GIRLS, HIV/AIDS AND EDUCATION

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GIRLS, HIV/AIDS AND EDUCATION

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1 THE CHANGING FACE OF HIV/AIDS

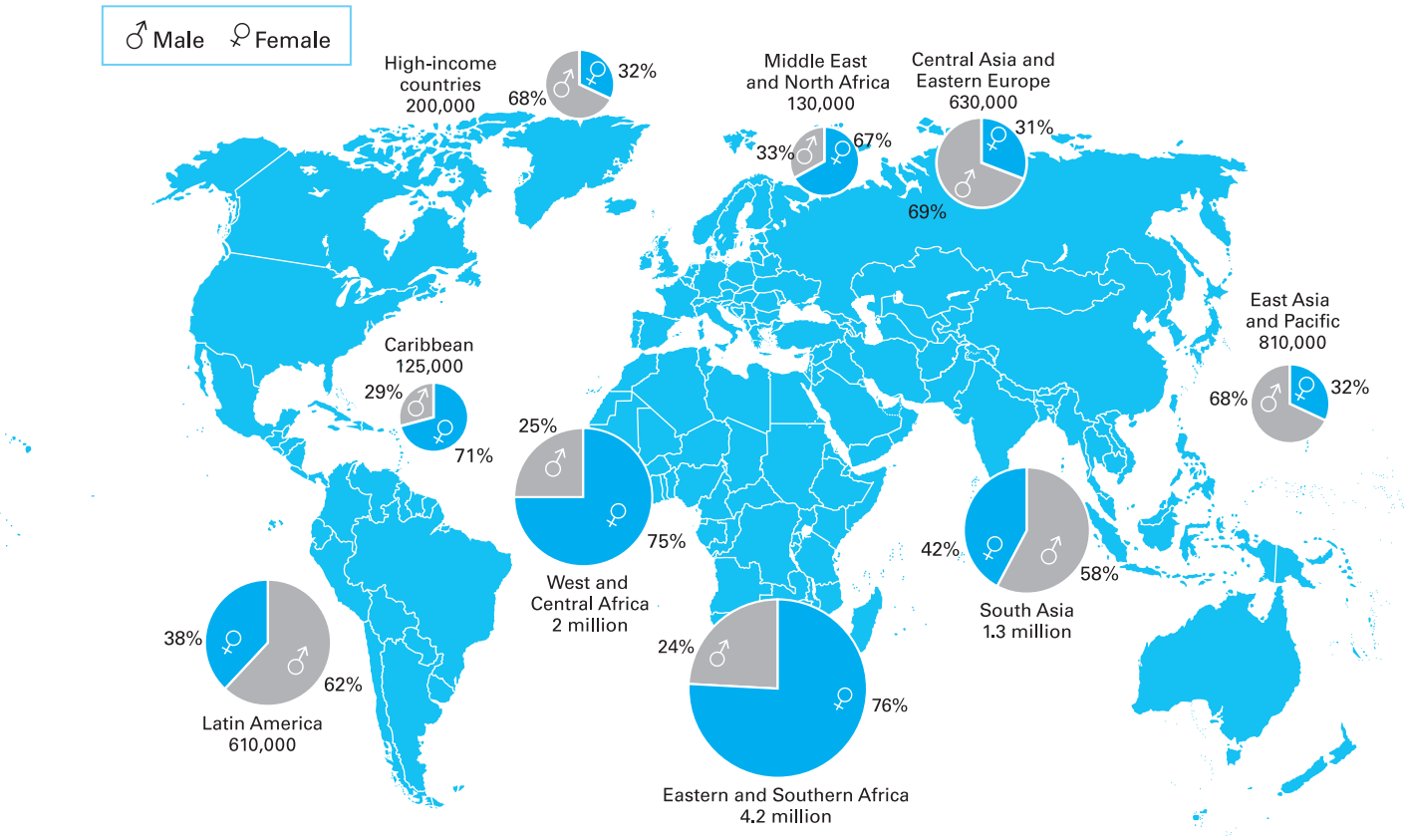
"Education is crucial to success against the pandemic. In fact, UNICEF remains convinced that until an effective remedy is found, education is one of the most effective tools for curbing HIV/AIDS."

Carol Bellamy
Executive Director
UNICEF

At the centre of an ever-strengthening HIV/AIDS storm, young people aged 15 to 24 now make up more than one quarter of the 38 million people living with the disease. More than half of the 5 million new infections in 2003 were among people under the age of 25. The majority of these new infections were among young women, who, for reasons typically beyond their control, are at greater risk of contracting HIV, and who, for reasons most fully explained by gender disparities, bear a disproportionate share of the HIV/AIDS burden.

While in Asia, Eastern Europe and Latin America, young men constitute the majority of young people who are HIV-positive, sixty-two per cent of the 15- to 24-year-olds living with HIV/AIDS globally are female (*see map below*). In sub-Saharan Africa, young women are three times more likely than young men to be living with HIV/AIDS. In parts of the region, more than one third of young women are known to be HIV-positive.

OVER 10 MILLION YOUNG PEOPLE (AGED 15-24) WERE LIVING WITH HIV/AIDS AT END-2003



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitations of any frontiers.

Dotted line represents approximately the line of control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Source: UNICEF/UNAIDS 2004.

But the pandemic's spread is not an irreversible force of nature that must be accepted and adjusted to. Based on recent analyses of nationally representative surveys in as many as 53 countries, it is now clear that education, particularly education for girls, has the potential to equip young people with the knowledge, attitudes and skills needed to reduce their risk. Data compared across countries and regions and disaggregated by education levels show that young women and men with higher levels of education are more likely to have increased knowledge about HIV/AIDS, a better understanding of ways to avoid infection, and an increased likelihood of changing behaviour that puts them at risk of contracting the disease.

Thus, it is clear that ensuring quality education for all children is one of the best ways to protect both the rights and the lives of young people threatened by HIV/AIDS.

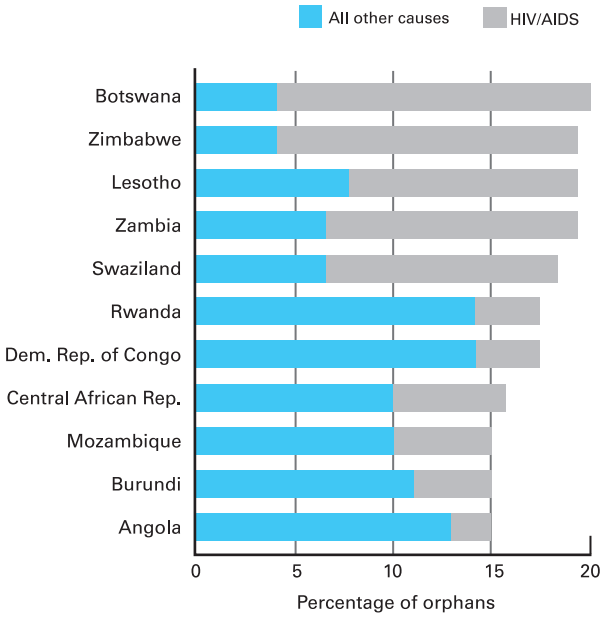
CHILDREN AFFECTED BY HIV/AIDS

Another aspect of the changing demographics of HIV/AIDS is the impact the pandemic is having on children. In addition to the more than 2 million children under 15 living with the virus, millions more, while not HIV-positive themselves, have been made vulnerable by the disease as their family members and other adults in their lives become ill. Children are frequently removed from school to take care of ailing family members, or forced to work in order to bring extra income into the household. Children whose family members are sick or dying are traumatized. They may often be left alone with their grief because of the isolation and stigma that can accompany HIV/AIDS.

The HIV/AIDS pandemic has created a generation of orphans. Globally, the number of orphans due to AIDS shot up from 11.5 million in 2001 to 15 million in 2003. HIV/AIDS is particularly catastrophic because it generally kills both parents. The rising numbers of children who have lost both parents are threatening traditional systems of care. While many grandparents or older siblings are assuming care of these children, other children often have no relatives to turn to, and may face hunger, poverty and discrimination.

Sub-Saharan Africa is home to an estimated 12.3 million children who have lost one or both parents to HIV/AIDS. In 11 of the 43 countries in the region, at least 15 per cent of children are orphans[1] (*see Figure 1 below*). In 5 of those 11 countries, HIV/AIDS is the cause of parental death more than 50 per cent of the time.[2] By 2010, more than 18 million children in the region will have lost one or both parents to the disease.[3]

FIGURE 1
IN 11 COUNTRIES IN SUB-SAHARAN AFRICA, AT LEAST 15% OF CHILDREN WERE ORPHANS IN 2003



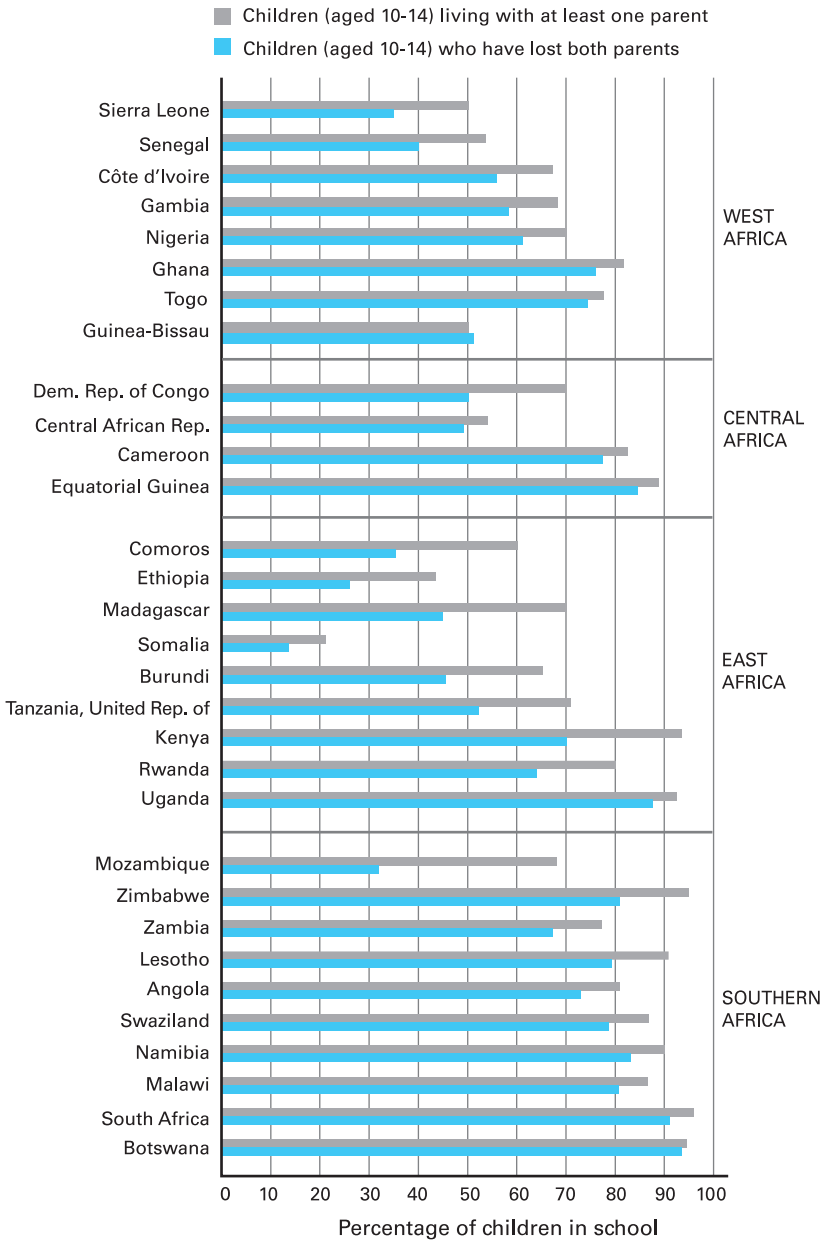
Source: UNAIDS, UNICEF and USAID, *Children on the Brink 2004*, July 2004.

Reduced parental care and protection, plus the inevitably increased economic hardship for these families, mean that vulnerable children – including orphans – may fail to receive an education. Their absence from school may prevent them from learning about HIV/AIDS and how to avoid infection. They may also be more susceptible to abuse and exploitation, which further increases their risk of contracting the disease.

Recent data from sub-Saharan Africa found that children aged 10 to 14 who had lost both of their parents were less likely to be in school than their peers who were living with at least one parent (*see Figure 2*). Studies in Kenya, the United Republic of Tanzania and Zambia found that even when orphans attended school, they were less likely than non-orphans to be at the correct grade level for their age group (*see Figure 3, page 4*).

The irony is that orphans are frequently deprived of quality education, which is the very thing they need to help protect themselves from HIV.

FIGURE 2
ORPHANS ARE LESS LIKELY TO ATTEND SCHOOL



Source: Demographic and Health Surveys, 1997–2001.

AN INTERNATIONAL COMMITMENT

In the face of these challenges, the international community has been active in developing strategies and seeking measures to combat HIV/AIDS. The Declaration of Commitment adopted by 189 governments during the UN General Assembly Special Session on HIV/AIDS in 2001 set prevention targets and benchmarks that must be met to reverse the pandemic by 2015 (*see Box 1, page 5*).

A key goal related to young people – whether they have access to the information and skills they need to reduce their risk of infection – is measured by assessing

how much knowledge young women and men have about HIV/AIDS. Of the 47 countries with data available for this indicator, none is likely to reach the first target of 90 per cent of 15- to 24-year-olds with comprehensive correct knowledge of HIV/AIDS by 2005. In most countries, those least equipped to deal with HIV are inevitably those with the lowest educational status (*see Figure 4, page 6*).

A RESPONSIBILITY FOR EDUCATORS

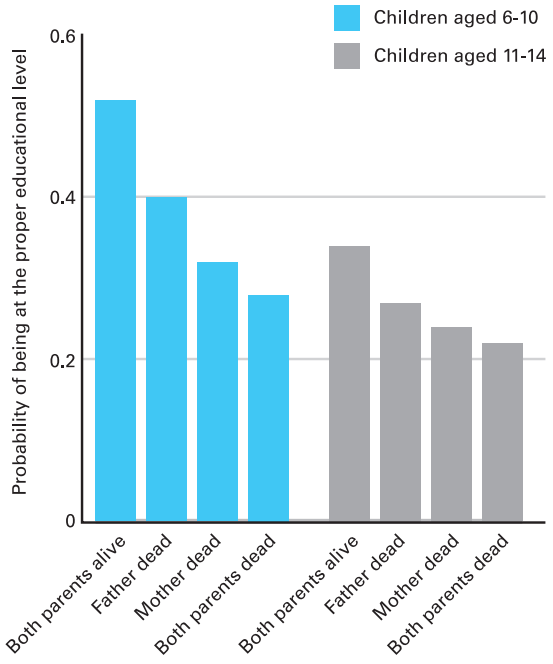
The data on the link between education level and HIV/AIDS underscore what people know intuitively – education is one of the best defences against HIV infection. To change the course of the pandemic, good-quality basic education and skills-based HIV/AIDS prevention education must be extended to girls and boys equally. Efforts that have been successful in ensuring girls their right to an education must be brought to scale.

Never before has quality education been such a powerful force for breaking the stranglehold of a deadly pandemic. Educators have an extraordinary opportunity – and a responsibility – to provide children and young people with a safe space to understand and cope in a world of HIV/AIDS. Eduction represents the best opportunity not only for delivering crucial information on HIV/AIDS, but also for chipping away at the ignorance and fear, the attitudes and practices that perpetuate infection. But education itself has been felled (*see Box 2, page 7*).

FIGURE 3

ORPHANS ARE LESS LIKELY TO BE AT THE PROPER EDUCATIONAL LEVEL

Probability of being at the proper educational level in Kenya, the United Republic of Tanzania and Zimbabwe, 1998 and 1999



Source: Bicego, G., S. Rutstein and K. Johnson, 'Dimensions of the emerging orphan crisis in sub-Saharan Africa', *Social Science & Medicine*, vol. 56, no. 6, March 2003, pp.1235-1247.

BOX 1

GLOBAL COMMITMENTS

Millennium Development Goals related to HIV/AIDS, education and girls (September 2000):

- Universal Primary Education. Ensure that by 2015 all boys and girls complete a full course of primary schooling.
- Promote gender equality and empower women. Eliminate gender disparity in primary and secondary education by 2005, and at all levels by 2015.
- Combat HIV/AIDS, malaria and other diseases. Halt and begin to reverse the spread of HIV/AIDS. Halt and begin to reverse the incidence of malaria and other major diseases.

Dakar Framework for Action related to girls' education (April 2000):

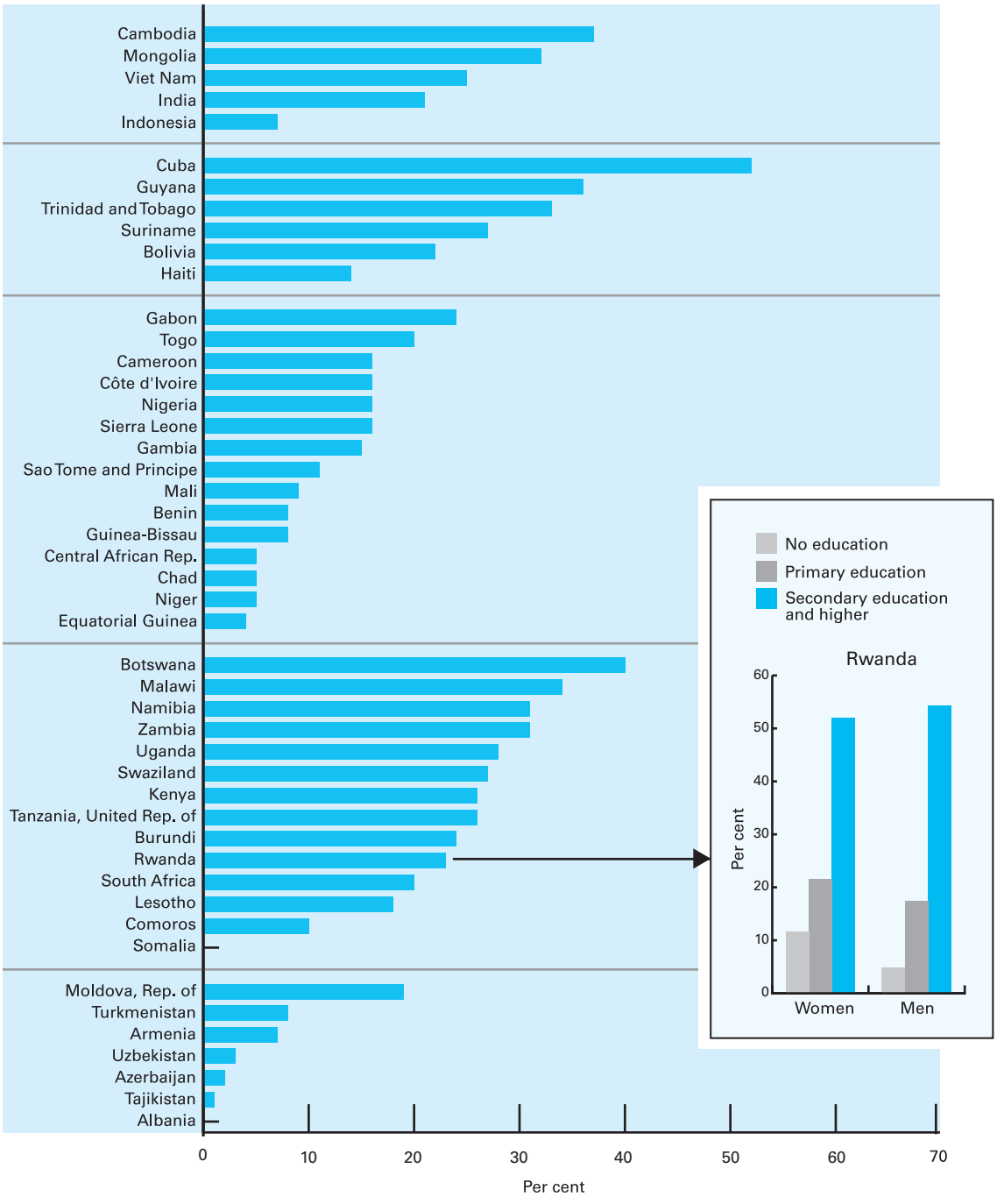
- Ensure that by 2015 all children – particularly girls, children in difficult circumstances and those belonging to ethnic minorities – have access to and complete free and compulsory primary education of good quality.
- Ensure that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.
- Eliminate gender disparities in primary and secondary education by 2005, and achieve gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.

United Nations General Assembly Special Session on HIV/AIDS, relevant targets (June 2001):

- Ensure that by 2005 at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education – including peer education and youth-specific HIV education – and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with youth, parents, families, educators and health-care providers.
- By 2003 develop, and by 2005 implement, national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans, and girls and boys infected and affected by HIV/AIDS, including providing appropriate counselling and psychosocial support; ensure their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

FIGURE 4

PERCENTAGE OF WOMEN (AGED 15-24) WHO HAVE COMPREHENSIVE AND CORRECT KNOWLEDGE OF HIV*



* Comprehensive and correct knowledge implies that they can identify two methods of avoiding HIV transmission (limiting sexual partners and using condoms) and know three common misconceptions about HIV transmission.

Sources: Multiple Indicator Cluster Surveys, Demographic and Health Surveys, and other nationally representative surveys, 1998–2003.

BOX 2

EDUCATION UNDER SIEGE

The HIV/AIDS pandemic has devastated the education sector in many countries, robbing schools of critical resources, both human and economic.

In countries hard-hit by HIV/AIDS, school availability has fallen precipitously. Substantial numbers of teachers are ill, dying or caring for family members. In the late 1990s, for instance, more than 100 schools were forced to close in the Central African Republic because of AIDS-related deaths. In 2000, AIDS was reported to be responsible for 85 per cent of the 300 teacher deaths there.[4]

The quality of education has also dropped in many regions. The illness and death of qualified personnel threaten management of the education system. Rural schools often lose staff because teachers affected by HIV flock to urban areas so that they or family members can be closer to hospitals and other health-care services. In Malawi, for example, the pupil-teacher ratio in some schools swelled to 96 to 1 as a result of AIDS-related illness.[5] Quality has been a casualty of overcrowded classes, limited resources, and untrained teachers and administrators.

The education sector must be strengthened in order to tackle these challenges and provide good-quality education for all children.

2 GIRLS AND WOMEN UNDER THREAT

"Why are women more vulnerable to infection? Why is that so, even where they are not the ones with the most sexual partners outside marriage, nor more likely than men to be injecting drug users? Usually, because society's inequalities put them at risk – unjust unconscionable risk."

Kofi A. Annan
Secretary-General
United Nations

Numbers alone do not tell the whole story of how HIV/AIDS spreads through a community. And access to education will not change the course of the pandemic if it neither empowers young girls nor ensures equal rights for each child.

Gender disparities are among the significant factors that place women at greater risk of contracting HIV and cause them to bear the greater burden of the disease. Gender imbalances make the risks and consequences of contracting HIV differ dramatically for girls and boys, and young women and men, as biological, social and economic factors weave together in a complex web – a web further reinforced by poverty.

With girls and women more likely to be poorer and less educated than men, they are more likely to be financially and socially dependent on men. This power imbalance reduces young women's choices as they negotiate their relationships with men, determine if and when to have sex, and even whether that sex is safe. In addition, poverty prevents poor women from receiving adequate health care and education – two essential elements for preventing HIV/AIDS.

AT GREATER RISK

The risk of becoming infected during unprotected sex is two to four times greater for women than for men.[6] For young girls, the risk can be even higher. An immature genital tract can easily tear during sexual activity, especially if it is forced or violent, raising the chances of exposure to infections.

In many societies, gender norms and expectations keep women uninformed about their bodies and sexual health. They are often denied health services, especially reproductive health care, which cuts them off from treatment and information about HIV risks. Additionally, cultural mores may encourage men to have many sexual partners. The result is that a man's partner remains at risk for contracting HIV even when she has been faithful to him.[7]

WITH MORE SERIOUS CONSEQUENCES

Power imbalances are the cornerstone of violence against girls and women, furthering the impact of HIV/AIDS in their lives. Young women are often not safe, even in their own homes. The extent of familial violence, particularly sexual abuse, is difficult to quantify. A conspiracy of silence allows physical and sexual abuse of girls and young women to remain behind closed doors. It is estimated that globally 40 million children are abused each year.[8] For the most part, they remain hidden.

Inside and outside the home, girls and women face discrimination and danger. A large, national survey of secondary schoolgirls in Kenya found that 40 per cent of those reporting sexual activity indicated that their first sexual experience was forced or that they were "cheated into having sex."[9] In some regions, HIV-infected men coerce young girls into having sex with them because they mistakenly believe that having sex with a virgin cures AIDS.

Powerlessness and inequality make a woman less likely to know how to protect herself from infection and, if she does know, less likely to demand condom use or seek reproductive health services. A Botswana study in 12 schools in four districts found that 48 per cent of sexually active young women had never used a condom during intercourse.[10]

GENDER-BASED VIOLENCE IN SCHOOLS

Education is an important tool in the fight against HIV/AIDS. And while most schools are welcoming to children, some schools fail to provide the necessary protection for children to flourish and, in fact, may expose young people – especially girls – to violence.

School cultures can contribute to gender violence. Often, gender stereotypes and inequities abound in the classroom, where different behaviours and roles are expected from girls and boys. Gender-based school violence takes many forms. Sexual harassment, aggressive or unsolicited sexual advances, touching, groping, intimidation, verbal abuse or sexual assaults are explicit forms of gender violence that can permeate school environments.

Schools that are not safe or that promote gender disparity breed the inequality that lasts a lifetime. HIV/AIDS-prevention education is undermined in these hostile environments because the curriculum teaches one thing and the atmosphere models the opposite.

In an educational setting in Ecuador, 22 per cent of adolescent girls reported being sexually abused at school.[11] A Human Rights Watch study of violence in eight South African schools in KwaZulu-Natal, Gauteng and the Western Cape found that sexual abuse and harassment of girls by both teachers and other students were rampant in many schools. Girls were raped in school lavatories, dormitories and empty classrooms.[12]

Perpetrators of gender-based school violence are generally older male classmates, but teachers are also offenders. A 2003 study in Dodowa, Ghana, found that teachers were responsible for 5 per cent of these assaults on students. Additionally, one third of the 50 teachers interviewed said that they knew of at least one teacher who had sex with students.[13]

Efforts are being made to counter gender-based school violence. For example, the Study on Violence Against Children commissioned by the United Nations Secretary-General will build upon what is already known about this phenomenon and identify interventions to end this threat to young people. The study is looking at all institutions that can effect change, particularly schools and other educational settings.[14]

AN EDUCATION TO TRANSFORM GENDER RELATIONSHIPS

Education can either reproduce social imbalances and inequities, or transform societies.

If the HIV/AIDS pandemic is to be halted, the international community must, for a start, deliver on the promise of universal education. But it must go further than the imperative of equal access to education and ensure equal quality in the process, content and experience of education.

While access to, and the availability of, life skills classes are important to stopping the spread of HIV/AIDS, so too is a school environment that is child-friendly, models equality and fairness, and protects the rights of all children equally (*see Box 3, page 11 and Chapter 4, page 18*).

If the course of the pandemic is to change, young people must receive good-quality education in a safe and secure environment – one that includes linkages to schools and community services. All these ingredients will help young people gain knowledge, learn skills, change attitudes and ultimately acquire behaviours that will protect them from infection.

And in turn, the benefits of education will spread beyond the school walls to undo the social disparities that would otherwise continue to leave young women at risk of HIV/AIDS.

BOX 3

A CHILD-FRIENDLY SCHOOL

- Is gender-sensitive for both girls and boys
- Protects children; there is no corporal punishment, no child labour and no physical, sexual or mental harassment
- Involves children in active and participatory learning
- Involves all children, families and communities; it is particularly sensitive to and protective of the most vulnerable children
- Is healthy; has safe water and adequate sanitation, with separate toilet facilities for girls and boys
- Teaches children about life skills and HIV/AIDS

THE POWER OF GIRLS' EDUCATION

"Study after study has taught us that there is no tool for development more effective than the education of girls. No other policy is as likely to raise economic productivity, lower infant and maternal mortality, or improve nutrition and promote health – including the prevention of HIV/AIDS."

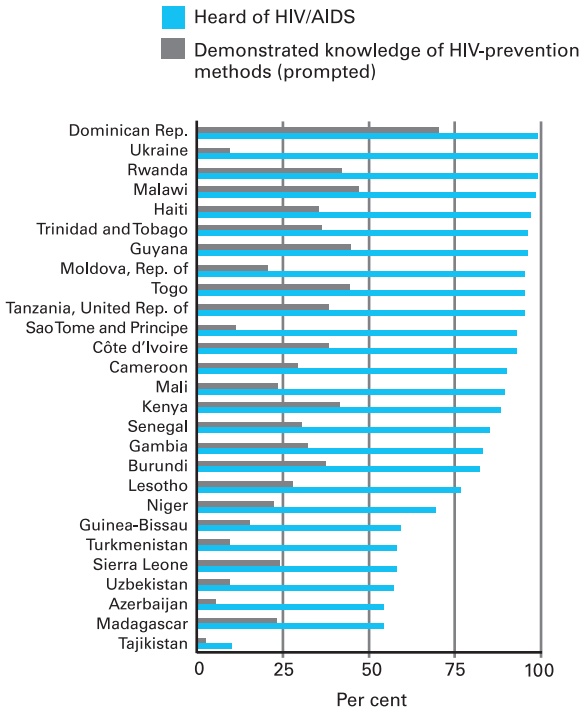
Kofi A. Annan
Secretary-General
United Nations

GAINING KNOWLEDGE

The underlying principle of HIV/AIDS prevention education is that all people have the right to know what HIV is, how it is transmitted and how to prevent infection, and that special measures must be taken for those most vulnerable and most likely to effect change – among young people, girls especially.

The majority of young people in the developing world know alarmingly little about the three primary ways to avoid infection. Although many women had heard of AIDS, fewer than half of the young women surveyed in 26 of 27 countries could identify the ABCs of prevention: Abstinence, Being faithful, and using Condoms correctly and consistently (*see Figure 5, below*).

FIGURE 5
YOUNG WOMEN (AGED 15-24) WHO HAVE HEARD OF HIV/AIDS AND KNOW THREE WAYS OF PREVENTING HIV INFECTION*

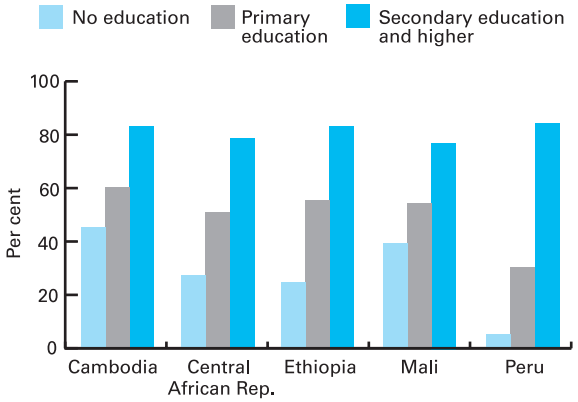


*The ABCs of prevention.

Sources: Demographic and Health Surveys, and other nationally representative surveys, 2000–2002.

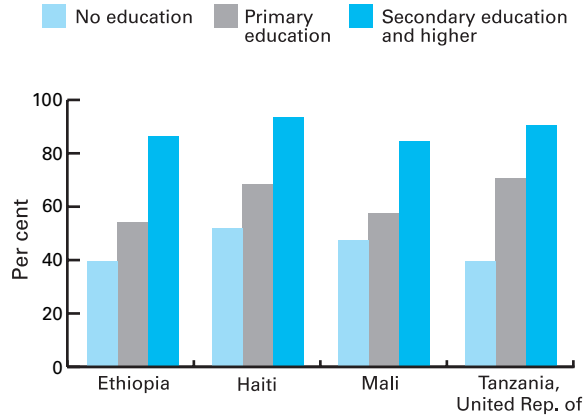
Newly analysed data make a direct link between education and sound knowledge of HIV. In Ethiopia, more than four out of five educated young women aged 15 to 24 knew that a healthy-looking person could be HIV-positive, compared with less than a quarter of women with no education (*see Figures 6 and 7 below*). Educated young women were also more likely to know where to go to be tested for HIV (*see Figure 8, page 14*).

FIGURE 6
YOUNG WOMEN (AGED 15-24) WHO KNOW A HEALTHY-LOOKING PERSON CAN TRANSMIT HIV



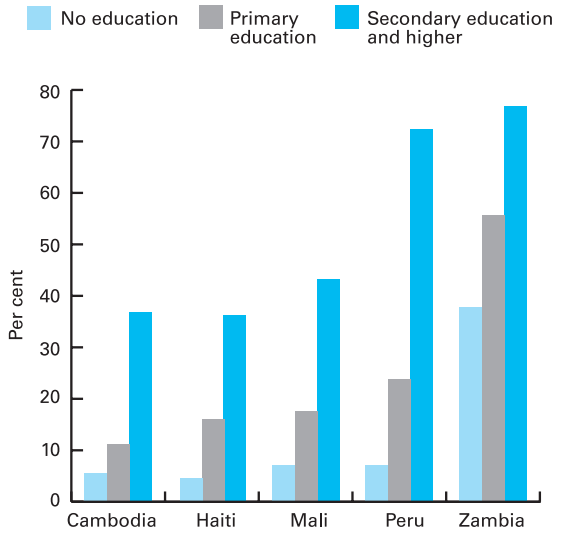
Sources: Multiple Indicator Cluster Surveys, and Demographic and Health Surveys, 2000–2001.

FIGURE 7
YOUNG MEN (AGED 15-24) WHO KNOW A HEALTHY-LOOKING PERSON CAN TRANSMIT HIV



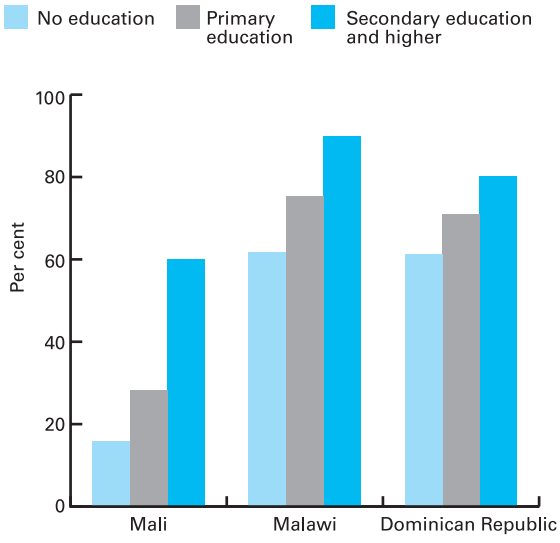
Source: Demographic and Health Surveys, 1999–2001.

FIGURE 8
YOUNG WOMEN (AGED 15-24) WHO KNOW WHERE TO BE TESTED FOR HIV



Source: Demographic and Health Surveys, 2000–2002.

FIGURE 9
MARRIED WOMEN (AGED 15-49) WHO REPORT DISCUSSING HIV/AIDS WITH THEIR PARTNER



Source: Demographic and Health Surveys, 2000–2002.

LEARNING SKILLS AND CHANGING ATTITUDES

School-based HIV/AIDS education must not be an optional add-on. It needs to be part of comprehensive skills-based health education programmes and included in the mainstream curriculum. At the very least, young people need to learn what HIV is, how it is transmitted, and how to avoid infection.

But knowledge alone is insufficient. Effective education programmes also promote critical thinking, decision-making, communication and interpersonal skills, all of which support the adoption of healthy behaviours and the reduction of high-risk behaviours.

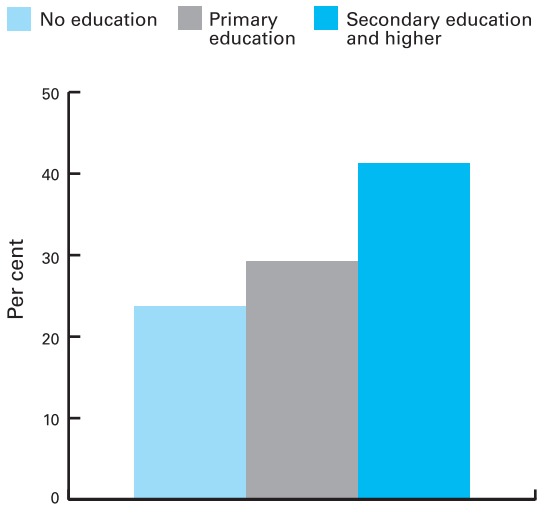
HIV/AIDS prevention is not only about individual risk reduction, but about tackling broader issues that also feed the spread of infection. Life skills-based education is interactive, allowing young people to analyse beliefs about culture and society. Discussions about gender roles, rights and responsibilities, discrimination, power relations and social stigma help them set and protect their personal boundaries, as well as negotiate relationships. These subjective discussions are as important as the objective presentation of facts.

Surveys show that educated married women are more likely to discuss HIV/AIDS with their husband and to know they have the right to refuse to have sex with him (*see Figure 9 at left and Figure10, page 15*).[15]

Demographic and Health Surveys in 15 countries also showed that more educated women were more likely to seek treatment for sexually transmitted infections.[16] These are linked to increased susceptibility to HIV, but early detection and treatment substantially reduce the risk of infection.

FIGURE 10

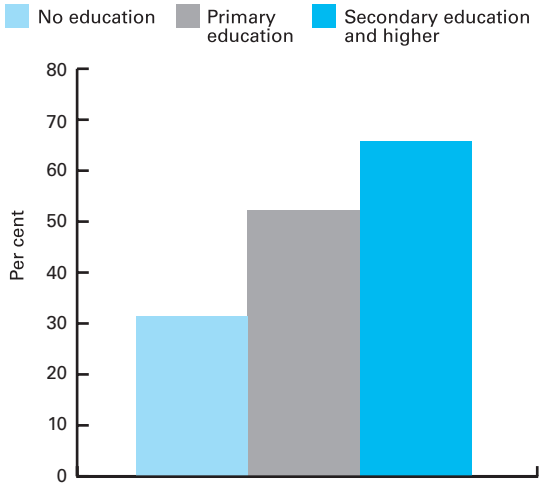
WOMEN (AGED 15-49) IN ZIMBABWE WHO BELIEVE A WIFE IS JUSTIFIED IN REFUSING TO HAVE SEX WITH HER HUSBAND



Source: Demographic and Health Survey, 1999.

FIGURE 11

WOMEN (AGED 15-49) IN CAMBODIA WHO SOUGHT TREATMENT FOR A SELF-REPORTED SEXUALLY TRANSMITTED INFECTION



Source: Demographic and Health Survey, 2000.

In Cambodia, for instance, less than one third of women with no education went for treatment, as opposed to two thirds of women with at least a secondary education (*see Figure 11 below left*).

NEW BEHAVIOURS

Girls and boys in most parts of the world begin sexual activity during adolescence, with a significant proportion reporting their first sexual experience before age 15. In 24 of 43 countries with national surveys, over 10 per cent of girls aged 15 to 19 reported having sex before age 15.[17]

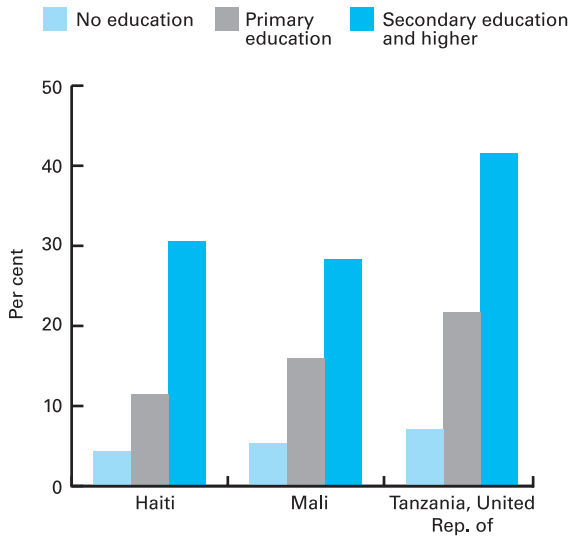
There is strong evidence that delaying sexual initiation is crucial in reducing HIV/AIDS infection. Education plays a role in delaying sex for young women. In a recent analysis of eight sub-Saharan countries, women with eight or more years of schooling were 47 to 87 per cent less likely to have sex before the age of 18 than women with no schooling.[18]

There is also evidence that education improves a young woman's choices regarding the use of condoms or abstaining from high-risk sex. Surveys in 22 countries showed a link between higher education levels and more condom use during high-risk sex (*see Figures 12 and 13, page 16 and Tables 7 and 8, page 31*) while surveys in Haiti, Malawi, Uganda and Zambia linked higher education to fewer sexual partners.[19]

The links between higher education levels and less risky behaviours is strikingly consistent across the regions described here.

FIGURE 12

YOUNG WOMEN (AGED 15-24) WHO USED A CONDOM AT LAST HIGH-RISK SEX*

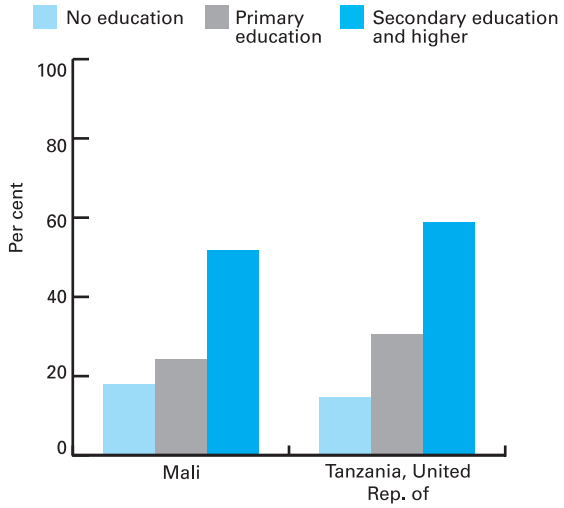


* High-risk sex is defined as sex with a non-marital, non-cohabiting partner.

Source: Demographic and Health Surveys, 1999–2001.

FIGURE 13

YOUNG MEN (AGED 15-24) WHO USED A CONDOM AT LAST HIGH-RISK SEX*



* High-risk sex is defined as sex with a non-marital, non-cohabiting partner.

Source: Demographic and Health Surveys, 1999–2001.

THE POTENTIAL TO STOP THE PANDEMIC

Quality education empowers individuals by providing them with knowledge and skills to make informed decisions and adopt behaviours that reduce their risk of HIV infection. Accurate information about sexuality, reproductive health and HIV/AIDS, along with life skills and links to services, are integral components of a quality education.

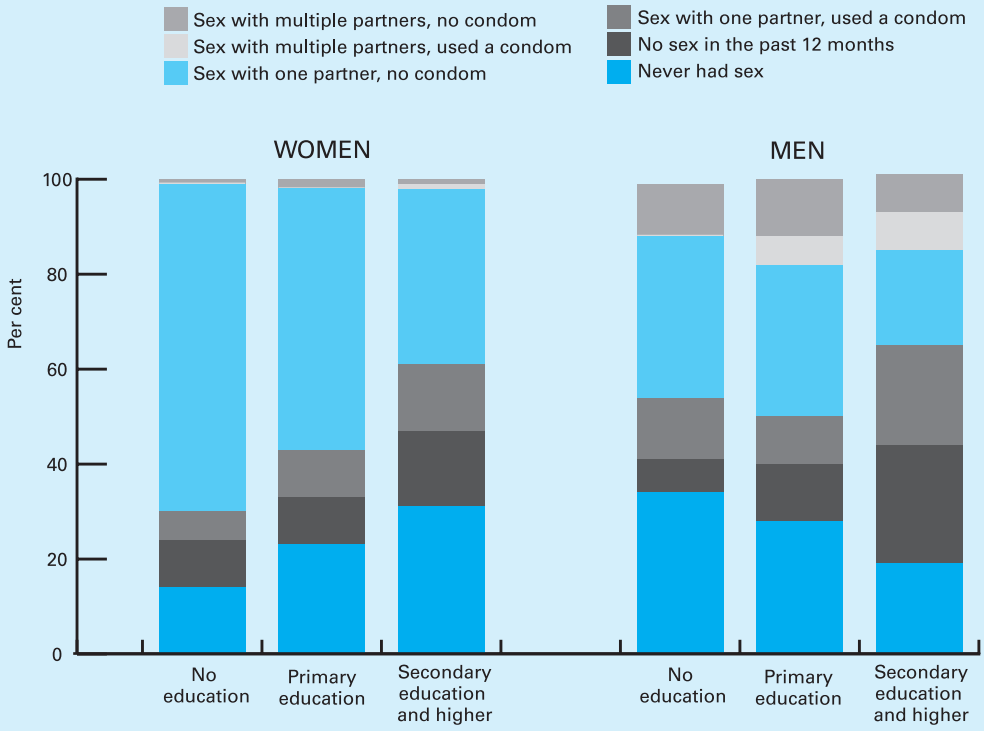
The potential of quality education will not be reached unless it is extended to both girls and boys. In fact, the spread of HIV/AIDS will not be stopped unless the human rights of women and girls are at the centre of the response.[20]

BOX 4

SEXUAL BEHAVIOUR VARIES BY EDUCATIONAL LEVEL

The graph below presents the most risky behaviour at the top of each bar, and the least risky behaviour at the bottom. Women with secondary and higher education are more likely to delay sex, while those with no education are more likely to have sex with one partner without a condom. However, the picture is less straightforward for men. Men with no education are more likely to abstain, while more educated young men are more likely to use condoms with their partners.

SEXUAL BEHAVIOUR AMONG WOMEN AND MEN (AGED 15-24) IN ZAMBIA



Source: Demographic and Health Survey, 2001.

CALL TO ACTION

"Besides explanations of what the disease is and how it's transmitted, it is also important to challenge harmful concepts of masculinity, including the way adult men look on risk and sexuality and how boys are socialized to become men. At the same time, young women must be educated to recognize their vulnerability to infection, their responsibility to protect themselves, and their right to insist upon protection in sexual relationships."

Dr. Peter Piot
Executive Director
UNAIDS

Education, particularly for girls, is fundamental to reversing the spread of HIV/AIDS. Educated young women and men are more likely to know what HIV is, and how to avoid infection, because they are more likely to have the attitudes and skills that enable them to resist pressure and to take responsibility for their own lives. They are more likely to utilize their knowledge and skills to make healthy choices, including protecting themselves from HIV.

Three strategic priorities support schools in playing an optimal role in protecting girls and mitigating the impact of HIV/AIDS.

- **Get and keep girls in school**

Far too many children – especially girls – are out of school. In countries hard hit by HIV/AIDS, school enrolment has plummeted. In sub-Saharan Africa, for instance, 40 per cent of boys and 44 per cent of girls are out of school. In South Asia, 22 per cent of boys and 29 per cent of girls are not in school.[21] Efforts to get girls into the classroom bring boys in as well.

- **Provide life skills-based education**

Education must enable young people to develop the life skills they need to survive and thrive in their local contexts. Life skills-based education teaches critical thinking, problem-solving, self-management and interpersonal skills that allow young people to acquire knowledge and attitudes that support the adoption of healthy behaviours. This is particularly important in the prevention of HIV/AIDS.

- **Protect girls from gender-based school violence**

Environments in and around schools should be safe and healthy. Schools that offer an attractive and secure environment encourage children to attend, as well as reassure parents that their daughters and sons are safe.

NATIONAL POLICIES AND STRATEGIES

National governments should implement and monitor their national Education for All plans of action to ensure that girls' education is a priority. Along with the international community, governments can mobilize resources and build capacity for quality education, teacher recruitment and training, curriculum development and review, and HIV/AIDS-prevention education.

The crisis in girls' education and the urgency to halt the spread of HIV/AIDS requires action by a variety of ministries, not just the education ministry. Safe water and adequate sanitation are as crucial to getting and keeping girls in school as are desks, books and pencils. Linking schools to health services, including reproductive health and HIV/AIDS testing, improves the quality of education and benefits overall community health.

INTERNATIONAL INITIATIVES

International donors, such as the World Bank, are investing in strategies that get and keep girls in school (*see Box 5, page 21*). Organizations like UNICEF and UNESCO are advocating for the political will to improve girls' school enrolment and are providing technical assistance to jump-start girls' education in countries that are in grave danger of failing to meet Education for All goals (*see Box 6, page 23*).

ABOLITION OF SCHOOL FEES

Education should be free and compulsory as school fees often pose insurmountable blocks to children receiving an education. When poor families are forced to make difficult choices about household expenditures, school is often the first thing dropped, and daughters are often the first casualties. National education plans should work towards ending school fees and other hidden costs as part of well-planned educational reform strategies. By taking this step, countries will move closer to meeting the Millennium Development Goal of universal education, as well as parity in school attendance between orphans and non-orphans.

Countries that have eliminated school fees, such as Kenya and Uganda, have witnessed skyrocketing school attendance. A rapid growth in enrolment can cause its own problems, however, such as overflowing classrooms. To maintain the quality of education in the face of surging enrolment, countries must plan ahead. Uganda, for instance, first rallied support from agencies and donor countries that worked cooperatively within a single education programme led by the government.

TARGETED FINANCIAL MECHANISMS

Even when schools are free, poor children may be forced to leave in order to work. Children may need to provide extra household income or care for younger siblings so that both parents can work outside the home. Conditional cash transfers have been used as effective incentives for parents to enrol their children in school in Latin America. Families receive money on the condition that their children attend school and go to health-care appointments (*see Box 7, page 25*). In addition, grants can go directly to teachers and to schools. In Nicaragua, teachers receive a small bonus for each child in the school, and half of the available funds is earmarked for supplies. In Honduras, grants go directly to the school.

A study of these initiatives in Latin America and the Caribbean found that school enrolment rose and preventive health care improved.[22]

SCHOOL FOOD AND NUTRITION PROGRAMMES

Food is the greatest need for many families affected by HIV.[23] Children may be removed from school to search for food. School food and nutrition programmes can reduce the burden on HIV-affected families and free girls to pursue their education. Providing food draws children, alleviates short-term hunger, provides essential micronutrients, and fosters community involvement. School nutrition programmes are also linked to increased attendance and better performance. Food may be served to the students at school, or rations may

BOX 5

INTERNATIONAL INITIATIVES TO IMPROVE GIRLS' EDUCATION

Fast-Track Initiative: The Education for All Fast-Track Initiative is an evolving global partnership of developing and donor countries and agencies to support the global Education for All goals and the Millennium Development Goals. It focuses on accelerating progress towards universal primary school completion for boys and girls by 2015.

United Nations Girls' Education Initiative: The UN Secretary-General launched the United Nations Girls' Education Initiative to improve the quality and availability of girls' education at the global, regional and country levels.

Global Coalition on Women and AIDS: This initiative, made up of activists, government representatives, community workers and celebrities, seeks to generate concrete action on the ground to improve the daily lives of women and girls, including efforts to prevent new HIV infections, promote equal access to HIV/AIDS care and treatment, accelerate research, protect women's property and inheritance rights, reduce violence against women and improve girls' education.

UNICEF and its partners are taking measures to ensure that the special needs of girls and young women, orphans and others made vulnerable by HIV/AIDS are being addressed.

be given directly to families if they send their children to school. The World Food Programme found that in some places when families received food rations for sending their daughters to school, girls' enrolment tripled.[24]

CHILD-FRIENDLY, HEALTH-PROMOTING SCHOOLS

A child-friendly school reaches out to all children, making a particular effort to enrol girls, children orphaned by HIV/AIDS and other excluded groups. It is a dynamic place for students and staff, and works to ameliorate conditions that hinder children's opportunities to succeed. Schools should nurture both mind and body. In a child-friendly school, health, nutrition, hygiene and family involvement are as much a part of its fabric as reading, writing and arithmetic.

Focusing Resources on Effective School Health (FRESH) is a model for getting and keeping girls in school and improving the well-being of the community. FRESH helps create child-friendly environments in even the most resource-poor schools. This approach has four components: health-related policies that ensure children are safe and protected from abuse, sexual harassment, school violence, bullying and corporal punishment; safe water and sanitation; school-based health and nutrition services; and skills-based health education (*see Box 8, page 25*).

EXTENDING THE REACH OF SCHOOLS

Schools must fit students, not the other way around. Flexible class schedules can reach young people who may miss school because they are caring for ill family members or are working to supplement household income. Flexible schooling can reach young people who have dropped out of traditional schools. BRAC (formerly the Bangladesh Rural Advancement Committee) schools in Bangladesh are successful in increasing girls' enrolment. Classes are scheduled in two-hour blocks that meet six days a week. The specific time of classes and the school calendar are determined locally to meet family and community needs.[25]

QUALITY LIFE SKILLS-BASED EDUCATION

Skills-based HIV/AIDS education fosters behaviour that reduces the risk of HIV infection, and tackles broader social and environmental factors that make people vulnerable. Analysing customs and gender roles, questioning myths and stereotypes, learning to make life-affirming decisions and working cooperatively, as well as receiving accurate, complete information, are powerful tools in the fight against HIV/AIDS.

Life skills-based education must start early, be age-appropriate, sequential, interactive, child-centred and relevant to students and their community. It can fit into formal schools, non-formal classes, peer education and community-based programmes – almost any place where children meet. It requires personnel who are trained in student-centred teaching methods that engender trust, open communication and respect.

A study of the effectiveness of a life skills curriculum in KwaZulu-Natal Province in South Africa found that young people exposed to life skills education were more likely to use condoms than those who were not. In fact, the more years they were involved in life skills education, the higher the rate of condom use.[26]

BOX 6

STRATEGY FOR GENDER PARITY IN EDUCATION: '25 BY 2005'

The Millennium Development Goal of gender parity in education is set to be realized in 2005. Efforts to meet this deadline have faltered under the weight of tremendous obstacles, including HIV/AIDS.

UNICEF launched the '25 by 2005' campaign to help all countries eliminate gender disparity in education. The initiative focuses on 25 countries judged to be in grave danger of failing to achieve this goal. Among those selected, nine countries, Central African Republic, Djibouti, Ethiopia, India, Malawi, Nigeria, Papua New Guinea, the United Republic of Tanzania and Zambia, have pronounced gender gaps in education and have been especially affected by the HIV/AIDS pandemic.

The '25 by 2005' initiative identifies and develops practical measures to get and keep girls – and boys – in school. These interventions include operating double shifts, using multigrade teaching in small rural schools, holding classes in tents or under trees, providing mobile schools to reach transient or nomadic groups, expanding non-formal education schemes – whatever it takes to ensure that children stake their claim to an education.

Better educated people have lower rates of HIV infection. The '25 by 2005' campaign, designed to end gender disparity in education, has emerged as a key strategy in the fight against HIV/AIDS.

ENSURING SAFE ENVIRONMENTS IN AND AROUND SCHOOLS

School-related gender-based violence remains an obstacle to girls' education. Efforts to address school safety are needed at all levels, including teacher training, community intervention and ministerial policy and practice. Ministries of Education can send a clear message that gender-based school violence will not be tolerated by firmly and quickly prosecuting perpetrators. Teacher training should include strong messages about professional and ethical conduct. The use of outside experts, such as police, social welfare and non-governmental organizations, can clarify what constitutes abuse and suggest ways to stop it. Schools should initiate student representation and participation in order to have their voices heard.

Teachers should listen to both girls and boys and engage them in constructive dialogue. Participatory approaches – such as drama, media, art, poetry and storytelling – can encourage young people to rethink gender roles, behaviours and expectations. The use of peer educators or counsellors who model appropriate behaviour is also helpful to ensure safe schools. Additionally, boys and men must be seen as part of the solution, not the problem, and be included in gender-equality and conflict-resolution initiatives.

CLASSROOM DOORS SWING OPEN

The long-term, broad and complex nature of the HIV/AIDS crisis demands an accelerated, innovative and flexible response grounded in the provision of safe, quality education for all children, especially for girls.

Governments, international agencies, non-governmental organizations, community groups and, most importantly, educators, must recognize that they have a vital role to play in reversing the course of the pandemic.

Young people are at the heart of the HIV/AIDS pandemic. The world's success in fighting HIV/AIDS ultimately hinges on how well we have equipped them with the skills and information they need.

BOX 7

MEXICO'S CHILDREN HAVE NEW OPPORTUNITIES

In 1995, one fifth of Mexico's population could not afford the minimum daily nutritional requirements. Some 10 million people lacked even the most basic health care, and more than 1.5 million children were out of school. In 1997, the education, health and nutrition programme, Progresa, initiated conditional cash transfers for poor families. They received monthly stipends if their children attended school and family members visited health clinics regularly for nutrition and hygiene education and check-ups.

Rigorous evaluations deemed the programme an overwhelming success. President Vincente Fox embraced the initiative, renaming it Oportunidades. In 2003, the programme reached 4.2 million families. Almost 60 per cent of cash transfers go to households in the poorest 20 per cent of the population. Benefits increase for girls in middle school to encourage their enrolment. Since the initiative's inception, girls' enrolment has jumped from 67 per cent to 75 per cent, and boys' enrolment has risen from 73 per cent to 78 per cent. A subsequent by-product of the programme has been a reduction in child labour.

BOX 8

A HEALTH-PROMOTING SCHOOL

- Fosters health and learning with all the measures at its disposal
- Engages health and education officials, teachers, students, parents and community leaders in efforts to promote health
- Strives to provide a healthy environment, school health education and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion
- Implements policies, practices and other measures that respect an individual's self-esteem, provide multiple opportunities for success and acknowledge good efforts and intentions as well as personal achievements
- Strives to improve the health of school personnel, families and community members as well as students, and works with community leaders to help them understand how the community contributes to health and education.

Source: *Preventing HIV/AIDS/STI and Related Discrimination: An important responsibility of health-promoting schools*, World Health Organization Information Series on School Health, Document Six, WHO, Geneva, 1999.

TABLES

TABLE 1 YOUNG WOMEN (AGED 15-24) WHO HAVE COMPREHENSIVE AND CORRECT KNOWLEDGE OF HIV, BY EDUCATIONAL LEVEL*

Millennium Development Indicator 19b

	No education	Primary education	Secondary education and higher	Total	Year/Source	
Albania	-	0.0	0.4	0.2	2000	MICS
Angola	5.1	11.3	33.5	12.6	2000	MICS
Armenia	-	-	6.6	6.6	2000	DHS
Azerbaijan	-	0.6	2.7	2.1	2000	MICS
Benin	3.2	6.6	26.7	8.4	2001	DHS
Botswana	13.1	15.2	31.2	28.0	2000	MICS
Cambodia	22.0	32.7	61.8	37.1	2000	DHS
Cameroon	5.3	8.3	29.6	16.1	2000	MICS
Central African Republic	1.5	4.6	14.2	5.1	2000	MICS
Chad	3.7	3.8	18.1	5.0	2000	MICS
Comoros	6.6	8.0	17.3	10.0	2000	MICS
Dominican Republic	-	23.3	43.1	34.2	2000	MICS
Gabon	2.5	12.5	31.4	23.9	2000	DHS
Gambia	9.0	17.1	29.9	15.4	2000	MICS
Guinea-Bissau	2.8	14.3	21.9	8.4	2000	MICS
Guyana	32.4	19.8	37.2	35.5	2000	MICS
Haiti	1.3	7.9	25.9	14.2	2000	DHS
Kenya	21.0	23.1	38.7	26.4	2000	MICS
Lesotho	16.3	17.3	34.7	17.6	2000	MICS
Malawi	23.4	31.9	53.4	34.2	2000	DHS
Mali	5.0	13.1	31.0	9.1	2001	DHS
Moldova, Republic of	-	14.6	23.0	19.0	2000	MICS
Nicaragua	4.1	7.9	28.7	18.7	2001	DHS
Niger	2.1	7.8	31.1	4.9	2000	MICS
Rwanda	11.7	21.6	52.1	23.4	2000	DHS
Senegal	6.4	15.0	38.6	13.0	2000	MICS
Sierra Leone	12.2	15.9	27.2	15.7	2000	MICS
South Africa	14.0	9.7	22.2	20.0	1998	DHS
Suriname	-	10.0	36.2	26.8	2000	MICS
Swaziland	21.3	21.1	31.6	27.0	2000	MICS
Tajikistan	-	0.0	1.0	1.0	2000	MICS
Tanzania, United Republic of	9.6	27.6	51.8	25.5	1999	DHS
Togo	14.3	14.5	39.0	20.3	2000	MICS
Uganda	9.8	23.4	51.9	28.5	2000	DHS
Uzbekistan	-	0.0	3.4	3.4	2000	MICS
Venezuela	2.3	3.0	11.2	9.6	2000	MICS
Viet Nam	1.1	9.4	32.5	25.4	2000	MICS
Zambia	10.4	22.3	50.4	30.8	2002	DHS

TABLE 2 YOUNG MEN (AGED 15-24) WHO HAVE COMPREHENSIVE AND CORRECT KNOWLEDGE OF HIV, BY EDUCATIONAL LEVEL*

Millennium Development Indicator 19b

	No education	Primary education	Secondary education and higher	Total	Year/Source	
Armenia	-	-	7.8	7.7	2000	DHS
Benin	5.9	7.7	25.7	14.2	2001	DHS
Gabon	-	10.3	27.1	22.1	2000	DHS
Haiti	1.8	12.0	42.1	24.3	2000	DHS
Malawi	19.5	37.6	55.1	40.6	2000	DHS
Mali	4.8	13.6	37.7	14.9	2001	DHS
Rwanda	4.9	17.4	54.3	20.0	2000	DHS
Tanzania, United Republic of	9.4	29.6	60.7	29.1	1999	DHS
Uganda	-	31.5	63.3	40.4	2000	DHS
Zambia	-	17.7	54.6	32.5	2002	DHS

– Less than 25 cases, estimate was suppressed

* Prevention methods include condom use and remaining faithful to one partner. Misconceptions included that a healthy-looking person cannot have HIV, and that HIV is transmitted by mosquitoes, sharing food, or witchcraft.

N.B. The notes above apply to Tables 1 and 2.

DHS - Demographic and Health Surveys, ORC Macro (www.measuredhs.com)

MICS - Multiple Indicator Cluster Surveys, UNICEF (www.childinfo.org)

TABLE 3 YOUNG WOMEN (AGED 15-24) WHO KNOW THAT A HEALTHY-LOOKING PERSON CAN TRANSMIT HIV, BY EDUCATIONAL LEVEL

	No education	Primary education	Secondary education and higher	Total	Year/Source
Albania		35.8	45.3	40.4	2000 MICS
Angola	21.2	43.6	86.6	43.3	2000 MICS
Armenia	-	-	53.1	53.0	2000 DHS
Azerbaijan	-	19.4	41.0	35.1	2000 MICS
Benin	47.6	58.1	79.8	56.2	2001 DHS
Bolivia	7.4	28.3	77.2	63.7	1998 DHS
Bosnia and Herzegovina	-	52.7	80.2	73.7	2000 MICS
Botswana	49.6	59.9	82.6	77.8	2000 MICS
Burkina Faso	34.2	58.5	87.6	42.0	1999 DHS
Cambodia	45.4	60.4	83.2	62.4	2000 DHS
Cameroon	18.1	42.9	83.3	53.7	2000 MICS
Central African Republic	27.5	50.9	78.6	45.9	2000 MICS
Chad	20.8	33.8	60.7	27.7	2000 MICS
Colombia	-	59.8	89.3	82.4	2000 DHS
Comoros	44.3	57.0	69.6	54.9	2000 MICS
Côte d'Ivoire	50.3	69.5	92.6	64.4	1998 DHS
Dominican Republic	-	81.7	96.5	89.8	2000 MICS
Ethiopia	24.6	55.5	83.2	38.8	2000 DHS
Gabon	39.5	54.2	83.2	71.6	2000 DHS
Gambia	44.6	52.1	72.4	52.7	2000 MICS
Ghana	45.2	67.7	79.7	71.0	1998 DHS
Guinea	54.2	69.8	86.2	60.4	1999 DHS
Guinea-Bissau	17.6	41.9	69.3	30.7	2000 MICS
Guyana	34.4	62.2	87.0	84.3	2000 MICS
Haiti	49.4	61.8	81.0	67.9	2000 DHS
Indonesia	5.0	21.0	51.3	32.2	2000 MICS
Kazakhstan	-	-	62.8	62.6	1999 DHS
Kenya	60.2	74.1	82.0	74.6	2000 MICS
Lesotho	27.9	46.0	85.7	46.1	2000 MICS
Madagascar	9.3	25.2	50.3	27.2	2000 MICS
Malawi	71.8	82.6	97.3	83.5	2000 DHS
Mali	39.4	54.3	77.2	45.8	2001 DHS
Moldova, Republic of	-	73.8	83.7	78.9	2000 MICS
Nicaragua	34.9	61.6	86.7	72.9	2001 DHS
Niger	16.1	35.2	63.8	22.1	2000 MICS
Nigeria	15.5	44.3	62.3	45.0	1999 DHS
Peru	5.1	30.2	84.4	71.7	2000 DHS
Rwanda	50.5	62.4	91.2	63.7	2000 DHS
Senegal	37.4	53.2	72.3	46.4	2000 MICS
Sierra Leone	24.9	45.5	66.1	35.3	2000 MICS
South Africa	29.1	39.3	56.9	53.5	1998 DHS
Suriname	42.6	48.6	82.0	70.4	2000 MICS
Swaziland	73.5	73.4	86.2	80.5	2000 MICS
Tajikistan	-	2.4	8.0	7.9	2000 MICS
Tanzania, United Republic of	39.5	70.0	89.3	65.3	1999 DHS
Togo	56.2	65.8	86.4	67.4	2000 MICS
Uganda	61.8	73.6	88.8	75.8	2000 DHS
Uzbekistan	-	7.7	41.3	41.1	2000 MICS
Venezuela	29.7	56.8	83.2	77.9	2000 MICS
Viet Nam	9.6	38.6	71.9	60.6	2000 MICS
Zambia	53.8	69.8	86.6	74.0	2002 DHS
Zimbabwe	-	56.5	82.2	73.5	1999 DHS

- Less than 25 cases, estimate was suppressed

DHS - Demographic and Health Surveys, ORC Macro (www.measuredhs.com)

MICS - Multiple Indicator Cluster Surveys, UNICEF (www.childinfo.org)

TABLE 4 YOUNG MEN (AGED 15-24) WHO KNOW THAT A HEALTHY-LOOKING PERSON CAN TRANSMIT HIV, BY EDUCATIONAL LEVEL

	No education	Primary education	Secondary education and higher	Total	Year/Source
Armenia	-	-	47.6	47.7	2000 DHS
Benin	60.1	61.8	81.3	68.9	2001 DHS
Bolivia	-	42.8	79.1	73.8	1998 DHS
Burkina Faso	52.1	74.1	91.1	63.6	1999 DHS
Cameroon	14.9	48.2	80.6	62.8	1998 DHS
Côte d'Ivoire	39.7	66.3	91.4	66.9	1998 DHS
Dominican Republic	-	87.3	95.6	91.0	1999 DHS
Ethiopia	39.6	54.3	86.2	53.8	2000 DHS
Gabon	-	64.9	86.9	80.9	2000 DHS
Ghana	49.8	53.5	85.1	76.9	1998 DHS
Guinea	44.4	51.5	77.7	56.2	1999 DHS
Haiti	52.0	68.2	93.4	78.1	2000 DHS
Kazakhstan	-	68.5	81.6	73.1	1999 DHS
Kenya	-	73.5	93.8	80.2	1998 DHS
Malawi	72.1	88.0	94.2	88.6	2000 DHS
Mali	47.3	57.6	84.6	58.8	2001 DHS
Nicaragua	54.7	73.5	92.1	80.3	1998 DHS
Niger	29.3	42.9	73.4	41.4	1998 DHS
Nigeria	21.8	39.0	60.7	50.8	1999 DHS
Rwanda	56.0	67.5	92.8	68.9	2000 DHS
Tanzania, United Republic of	39.4	70.7	90.6	68.3	1999 DHS
Togo	45.6	60.8	89.7	72.8	1998 DHS
Uganda	-	80.0	89.9	83.2	2000 DHS
Zambia	-	62.5	88.9	73.0	2002 DHS
Zimbabwe	-	66.1	89.3	82.6	1999 DHS

- Less than 25 cases, estimate was suppressed

DHS - Demographic and Health Surveys, ORC Macro (www.measuredhs.com)

MICS - Multiple Indicator Cluster Surveys, UNICEF (www.childinfo.org)

TABLE 5 YOUNG WOMEN (AGED 15-24) WHO KNOW WHERE TO GET TESTED FOR HIV, BY EDUCATIONAL LEVEL

	No education	Primary education	Secondary education and higher	Total	Year/Source	
Albania	-	17.1	31.9	24.2	2000	MICS
Angola	9.6	24.7	57.6	25.0	2000	MICS
Azerbaijan	-	3.5	10.7	8.7	2000	MICS
Benin	10.5	17.4	44.7	18.6	2001	DHS
Botswana	24.7	32.9	50.9	47.2	2000	MICS
Cambodia	5.6	11.2	36.8	15.9	2000	DHS
Cameroon	23.2	49.9	82.4	57.2	2000	MICS
Central African Republic	10.6	25.9	62.9	26.3	2000	MICS
Chad	5.1	12.3	30.0	9.2	2000	MICS
Colombia	-	51.0	74.6	69.0	1999	DHS
Comoros	23.7	28.3	39.9	29.5	2000	MICS
Dominican Republic	-	76.5	86.0	81.7	2000	MICS
Gambia	17.3	20.9	42.0	24.2	2000	MIC
Guinea-Bissau	11.0	25.2	54.7	20.3	2000	MICS
Guyana	20.2	49.9	70.4	68.1	2000	MICS
Haiti	4.5	16.1	36.2	22.7	2000	DHS
Indonesia	1.3	17.9	41.6	26.6	2000	MICS
Kenya	42.8	55.8	70.6	57.9	2000	MICS
Lesotho	33.7	51.5	75.5	51.4	2000	MICS
Malawi	52.4	70.5	91.9	71.6	2000	DHS
Mali	7.0	17.5	43.3	12.6	2001	DHS
Moldova, Republic of	-	46.4	65.9	56.5	2000	MICS
Nicaragua	10.1	30.5	52.6	40.7	2001	DHS
Niger	6.7	20.0	51.6	11.6	2000	MICS
Peru	7.1	23.7	72.3	60.9	2000	DHS
Rwanda	59.6	67.3	88.6	68.5	2000	DHS
Senegal	19.2	30.0	50.7	26.3	2000	MICS
Sierra Leone	4.7	13.0	20.7	8.8	2000	MICS
Suriname	20.6	38.9	70.4	58.7	2000	MICS
Swaziland	49.8	47.5	64.6	57.3	2000	MICS
Tajikistan	-	2.4	5.7	5.6	2000	MICS
Tanzania, United Republic of	22.2	50.0	74.3	46.1	1999	DHS
Togo	12.4	25.0	46.4	25.8	2000	MICS
Uganda	19.4	32.3	56.8	36.5	2000	DHS
Uzbekistan	-	15.4	42.7	42.6	2000	MICS
Venezuela	29.6	45.6	73.4	68.0	2000	MICS
Viet Nam	7.7	29.1	61.9	51.2	2000	MICS
Zambia	37.7	55.6	76.9	61.2	2002	DHS
Zimbabwe	-	27.5	46.6	40.1	1999	DHS

TABLE 6 YOUNG MEN (AGED 15-24) WHO KNOW WHERE TO GET TESTED FOR HIV, BY EDUCATIONAL LEVEL

	No education	Primary education	Secondary education and higher	Total	Year/Source	
Benin	17.6	25.4	54.2	34.4	2001	DHS
Ethiopia	0.0	1.7	4.2	1.5	2000	DHS
Haiti	16.7	22.9	50.0	34.1	2000	DHS
Kenya	-	47.4	79.8	58.3	1998	DHS
Malawi	57.6	75.7	94.6	79.0	2000	DHS
Mali	14.2	24.1	52.4	25.9	2001	DHS
Rwanda	33.5	45.3	80.4	47.8	2000	DHS
Tanzania, United Republic of	25.2	55.4	82.6	53.5	1999	DHS
Uganda	-	43.4	66.9	50.3	2000	DHS
Zambia	-	50.4	82.2	62.5	2002	DHS
Zimbabwe	-	17.3	38.8	32.5	1999	DHS

- Less than 25 cases, estimate was suppressed

DHS - Demographic and Health Surveys, ORC Macro (www.measuredhs.com)

MICS - Multiple Indicator Cluster Surveys, UNICEF (www.childinfo.org)

N.B. The notes above apply to Tables 5 and 6.

TABLE 7 YOUNG WOMEN (AGED 15-24) WHO USED A CONDOM AT LAST HIGH-RISK SEX, BY EDUCATIONAL LEVEL

Millennium Development Indicator 19a

	No education	Primary education	Secondary education and higher	Total	Year/Source
Benin	6.7	16.2	30.3	18.7	2001 DHS
Burkina Faso	27.2	47.5	63.9	41.2	1999 DHS
Cameroon	-	8.2	21.4	16.4	1998 DHS
Colombia	-	19.6	32.6	30.2	2000 DHS
Côte d'Ivoire	14.7	21.7	41.5	24.7	1998 DHS
Ethiopia	11	19.9	25.5	17.1	2000 DHS
Gabon	-	22.9	36.4	32.4	2000 DHS
Guinea	8.4	14.6	34.1	16.7	1999 DHS
Haiti	4.3	11.5	30.5	19.1	2000 DHS
Kazakhstan	-	-	28.7	28.7	1999 DHS
Kenya	-	11.7	20.5	14.1	1998 DHS
Malawi	-	24.7	51.3	31.9	2000 DHS
Mali	5.3	16	28.3	14.2	2001 DHS
Nicaragua	-	10.7	20.2	17	2001 DHS
Peru	-	5.2	22.4	19.3	2000 DHS
Rwanda	-	17.8	36.1	22.5	2000 DHS
South Africa	-	10	21.9	19.8	1998 DHS
Tanzania, United Republic of	7.1	21.7	41.5	21.3	1999 DHS
Togo	6.4	18.5	32.5	21.5	1998 DHS
Uganda	-	34.2	60.4	44.4	2000 DHS
Zambia	-	25.2	48.1	33.3	2002 DHS
Zimbabwe	-	38.4	43.1	42	1999 DHS

TABLE 8 YOUNG MEN (AGED 15-24) WHO USED A CONDOM AT LAST HIGH-RISK SEX, BY EDUCATIONAL LEVEL

Millennium Development Indicator 19a

	No education	Primary education	Secondary education and higher	Total	Year/Source
Benin	25.8	21	52.6	34.5	2001 DHS
Burkina Faso	40.9	53.8	93.4	55.5	1999 DHS
Cameroon	-	30	32.3	31.4	1998 DHS
Côte d'Ivoire	-	53	67.5	55.7	1998 DHS
Ethiopia	-	29.8	77.6	30.5	2000 DHS
Gabon	-	74.5	85	83.3	2000 DHS
Guinea	21.8	29.3	43	32.1	1999 DHS
Haiti	-	15.6	44.4	29.9	2000 DHS
Kenya	-	36.1	53.5	42.9	1998 DHS
Malawi	-	32.2	58	37.7	2000 DHS
Mali	18.1	24.3	51.7	30.3	2001 DHS
Niger	6.7	27.9	63	29.7	1998 DHS
Tanzania, United Republic of	14.8	30.6	58.8	30.7	1999 DHS
Togo	28.4	29.3	50.6	41	1998 DHS
Uganda	-	54.2	75.3	62	2000 DHS
Zambia	-	32.5	57.3	42.3	2002 DHS
Zimbabwe	-	51.9	76	68.8	1999 DHS

- Less than 25 cases, estimate was suppressed

DHS - Demographic and Health Surveys, ORC Macro (www.measuredhs.com)

MICS - Multiple Indicator Cluster Surveys, UNICEF (www.childinfo.org)

N.B. The notes above apply to Tables 7 and 8.

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