of good quality HIV and sexuality education is to be implemented and sustained.

Limitations in resources may be to blame for the failure to scale up regionally, as there is evidence that individual programmes have been designed and initiated in almost all countries in the region. Resource shortcomings also impact on quality and are responsible for some of the school-level challenges. The scaling up of school-based HIV and sexuality education needs to be planned, costed and funded. This can be a cost-effective intervention with widespread societal benefits (UNESCO, 2011). Lack of resourcing indicates a lack of ownership of HIV education and political commitment towards young people's ability to transition to an AIDS-free society.

HIV and sexuality education programmes must of course be designed in the context of local values and beliefs. This has been identified as characteristic of effective curriculum-based HIV and sex education work. In developing contextually relevant approaches, there is value in national and local conversations about HIV and sexuality education to provide space for the voices of young people to articulate their perspectives. A consensus process could be initiated to determine what key stakeholders agree on with regard to approach and content.

Non-governmental organisations (NGOs) play a key role in the provision of HIV and sexuality education in many Asian countries (including India and Malaysia – Gabler, 2012; Hassan and Weiss, 2004). Although it is not within the scope of the current paper to explore their contribution in detail, NGOs working in this field can provide examples of best practice in HIV and sexuality education, particularly in terms of curriculum content and the use of creative strategies to overcome cultural barriers (Chowkhani, 2013; Gabler, 2012).

A key characteristic of effective HIV and sexuality education programmes is that they are implemented as designed (Kirby et al. , 2006). Fidelity in implementation can only be achieved in the presence of a strongly enabling environment, and such an environment is not yet in place in most countries in the region. More support is needed by Ministries of Education to ensure that they have detailed policies and costed strategies for implementing education about HIV and sexuality at a systemic level. These need to be disseminated throughout the educational system and accessible to all stakeholders.

School-level factors largely accrue from resource constraints: human, material and financial. However, the importance of teacher involvement cannot be overstressed. Teachers need to be treated as partners in HIV and sexuality education, and ways need to be found to enable them to deliver the curriculum effectively. This may mean new forms of initial and continuing education and support. It may also require a move beyond the generic forms of life-skills education that sometimes allow teachers to avoid teaching about sex, sexuality, drugs and relationships (Yankah and Aggleton, 2008), in favour of more explicit but contextually relevant approaches. Not all teachers may be up to this work, but the presence of credible curriculum champions within schools can help achieve positive goals (UNESCO, 2005).

Each of the cultural and contextual factors, policy factors, resource constraints and school-level factors outlined in this paper needs to be taken into consideration and addressed at national, local and individual levels in order to improve the provision of HIV and sexuality education across countries in Asia. While this is no small task, ongoing support by national and local education authorities, closer partnerships between Ministries of Education and Health, and the desire to engage honestly with rapid changes in society are all central to ensuring the development and implementation of good quality HIV and sexuality education.

Notes

1. Comprehensive sexuality education (CSE) has been described as “a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy” (SIECUS, 2004). The use of the term “comprehensive” indicates that this approach encompasses the full range of information skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality (IPPF, 2012). Thus, CSE addresses both abstinence and age-appropriate, medically accurate information about contraception. It also aims to be developmentally appropriate, introducing information on relationships, decision making, assertiveness, and skill building to resist social/peer pressure, depending on age/grade level (Advocates for Youth, 2013).
2. The 2001 Declaration of Commitment on HIV and AIDS resulted in the preparation

of core indicators to track the progress of countries. These included a specific indicator to assess progress towards the implementation of life skills-based HIV education in all schools: Indicator 11 – the percentage of schools that provided life skills-based HIV education in the last academic year. Unfortunately, this indicator was removed from the set of core indicators for reporting on the follow-up 2011 UN Political Declaration on HIV/AIDS (UNAIDS, 2013) and consequently, international data on the education response to HIV will be much harder to obtain.

3. UNGASS Indicator 13 measures knowledge about HIV based on responses to a set of five questions relating to HIV transmission and risk reduction (see Clarke and Aggleton, 2012, p. 12).
4. According to UNAIDS, 4.9 million people were living with HIV in South, South-East and East Asia in 2011 (UNAIDS, 2012b). Of this number, 500,000 people were 15-24 year olds (Cheetham et al., 2012). In total, 95 per cent of all new HIV infections in young people are from those in key affected populations – young people who buy and sell sex, young men who have sex with men, young transgender persons and adolescent drug users (UNAIDS, 2012c).

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