Published in

Uniting Three Initiatives on Behalf of Caribbean Youth and Educators: Health and Family Life Education and the Health Promoting School in the Context of PANCAP's Strategic Framework for HIV/AIDS

Cheryl Vince Whitman
Health and Human Development Programs
Education Development Center, Inc.

Introduction

To protect young people and education personnel in the Caribbean Region from the HIV/AIDS epidemic and to promote their healthy development, three powerful movements in the education sector must come together: the model of the Health Promoting School (HPS) (WHO, 1998) or FRESH (Focusing Resources on Effective School Health) (UNESCO, UNICEF, WHO, & World Bank, 2000); the Caribbean tradition of Health and Family Life Education, dating back to the early eighties (CARICOM & UNICEF, 2001); and the Pan-Caribbean Partnership's Regional Strategic Framework for HIV/AIDS (2002–2006) (Pan-Caribbean Partnership, 2002; Kelly & Bain, 2003). The collaboration of these forces stands to exert the greatest influence, apply the most technical know-how, and leverage the best possible resources to combat the deadly disease and to offer Caribbean youth improved opportunities for better health and development.

Most young people and teachers in the region enjoy good health, and there is a high level of school enrolment. A majority of young people report that they have not had sexual intercourse (65.9%), they do not use alcohol or other drugs (89.4%), and they get along with their teachers (96.4%). *A Portrait of Adolescent Health in the Caribbean* notes, "Of the one-third who are sexually active, half report that sexual intercourse was forced and half of the boys and about ¼ of the girls say that their age of first intercourse was ten years old. Almost two-thirds had intercourse before the age of 13. Males were about three times more likely than females to have five or more sexual partners" (Halcon, Beuhring, & Blum, 2000, p. 14). With these risk behaviours, practiced by a third of Caribbean youth who tend not to use condoms, HIV/AIDS poses a grave threat (World Bank, 2001).

The region has the second-highest prevalence rate of HIV/AIDS after sub-Saharan Africa, and the disease is present in the mainstream population. A World Bank study noted that self-reported heterosexual contact is now acknowledged as the main route of HIV transmission and accounts for approximately two-thirds of all AIDS cases in Caribbean countries. Of particular concern is the dramatic and constant increase of HIV/AIDS among Caribbean women, who also have one of the highest rates of cervical cancer in the world, which is related to sexually transmitted infections (PAHO, 2003). These patterns cry out for schools to reach children at early ages, and to provide programs and services for teachers and other education personnel.

Since the epidemic began, the public health sector has dominated the response to HIV/AIDS, disseminating important information about how the disease is transmitted and behavioural change strategies for prevention and access to care. But these efforts can be

strengthened by focusing even more on the human dimension of relationships and sexuality, as well as strategies to shape people's positive behaviour and skills early in the life cycle. The education sector, which plays a central role in the transmission of culture and customs, can and must play a significant role in protecting the health of young people and in the fight against HIV/AIDS—especially since research has repeatedly shown that reproductive health education does not lead to earlier or increased sexual activity among young people and can in fact reduce sexual risk behaviour (e.g., UNAIDS, 1997a; Kirby, 2001a). The school as a setting needs to return to the invaluable role it played in the Caribbean immediately after World War II where it was the focal point for delivering very effective health promotion programmes (Kelly and Bain, 2003). The formal education system must once again move beyond a primary focus on academic achievement to embrace a broader mission that will preserve the health of students and education personnel as well as the survival of the education system itself—a major force in sustainable development for the Caribbean people.

Health and economic development are highly interdependent; the Nassau Declaration (2001) stated, "The health of the Caribbean Region is the wealth of the region." Yet, there is a third critical factor—often overlooked and undervalued—and that is education, which is vital in the formation of human and social capital and healthy human development. Dr. Amartya Sen, winner of the 1998 Nobel Prize in Economics, argues that the development of nations is strongly dependent on their citizens' freedom to participate in processes that affect their future and their access to education and health care. These freedoms are essential factors in reducing poverty and promoting human and economic development (Sen, 1999). Education has a key role to play in developing the knowledge, skills, confidence, and political participation of young people and school personnel to protect their health and to safeguard accomplishments the region has gained.

A growing body of research, which education leaders cannot ignore, links academic performance and school completion to student and teacher health. Physical, social, and emotional health has a significant impact on academic performance, school completion, teacher morale, and absenteeism. Global examples have found that:

- The physical and mental health of the teaching staff affects students directly through the quality of teaching and the school's psychosocial environment (WHO, 1997).
- Schooling pays off in terms of higher incomes and a healthier workforce (World Bank, 1993).
- The report of the Dakar World Education Forum states that education can be a powerful force—perhaps the most powerful force of all—in combating the spread of HIV/AIDS (UNESCO, 2000).

This research base shows an inextricable connection between education and health. For that reason, focusing solely on cognitive performance as a way to foster school success is entirely inadequate. Further, the Caribbean Region could find itself facing increased absenteeism of staff and students because of HIV/AIDS, which will weaken the overall educational system (UNESCO & IIEP, 2003). Recent evidence also shows that more-educated young people are emerging as less likely to be HIV-infected. Evidence is making

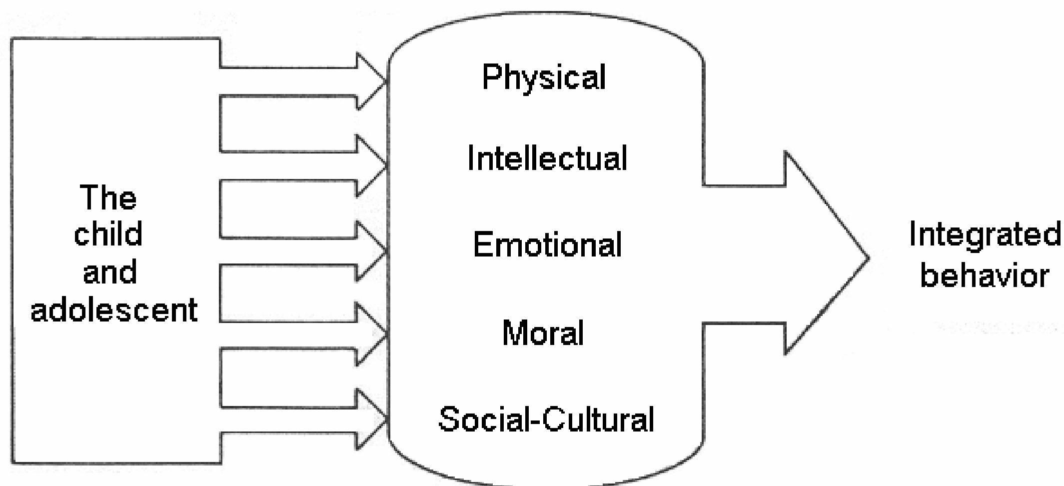
it more clear that education does help individuals protect themselves against HIV infection (Kelly & Bain, 2003).

This chapter concentrates on the role of the formal educational system—the fundamental institutional foundation for HIV/AIDS education to reach students and staff on a large scale. The formal system has a key role to play in planning ways to mitigate the impact of HIV/AIDS on individuals and on education processes and systems, and in delivering effective prevention education and services (World Bank, 2002). We describe three Caribbean movements and how they can be integrated into the education system to address the full continuum from stigma and discrimination to prevention, voluntary counselling and testing, access to anti-retroviral drugs, and support for bereavement (UNESCO & IIEP 2003). Through these efforts, the formal system can be strengthened by linking with the informal education sector in the community to reach those at risk who are not in school and to use educational strategies more broadly, including the media and arts, to touch people's emotions where change begins, to influence policy, and to galvanize action.

Healthy Child and Adolescent Development: Underlying Factors

The biopsychosocial model of human development describes how biological (e.g., genetics, pregnancy, birth), psychological (e.g., cognitive development, perceptual development), and socio-cultural forces (family, school, media) interact to shape human behaviour across the lifespan, as depicted in Figure I (Dacey & Travers, 1991).

Figure I: The Biopsychosocial Model of Development



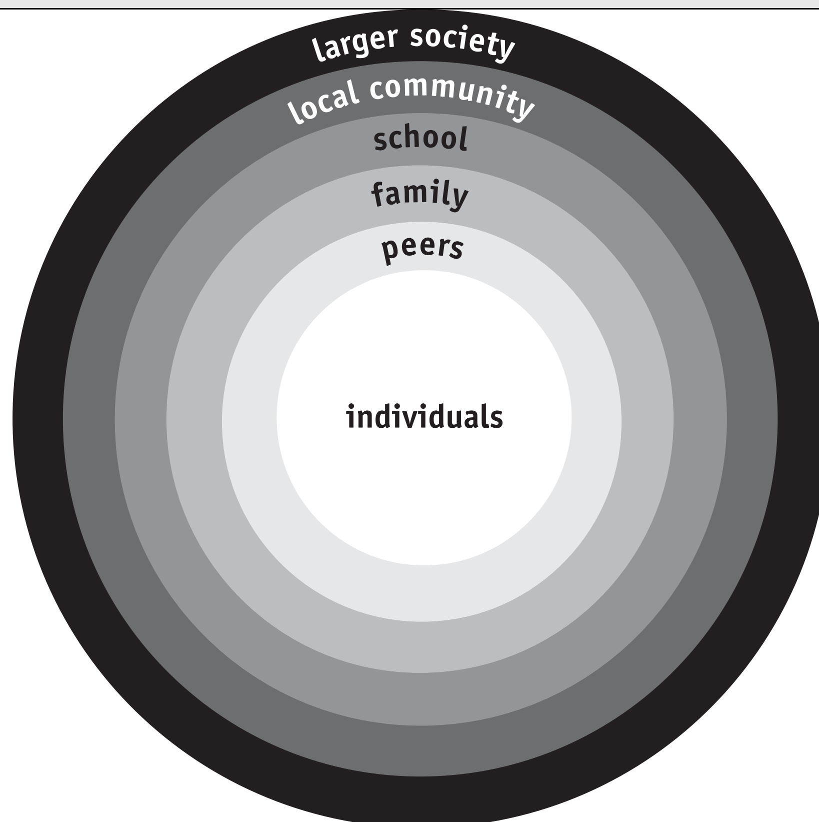
Robert Havighurst (1972) identified critical *development tasks* that occur throughout each individual's lifespan, the successful achievement of which leads to happiness and success

with later tasks, whereas failure can lead to social disapproval and difficulty with later tasks. He grouped the tasks into three categories:

- Tasks that arise from *physical* changes, such as learning to walk, talk, and behave acceptably with the opposite sex, or the hormonal changes brought on by adolescence or menopause.
- Tasks that arise from *intra-personal* sources that take the form of personal values and aspirations, such as learning skills for a new job.
- Tasks that have their source in the *socio-cultural* pressures of society, such as mores or taboos about sexual behaviours of men and women, or conforming to certain styles of dress or to a religious doctrine.

Development tasks are specific to a particular life stage. Typical development tasks of middle childhood and adolescence, for example, include learning to get along with age-mates, acquiring values and ethics to guide behaviour, and achieving a masculine or feminine social role. While a person's genetic and biological characteristics predispose his or her approach to these tasks, the individual is constantly influenced by the broader environmental forces in the family, school, community and society, as shown in Figure II.

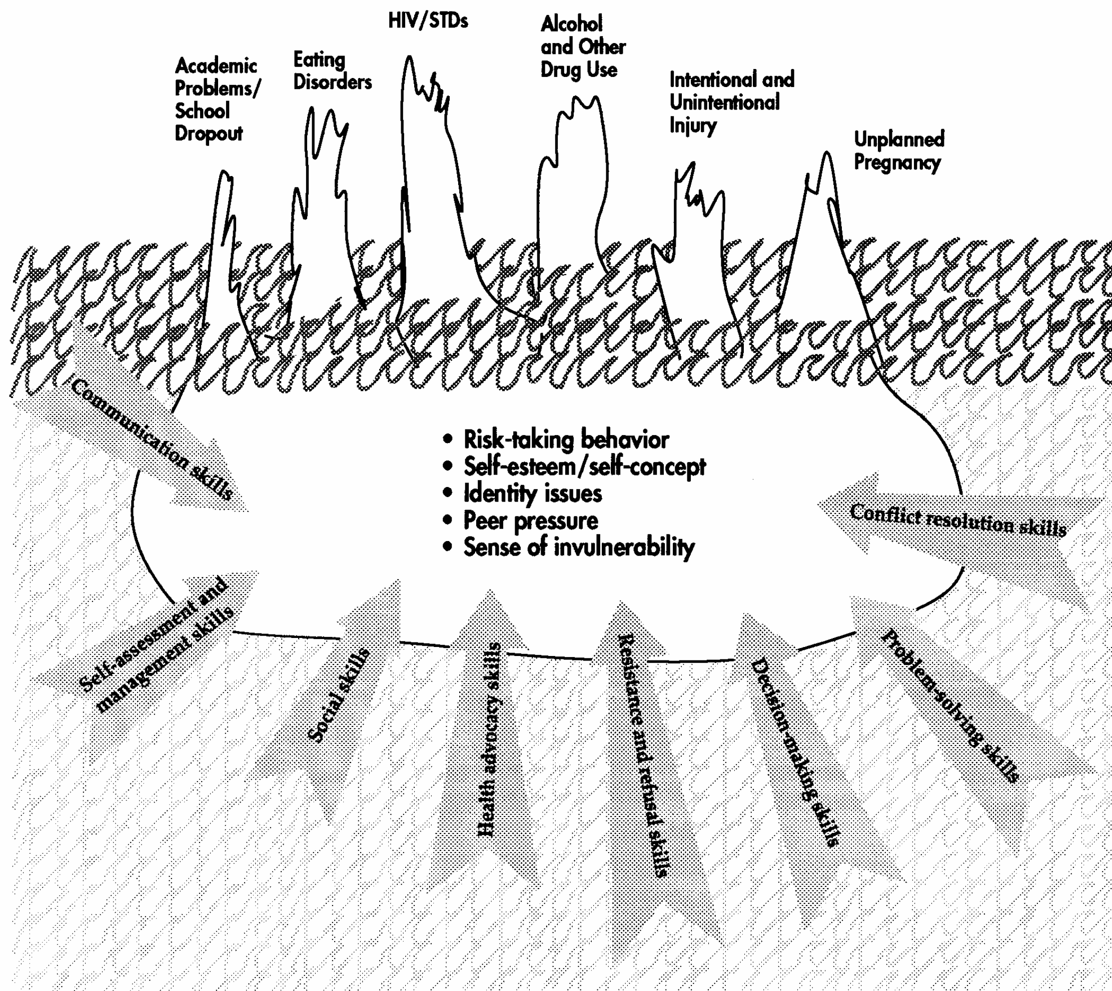
Figure II: Spheres of Influence in a Person's Life



Healthy development involves the physical, mental, emotional, spiritual, and social dimensions of a person's life. School is a major force in a young person's human development, both directly, through the curriculum, and indirectly, through the values it transmits and the role-modelling and actions of teachers, who are especially important people in the lives of students. Schools can strengthen the ways in which they positively affect students' progression through these development tasks, protecting their health and minimizing risks or threats to their well-being.

The adoption of a healthy lifestyle is promoted as a way for students to reach their full potential. Reaching this potential involves the development of knowledge and skills to make healthy choices as one seeks to master the developmental tasks, as illustrated in Figure III (Education Development Center, 1991; Gold, 1982). As young people negotiate these tasks, they often experiment with or engage in multiple, interrelated risk behaviours. For example, alcohol use exacerbates the risk for HIV infection and pregnancy as it reduces one's inhibitions and sense of responsibility. Skill development, such as resolving conflicts, communicating effectively and refusing or resisting sexual activity or substance abuse can avoid risk and favour safe and healthy outcomes.

Figure III: The Iceberg of Risk-Related Outcomes



Research has shown that the more risk factors a young person experiences, the more likely it is that he or she will engage in unhealthy practices. Conversely, the more risks in a child's life that can be reduced, the less vulnerable that child will be to health and social problems. Schools have an important role to play in strengthening protective factors and reducing risk factors, such as those illustrated in Figure IV (Dash, Vince Whitman, Harding, Goddard, & Adler, 2003; ESCAP/UNODC, 2003).

Figure IV: Selected Protective and Risk Factors		
Source	**Protective Factors**	**Risk Factors**
Individual/ Family	• Resilient temperament • Positive relationships and close bonds • Healthy beliefs and clear standards	• Friends who engage in risky or self-destructive behaviours • Lack of commitment to school • Early and persistent anti-social behaviour • Family conflict
School	• Caring and support • Sense of community • High expectations from school personnel • Clear standards and rules for behaviour	• Harsh or arbitrary student management practices • Ineffective leadership • Little emotional and social support
Community	• Recreational activities • Community norms and laws unfavourable to promiscuity and substance abuse • Easy access to confidential services	• Media portrayal of sex, violence, and gender inequity • Availability of alcohol and drugs

There are protective and risk factors within each domain of individual, family, school, and society. In the school domain, three major factors in reducing a child's risk behaviours are (1) the degree to which that child feels a sense of bonding or connection to school, (2) clear standards, and (3) parental involvement (McNeely, Nonnemaker, & Blum, 2002). In the school environment, reducing the risks to students that come from harsh or arbitrary student management practices or ineffective administrative leadership can also make a difference. Many program strategies in schools focus on strengthening these protective factors by creating greater teacher connection to students and by fostering social problem-solving, skill-building, or therapeutic interventions.

Related to strengthening protective factors, in 1997, CARICOM (Caribbean Community Member Countries) heads of government formulated a profile of the "new Caribbean citizen," whom they wish their education systems to form, as outlined in Figure V.

Figure V: Profile of the Ideal Caribbean Citizen
The “new Caribbean citizen” must: • Be imbued with a respect for human life • Be emotionally secure with a high level of self-confidence and self-esteem • Regard ethnic, religious, and other diversity as a source of potential strength and richness • Be aware of the importance of living in harmony with the environment • Have a strong appreciation for family and kinship values, community cohesion, and moral issues, including responsibility for and accountability to self and community • Have an informed respect for cultural heritage

In developing this profile, governments acknowledge the central role that formal education is thought to play in the transmission and reinforcement of values regarding national and regional development. Clearly, many of these qualities are related to development tasks, healthy development, and protection from HIV/AIDS (International Bureau of Education, 2002).

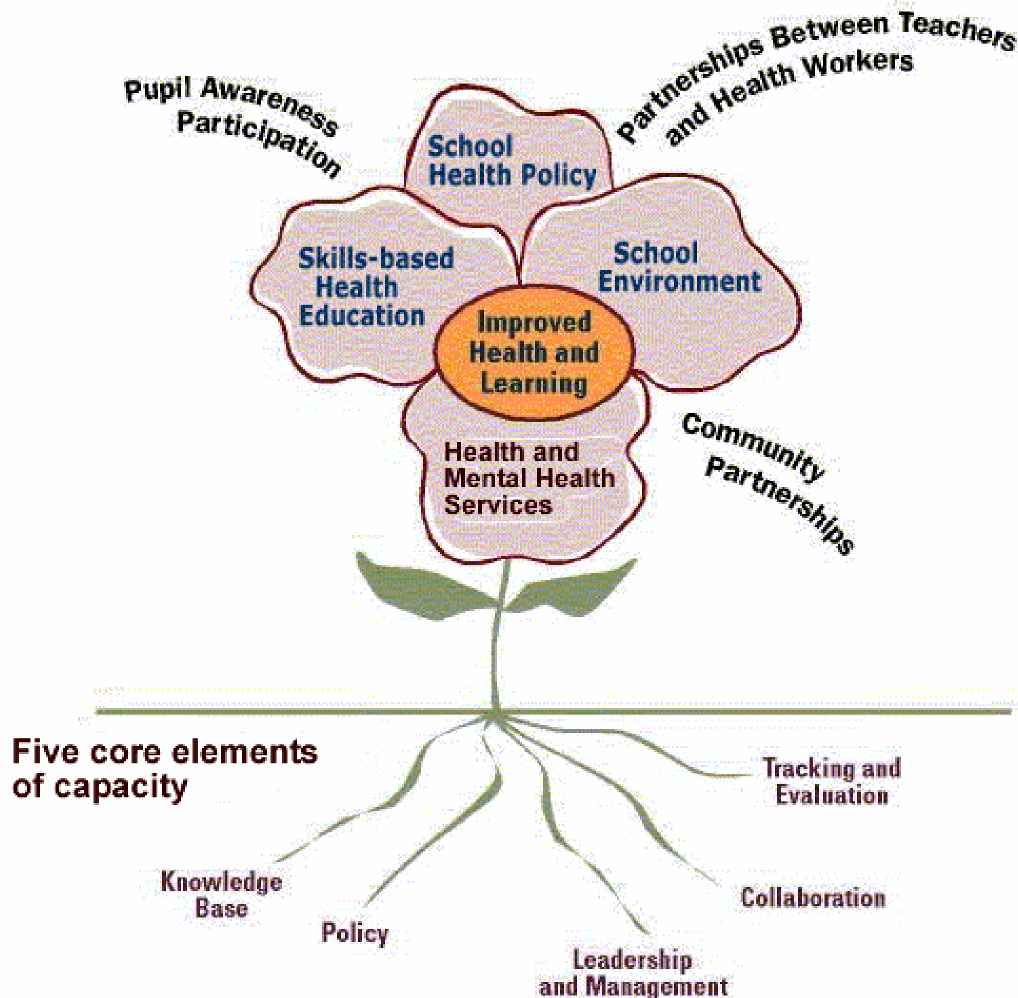
The underlying factors that affect child and adolescent development—the biopsychosocial model, development tasks at stages of the lifecycle, and risk and protective factors—have informed and influenced frameworks and initiatives for school health programmes, such as the Health Promoting School and Health and Family Life Education, which are described in the next section. Coordinating these initiatives can leverage many resources to achieve the Caribbean Regional Strategic Framework for HIV/AIDS 2002–2006.

Three Powerful Initiatives that Together Can Improve Health and Academic Success

Health Promoting Schools

A Health Promoting School (HPS) is one that fosters learning with all measures at its disposal. Figure VI illustrates the concept of the HPS, which engages health and education officials, teachers, students, parents, and community leaders in efforts to promote health (WHO, 1998).

Figure VI: Health Promoting Schools



The school is also a workplace for teachers and other staff; as such, it must protect their human rights. Schools should also offer health promotion activities and health services to teachers and staff.

Essentially, the HPS concept features the combination of an overarching policy to address health in the school environment via three essential coordinated components: skills-based health education, health services, and a healthy physical and psycho-social school environment. Health and Family Life Education in the Caribbean offers important

resources to address the skills-based (life skills) education component as well as linkages with parents and the community.

As shown in Figure VI, several core capacities are required to implement the concept at both the national and local levels, including leadership and management, a knowledge base of effective public health strategies, collaboration with the informal sector, policy, and systems to track and monitor progress. Tools and training materials exist for ministries and local schools to develop these capacities (Vince Whitman, 2002; WHO, 2000).

The concept of the Health Promoting School was born in Europe out of work by the European Commission, Council of Europe, and WHO Regional Office for Europe. It is based on public health theory and builds on the Ottawa Charter of Health Promotion, which recognized that health is created and lived by people within the settings of everyday life where they live, learn, work, play, and love (WHO, 1986). The earliest descriptions of the HPS, then called "Healthy Schools," were developed during the first major conference of all the European nations on school health promotion in Scotland in 1986. In 1995, the World Health Organization headquarters in Geneva launched the concept globally with its Global School Health Initiative. At the April 2000 Education for All meeting in Dakar, Senegal, UN agencies, donors, and non-governmental organizations expressed their unity for these basic concepts by rallying behind FRESH—Focusing Resources on Effective School Health (Vince Whitman, Aldinger, Levinger, & Birdthistle, 2001). In 2001, the Caribbean Network of Health Promoting Schools was created, and held its first meeting in Barbados to facilitate the exchange of knowledge and experiences regarding the successful implementation of health promotion and health education activities within and among countries (PAHO, 2002).

The value of the concept of the HPS is that it offers a positive approach for promoting health and preventing disease relevant to the underlying factors of youth development. Applying the framework to the region's strategic priorities for HIV/AIDS, in the formal education sector, the HPS concept offers a strategy to address the continuum of issues ranging from stigma and discrimination to prevention, services, care, bereavement, and linkages with the community and the informal sector. WHO headquarters and FRESH partners have outlined specific ways to address HIV/AIDS within the HPS concept and have created numerous training and resource documents to assist schools with the process. (WHO, 1999; IIEP, 2002; WHO, UNICEF, UNESCO, World Bank, EI, EDC, & PCD, 2003). Later in this chapter, we review the specifics of how HPS relates to the Caribbean Strategic Framework for HIV/AIDS and Health and Family Life Education.

Health and Family Life Education

Dating back to the early eighties, Health and Family Life Education has achieved many impressive accomplishments in the Caribbean Region. HFLE focuses primarily on the curriculum component of the Health Promoting School. HFLE is defined as a comprehensive life skills based programme (CARICOM & UNICEF, 2001). The overall

goal is that children and adolescents will be empowered to make life-enhancing choices, which they will carry into adulthood and that HFLE will:

- Enhance the potential of young persons to become productive and contributing adults;
- Promote an understanding of the principles, which underlie personal and social well-being;
- Foster the development of knowledge, skills and attitudes that make for healthy social and family life;
- Increase the awareness of children and youth of the fact that the choices they make in everyday life profoundly influence their health and personal development into adulthood.

HFLE includes age-appropriate instruction in specific health areas. HFLE fosters the development of laudable attitudes and values alongside the knowledge component. The emphasis is on helping children to develop the personal and social skills they need to become responsible, independent, and contributing adults. These life-skills include problem-solving, decision-making, critical and creative thinking, self-awareness, the ability to empathise, cope with emotions and to refuse and resist pressure to engage in risk behaviours. All such instruction is designed to promote parental involvement, foster self-concepts and to provide mechanisms for coping with the stresses of modern living.

The HFLE movement in the region has made substantial progress in placing the issue on the policy agenda of education leaders, advancing training and curricula guidelines for teacher education colleges, and offering some teacher training. Figure VII presents a timeline, highlighting HFLE from 1981 to the present, also noting a few critical events in the HPS/FRESH and HIV/AIDS arenas. Over the decades, there have been many key players, such as Dr. Phyllis MacPherson-Russell from the Fertility Management Unit at the University of the West Indies, Mona Campus, Jamaica, Ms. Elaine King from UNICEF, Ms Pat Brandon from PAHO, and Dr. Morella Joseph from CARICOM, who is lending her leadership to these efforts.

The HFLE initiative now stands on the threshold of an explosion of activity, with potential to transform the concept much more deeply into mandated policies that have resources behind them, to develop teachers' skills through more widespread training and to develop and disseminate region-specific materials more broadly to local schools.

In April 2003, HFLE received a booster shot from the CARICOM Council for Human and Social Development (COHSOD), which endorsed the urgent need for strengthening HFLE. With invigorated leadership from CARICOM and continued coordination by UNICEF, major new initiatives are underway.

Most notable and related to achieving the Strategic Objectives for HIV/AIDS 2002-2006 is the HFLE Regional Curriculum Framework Project. Working under the guidance of the HFLE Regional Working Group, a team of Caribbean HFLE experts, in partnership with Education Development Center, Inc. (EDC) are developing a Regional HFLE Curriculum

Framework. This Framework outlines the standards, pedagogical techniques, learning outcomes, skills, and knowledge for four themes: Sexuality and HIV/AIDS, Interpersonal Relationships, Fitness and Nutrition, and Managing the Environment. For each theme, there will also be age-appropriate sample lessons and references to a broad range of teaching materials. The Framework provides consistent standards for the region so that curriculum planners, teachers, education officers will all have a tool to use in reviewing and strengthening their teaching of HFLE for 9-14 year-olds.
At the HFLE Regional Working Group meeting in Jamaica, February 2004, members reviewed and accepted material for the first two themes of Sexuality and Interpersonal Relationships. Figures VIII and IX present these draft standards for Sexuality and HIV/AIDS (CARICOM/UNICEF, forthcoming), which are integrally tied to the Region's Strategic Objectives for HIV/AIDS in Figure XI.

Four countries will participate in pilot-testing the Framework in May 2004: Jamaica, Trinidad, St. Lucia and Guyana. The pilot-test will seek to learn how countries are able to use the Framework to develop or update and strengthen their HFLE curriculum work. Said Ms. Joycelyn Rampersad of the School of Education, University of West Indies, St. Augustine, one of the developers, "I see the HFLE Framework as one of building capacity for the region. My university students, who are working with us to develop the framework, are not only gaining expertise in developing skills-based HFLE curriculum and resource materials, but they are also positioned now to take the process further to train others." An outcome of the UNESCO meeting, Dialogue on Publishing for AIDS, is a developing relationship with publishers for broad and ongoing dissemination of these and related materials (UNESCO Office for the Caribbean, 2003).

In support of implementation of the Framework, CARICOM, UNICEF and EDC are working with the three-campus UWI system to establish a HFLE/HIV/AIDS Teacher Resource Centre that will institutionalize the provision of pre-service and in-service teacher training and ensure the availability and active dissemination of up-to-date teaching materials for the various themes. New courses, certified by UWI, are under development for a summer in-service institute and HFLE undergraduate course concentration in the education degree programme, beginning in 2004.

Talented and committed people in the region have worked tirelessly to achieve these milestones. But, it is not enough. Given the health threats that lie ahead, a determined focus across sectors is necessary to develop the infrastructure and capacity to address health through schools in a much more robust way. Efforts need to push beyond policy statements, publications, and training primarily at the tertiary level to make a difference on the ground with teachers and students, who are most at risk. Increased collaboration to advance implementation can achieve the shared goals of HFLE and the Strategic Objectives for HIV/AIDS.

Figure VII: Timeline Highlighting Selected HFLE, HPS Accomplishments: 1981-Present	
Year	**Event**
1981	The Pan American Health Organization (PAHO) and the University of the West Indies (UWI), Cave Hill Campus, Barbados, formed a partnership to strengthen the health curriculum in the teachers' colleges in the Eastern Caribbean.
1982 to 1984	The PAHO-UWI partnership conducted workshops to develop a prototype HFLE curriculum for teacher training programs and a plan to introduce the curriculum into teachers' colleges.
1986	***Health Promoting School concept originates with the European Commission***
1985 to 1991	The PAHO-UWI initiative lost significant momentum.
1991	PAHO, in response to CARICOM HFLE Guidelines, convened an interagency group that included UNESCO, the United Nations Population Fund (UNFPA), the Carnegie Project and Faculty of Education, UWI and Cave Hill Campus. The group developed "Core Curriculum Guide for Strengthening Health and Family Life Education in Teacher Training Colleges in the Eastern Caribbean in 1995." Many Teachers' Colleges used the Guide, devoting 40-60 hours of teaching time to HFLE as an optional course.
1993 to 1995	The Fertility Management Unit (FMU) of the Department of Obstetrics and Gynecology at the University of the West Indies at the Mona campus in Jamaica organized a regional meeting on life skills-based curriculum and training with representatives of Ministries of Education, the Teachers' Colleges, PAHO, and the Faculty of Education. BY 1995, FMU had trained approximately 300 people.
1993	The Regional Education Policy, developed through Caribbean Community Member Countries (CARICOM) and adopted by Ministers of Education, called for the development of life skills. Implementation was difficult to track.
1994	The CARICOM Standing Committee of Ministers of Education passed a resolution supporting the development of a comprehensive approach to life skills-based curriculum, giving rise to the CARICOM Multi-Agency Health and Family Life Education Project, coordinated by UNICEF (CARICOM Secretariat, Caribbean Child Development Centre, UWI Schools of Education and the Advanced Training and Research in Fertility Management Unit (FMU), PAHO/WHO, UNESCO, UNDCP, UNFPA, UNDP, UNIFEM).
1995	"A Strategy for Strengthening HFLE in CARICOM Member States" described progress, reporting most programs at the primary level, delivering information rather than skill development using participatory methods. The report outlined specific objectives for future activities and HFLE's dependence on larger vision of health promotion in schools.
1995	***WHO/HQ launches Global School Health Initiative and Health Promoting School***
1995 to 2001	Some countries developed curriculum and trained teachers.
1998	CARICOM formed Caribbean Task Force on HIV/AIDS, which led to the Pan-Caribbean Partnership on HIV/AIDS which further developed the Regional Strategic Framework.
2000	***Education for All, Dakar Senegal, UN, donors and Non-governmental organizations unite around FRESH, Focusing Resources on Effective School Health***
2001	***PAHO convenes First Meeting of the Caribbean Network of Health Promoting Schools,***
2001 to 2003	Numerous activities take place in training of teacher educators (participatory methods, alternative assessment and design of country training plans). UNICEF HFLE volunteers in sample countries advance training and implementation. Three countries have cabinet-approved HFLE National Policies and six other countries have draft policies awaiting adoption.
2003	UNESCO/UNICA/UWI Conference: HIV/AIDS: The Power of Education, Trinidad launches "Education and HIV/AIDS in the Caribbean.
2004	CARICOM meeting of HFLE Regional Working Group reviews HFLE Regional Curriculum Framework and establishes roles at the regional and national levels for committees to deepen implementation of HFLE.

Figure VIII: Regional Standards Sexuality and Sexual Health

1) Demonstrate an understanding of the concept of human sexuality as an integral part of the total person which finds expression throughout the life-cycle.
2) Analyze the influence of socio-cultural and economic factors as well as personal beliefs on the expression of sexuality and sexual choices.
3) Build individual capacity to recognize the basic criteria and conditions for optimal reproductive health.
4) Develop action competence to reduce vulnerability to priority problems including HIV/AIDS, cervical cancer and STIs.
5) Develop knowledge and skills to access age-appropriate sources of health information, products and services related to sexuality and sexual health.

Figure IX: Regional Standard 1

Regional Standard 1
Demonstrate an understanding of the concept of human sexuality as an integral part of the total person which finds expression throughout the life-cycle.

Descriptor: A differentiation needs to be made between the term's sex and sexuality. Sexuality is presented as including biological sex, gender and gender identity. One's sexuality also encompasses the many social, emotional and psychological factors that shape the expression of values, attitudes, social roles, and beliefs about self and others as being male or female. It is important to have students develop positive attitudes about self and their evolving sexuality.

Key Skills:
Coping Skills (healthy self-management, self-awareness)
Social skills (communication, interpersonal relations, assertiveness, refusal)
Cognitive Skills (critical and creative thinking, decision-making)

Core Outcomes **Age level 9–10**	**Core Outcomes** **Age level 11–12**	**Core Outcomes** **Age level 13–14**
1. Explore personal experiences, attitudes, and feelings about the roles that boys and girls are expected to play. 2. Demonstrate awareness of the physical, emotional and cognitive changes that occur during puberty.	1. Develop strategies for coping with the various changes associated with puberty. 2. Assess traditional role expectation of boys and girls in our changing society. 3. Assess ways in which behaviour can be interpreted as being "sexual".	1. Assess the capacity to enter into intimate sexual relationships. 2. Demonstrate use of strategies for recognizing and managing sexual feelings and behaviours.

Figure X: Regional Standard 4		
Regional Standard 4 Action competence to reduce vulnerability to priority problems including HIV/AIDS, cervical cancer and STIs. **Descriptor:** Beyond knowledge of HIV/AIDS, cervical cancer and STIs as a disease, efforts have to be intensified to render students less vulnerable to contraction and spreading HIV/AIDS, cervical cancer and STIs. Addressing issues related to the physical and emotional aspects of HIV/AIDS, stigma of living with HIV/AIDS and discrimination against people living with HIV/AIDS is critical. Importantly, students are encouraged to practice abstinence and a drug-free lifestyle. **Key Skills:** Coping Skills (healthy self-management, self monitoring) Social skills (communication, assertiveness, refusal, negotiation) Cognitive Skills (critical thinking, creative thinking, problem solving, decision making)		
Core Outcomes **Age level: 9–10**	**Core Outcomes** **Age level 11–12**	**Core Outcomes** **Age level 13–14**
1. Identify the risk behaviours/agents that are associated with contracting HIV, cervical cancer and STIs. 2. Demonstrate skills to assisting and respond compassionately to persons affected by HIV.	1. Make appropriate choices to reduce risk associated with contracting HIV, cervical, cancer and STIs. 2. Set personal goals to minimize the risk of contracting HIV, cervical cancer and STIs. 3. Demonstrate ways of empathizing and supporting persons and families affected by HIV/AIDS.	1. Critically examine abstinence, fidelity, condom use (if permitted) as preventive methods in transmission of HIV, STIs. 2. Make appropriate choices to reduce risk associated with contracting HIV, cervical, cancer and STIs. 3. Critically examine social norms and personal beliefs in light of current knowledge of the transmission and spread of HIV/AIDS. 4. Advocate for reducing the stigma and discrimination associated with HIV, cervical cancer and STIs.

Achieving Pan-Caribbean Partnership's (PANCAP) Regional Strategic Framework for HIV/AIDS in the Context of HPS and HFLE

In 2001, CARICOM heads of state established PANCAP to scale up the response to HIV/AIDS in the region. The PANCAP partnership includes governments, non-government organizations, private sector, multi/bi-lateral donors and the United Nations system. PANCAP developed the Regional Strategic Framework for HIV/AIDS to provide a basis for reducing the spread and impact of HIV/AIDS in the Caribbean. The framework identifies areas for priority action at the regional level that are focused on promoting a strengthened, effective and coordinated regional response and supporting expanded and multi-sectoral HIV programmes at the national level.

The framework sets forth seven priority areas for HIV/AIDS, see Figure XI. All seven priorities, not just Priority #3, "Prevention of HIV transmission with a focus on young people" include actions for the education sector and school system. These encompass advocacy, policy and legislation (#1), care and support (#2), workplace populations, such as teachers and other staff (#4), the protection of women (a large number are women) (#5), capacity building (#6), and resource mobilization (#7).

These priorities map directly ion the HPS and HFLE frameworks. They are also consistent with the UNESCO strategy to focus on five tasks:

1. Advocacy at all levels
2. Customizing preventive education to fit culture
3. Designing effective programmes to promote safe behaviour
4. Promoting a new role of education systems toward the infected and affected
5. Building capacity to enable the education sector to cope with the epidemic

The gender approach would permeate all aspects of each of the five tasks (UNESCO Office for the Caribbean, 2002).

A brief discussion of each component of a comprehensive approach in the formal education system follows, as illustrated in Figure VI of the Health Promoting School,: policy, curriculum, services and environment, its relationship to the priority areas and sample resources to carry out each one.

Policy

Policies set out clear national and local standards on health and HIV/AIDS to guide planning, implementation and evaluation of these efforts, with indicators to measure progress (Education Development Center, 2003). As stated by UNAIDS (1997b), in the school school-setting policies cover human rights, such as (the right to education, to non-discrimination, to confidentiality, to protection of employment, to protection from exploitation and abuse). Policies also cover access to schools by students and school workers living with HIV/AIDS, pre-service and in-service staff training, and

community/parent participation. The school-setting policies also extend to content of curricula and extra curricular activities, and the link to health services capable of providing prevention services, diagnosis and treatment of STIs for young people as well as the means of protection against unwanted pregnancy and HIV/AIDS, including contraceptives and condoms. Policies are developed at different levels, according to the degree of the centralization of the school system.

The Ministry of Education, Youth and Culture for Jamaica has developed and the Cabinet has now endorsed a "National Policy for HIV/AIDS Management in Schools" that includes a legal framework to protect rights and a policy to address the many other important issues (Jamaican Ministry of Education, 2003). The objectives are to:

- Highlight the existence of the HIV/AIDS epidemic in Jamaica and, in particular, in the education system;
- Provide guidelines for institutions on treatment of students and school personnel infected with HIV/AIDS;
- Promote the use of universal precautions in all potentially infectious situations;
- Ensure the provision of systematic and consistent information and educational material on HIV/AIDS to students and personnel throughout the system;
- Reduce the spread of HIV infection;
- Instil non-discriminatory attitudes towards persons with HIV/AIDS.

Jamaica was one of the pilot-test sites for the University of Natal in South Africa, which was funded by the UNAIDS Interagency Task Team on AIDS to create an instrument for ministries of education to use in developing or refining their HIV/AIDS policies. The University of Natal will be using this tool with several ministries of education in the Caribbean within a global sample of 100 high-prevalence countries worldwide (IATT, 2003).

Other sample policies include a national policy for Namibia (Government of Namibia, n.d.), a local-level policy for the Wyoming Public Schools (Peterson, 1998), and one in higher education for the University of Natal (University of Natal Aids Committee, 2002).

The International Labor Organization (ILO) has developed excellent policies[1] for the workplace with extensive training manuals that can be applied to all education personnel (ILO, 2002). Similarly, the WHO, Education International (the global teachers' union), and EDC have created training materials for teacher union leaders to know how to protect themselves, serve as educators in the community and educate their students about prevention (EI & WHO, 2001). In a January 2004 workshop in Guyana, January 2004, union leaders from 14 Caribbean countries were trained in a three-day workshop.

[1] http://www.ilo.org/public/english/protection/trav/aids/code/languages/index.htm

Curriculum: Skills-based Health Education

Priority Area #3 of the PANCAP Strategic Framework, Figure XI focuses on prevention of HIV/AIDS transmission for young people by ensuring that there is access to reliable and accurate information, recognition of gender issues and efforts to improve and support the implementation of HFLE. The new HFLE Regional Curriculum Framework also sets forth standards for teaching about sexuality, STIs and HIV/AIDS in the broader context of relationships and the development of the ideal Caribbean person as outlined in Figures V,VIII, IX, and X. The Framework addresses substance abuse prevention, and the "Theme on Relationships" provides added depth on this important aspect.

Education policy makers and planners, using the framework, need to decide what options they will choose for the educational messages, and at which age group (WHO, 1999). Those options include:

- Abstinence from sexual intercourse
- Non-penetrative sex
- Condom use
- Monogamy with an uninfected partner
- Abstinence from substance abuse

The HFLE approach to curriculum builds upon the research evidence of what works in health education. That research has found that:

- Developing *skills* for making healthy choices in life, in addition to imparting health-related knowledge, attitudes, values, services and support, is more likely to produce the desired outcomes.
- Skill development is more likely to result in the desired healthy behaviour when practicing the skill is tied to the content of a specific health behaviour or health decision;
- The most effective method of skill development is learning by doing—involving people in active, participatory learning experiences rather than passive ones (WHO, 2003a; Mangrulkar, Vince Whitman, & Posner, 2001).

Many curriculum and training resources are presently available from UN agencies globally, but there are few curricula designed specifically for the diversity of cultures, customs and languages of the region. UNESCO with Morton Publishing Company in Trinidad and Tobago has produced some of the first HIV/AIDS curricula for the Caribbean, aimed at developing literacy and AIDS awareness among youth, *Understanding HIV/AIDS and Drug Abuse (*UNESCO 2003).

There are global resources, not customized for the region, available from the international data base of HIV/AIDS school curricula created by UNESCO's International Bureau of Education.[2] WHO and UNICEF have created HIV/AIDS skills-based planning and training

[2]http://databases.unesco.org/IBE/AIDBIB/

modules (UNICEF, WHO, et al. 2002; WHO, 2003b); and the Inter American Development Bank (IADB) (2004) has developed with teachers' training institutions in Jamaica and Surinam, a draft "Caribbean HIV/AIDS Training Package for Teachers." The Teacher Resource Centre will concentrate on developing ways to put multiple copies of materials in schools through arrangements with publishers and through electronic methods to expand dissemination.

The greatest need in the region is to train teachers with accurate information and how to teach using active learning strategies, which runs against a tradition of a more didactic approach. The goal is to put in the hands of teachers the education resources and tools for effective teaching. Ideally, the proposed HFLE Teacher Resource Development Centre will be able to serve PANCAP, the HFLE Regional Working Group and UN agencies, working with individual countries, to strengthen the mechanisms to address these priorities.

School Environment: Psycho-Social and Physical

The school environment includes the social-emotional climate as well as the physical climate in terms of the quality of the buildings, availability of basic sanitation, water, etc. Relatively new research evidence supports the assumption that schools have an important role to play in creating a climate that not only produces academic outcomes, but also reduces risk behaviours (Blum & Rinehart, 2001; Karcher, forthcoming; Kirby, 2001b; McNeely & Whitlock, 2003). The less likely a young person is involved in risk behaviours, the better his or her academic performance.

Findings from the National Longitudinal Study on Adolescent Health in the U.S., involving 12,118 adolescents in grades 7 through 12, drawn from an initial national school survey of 90,118 adolescents from 80 high schools plus their feeder middle schools, found that young people's feelings of connectedness and belonging to their school was one of the most significant factors against every health risk behaviour measure except history of pregnancy.[3] Understanding what promotes school connectedness is a relatively new field of study, but school climate has historically been found – more than other factors in a young person's life – as a most significant factor in affecting risk behaviours. School climate involves: 1) the opportunity to participate in and influence school classroom policies and procedures, 2) relationships with caring, mentoring adults, 3) the perceptions that adults at school did not discriminate based on appearances, and 4) opportunities for creative involvement and expression (Nonnemaker & Blum, 2002; Whitlock, 2003).

An important investment that Caribbean schools can make in the healthy development of young people and HIV/AIDS prevention is to develop ways to improve school climate and the feelings of connectedness that young people have to the adults there. Educators in the region often comment on the challenges of shedding the vestiges of colonialism in the educational system --the authoritarian climate of schools, the power structure, the exclusive emphasis on academics and didactic way of teaching. Successful prevention for

HIV/AIDS may begin with assessing the school's climate and developing strategies to improve it with such tools as those developed by WHO, *Creating an Environment for Emotional and Social Well-Being* (WHO, 2003).

Other important aspects of school climate for health include gender equity between administrators and teachers, between teacher to teachers, between teachers to and students, and between students to student. Noting that in the survey of Caribbean young people, a large percentage reported that first sexual intercourse was forced, stresses the importance of the gender imbalance and how it can affect sexual relationships and the spread of HIV/infection. Schools as a socializing force can play a major role over time in fostering respect and equity for men and women and in preventing discrimination against gay and lesbian youth and reducing homophobia.

The physical environment and provision of safe drinking water and sanitation facilities are also important. Girls need private facilities once they have begun menstruation. These facilities can be important in keeping girls in school, which is an important preventive factor itself in preventing HIV/AIDS and too-early pregnancy. The school environment will need to have the means to take precautions for universal infection control in caring for wounds and cleaning up blood spills.

Services: Counselling and Access to Condoms, Testing and Treatment

The services component, least familiar and developed within the education sector, is the component that has terrific potential to make a difference in the future. While curriculum and school environments address the needs of a broad range of students, services are often required for those engaged in risk behaviours or for those who are on the verge of moving in that direction. For those at highest risk, services can be the last barrier for prevention before infection. For example, preventive education can be effective to a point, but if young people are sexually active, they need access to affordable condoms. What availability will schools provide either through distribution on site or by linking with health clinics or other vendors?

The service of counselling has several dimensions. For example, young people may need counselling to discuss dysfunctional or abusive relationships with family or friends, new feelings of love and attraction, and confusion about sexual orientation. The ability to resolve these feelings and inter-personal issues may be essential to protection for HIV/AIDS. Counselling has an important function to provide for those who have been tested and found to be HIV-positive. Finally, counselling to cope with loss and death will increasingly be needed for teachers losing partners and for students losing family members and friends.

A related service is Voluntary Counselling and Testing (VCT). It is unlikely that people will practice safe sex using condoms unless they know their HIV status. For those who are positive, VCT can help them prevent spread to others and receive treatment that enables

them to live healthier lives. For those who are not infected, the testing provides a teachable and valuable moment for them to commit to practices to remain that way.

But VCT is often not a high priority and not marketed heavily or easy to access. VCT requires financial and human resources and it takes time to establish the infrastructure for its delivery. Very little is known about the HIV prevalence rates for teachers or education staff. The stigma and fear of discrimination and job loss are obstacles. And, since most testing takes place in antenatal clinics, it is difficult to identify or use data for teachers as a group to know and project the impact on the system.

The component of services and their availability to those in the education sector is quite undeveloped. There are needs to strengthen the mental health and counselling capacity in schools. Some of the greatest breakthroughs in the next decade may be because of the innovative ways in which the education sector and teachers' unions develop new and stronger partnerships with the health sector—with clinics, with condom manufacturing companies, with distributors of testing kits for VCT, and with pharmaceuticals for dedicated distribution of antiretroviral drugs to affected members of the teaching profession. Innovation and bold steps in this area could have a significant positive impact on many aspects of the HIV/AIDS epidemic.

Summary and Recommendations

The traditional approach to health in schools has focussed on curriculum, which is necessary, but inadequate alone to address the range of risk and protective factors confronting young people and the threat of HIV/AIDS. Therefore, the education sector response needs to encompass a more comprehensive approach to ensure the health, teaching and learning of students and staff. Why?

- *Promoting positive behaviours and social norms, which most people in the Caribbean practice, and which are inherent in the approach of HFLE and HPS, can encourage and reinforce others to adopt them.* It is important in the face of the HIV/AIDS epidemic to continue to focus on the positive. More attention needs to be placed on the many young people and education staff who are healthy and free of the virus, emphasizing ways to keep them that way. There is tremendous benefit in promoting the positive social norms of fidelity, abstinence, or safe sex for those who are active. Health and Family Life Education and the HPS do not focus only on HIV/AIDS. They present strategies for the development of the whole person, including HIV/AIDS, and in this way reinforce the pride and proud heritage of the region. The two can work together –an overall approach to healthy development, taking advantage of the need and opportunity to address HIV/AIDS.

- *A coordinated approach provides a more effective way for the education system to plan and implement health programmes*. It is a challenge for the formal educational system to address health. Recent tradition emphasizes academic achievement and designates health to the health sector. However, with the need to address health

issues in the education system, it is very difficult for education planners and teachers to build a plan for each separate health topic. There must be an integrated and simple way to include school health policy and programmes with the capacity to train personnel in their implementation. By coordinating HIV/AIDS within the framework of the HPS and HFLE, there is a set of unified concepts that educators can rally behind and more easily plan implementation. The ability to see how these initiatives fit together can create a critical mass of people, committed with passion, working toward the same goals.

- *HFLE provides a two-decade foundation on which to build.* HFLE has established its Regional Working Group and is working to strengthen HFLE National Committees in countries. There is a long tradition and track record that is on the verge of creating expanded actions and capacity building.

- *Results will be strengthened when the education sector coordinates with the health, mental health and social welfare agencies.* In countries and throughout the region, more and more players want to contribute and have a role in school health and HIV/AIDS prevention in formal education. Clearly spelling out how the goals of each movement can guide ministries, universities, teacher education colleges, *UN Agencies, Donors and Non-governmental Organizations* in assuming a unified approach will enhance the contributions of funds, expertise, materials, etc.

How can those who care so much about children, teacher, other education sector staff and the people of the region and its proud heritage pull together to prevent so much preventable human loss and suffering? Many of the recommended actions have been described in great detail in "Education and HIV/AIDS in the Caribbean". Many of the recommendations by Michael Kelly and Brendan Bain focus on the need for capacity building, and these capacities are the same for the HPS, outlined in Figure VI depicting the roots beneath the flower of the HPS.

A few suggestions concerning how we might make progress to unite these three movements follow:

1. At the regional level of CARICOM, fostering close collaboration and a formal mechanism between PANCAP's HIV/AIDS initiative and CARICOM's HFLE Regional Working Group, in the context of the HPS, could produce greater focus for planning, implementation and resource allocation to achieve the HIV/AIDS Strategic Objectives. Each of the seven Priority areas has a different set of lead agencies. Yet, to provide comprehensive approaches for the education system, there needs to be a way for the HFLE Regional Group to plan with many of the seven.

2. At the country level, the HFLE National Working Groups need mechanisms to work closely with the National HIV/AIDS Committees so that a comprehensive approach can be applied to the education sector, moving beyond curriculum alone.

3. A top priority must be the training of education personnel and the development and dissemination of health promotion and disease prevention materials relevant to the cultures and customs of counties in the region. More emphasis must be placed on implantation by thousands of teachers at the local level on the ground strategies specific to HFLE and components of the HPS model that tie to the HIV/AIDS priorities.

4. New and bold partnerships can be negotiated between the education sector health sectors, among others, to support sexuality education and the continuum of HIV/AIDS components. And, building the capacity of ministries, teachers' unions through new partnerships with the business sector to provide affordable condoms, testing and antiretroviral drugs to education staff and students could save thousands of lives -- and the education system itself.

Figure XI: CARIBBEAN REGIONAL STRATEGIC FRAMEWORK FOR HIV/AIDS: 2002–2006 PRIORITY AREAS AND STRATEGIC OBJECTIVES
PRIORITY AREA #1: Advocacy, Policy Development and Legislation
• To inform and mobilize policy makers at highest levels with more comprehensive information on the course, consequences and costs of the epidemic • To promote the incorporation of human rights and non-discrimination practices in policy and legislation, in accordance with international guidelines, best practices and commitments; • To mobilize regional opinion leaders on HIV/human rights issues • To promote awareness at multi-sectoral level on HIV and human Rights issues • To ensure that national level policies reflect international standards, best practice/consistency with international guidelines • To ensure that prevention messages are integrated into as many general advocacy opportunities as possible
PRIORITY AREA #2: Care, Treatment, Support for People Living with HIV/AIDS
• To improve access to basic medication (for the prevention and treatment of opportunistic infections) • To improve access to antiretrovirals • To strengthen and extend counselling services
PRIORITY AREA #3: Prevention of HIV Transmission, with a Focus on Young People
• To ensure general access to reliable and accurate information about HIV/AIDS • To ensure recognition of gender issues within all prevention campaigns • To improve and support the implementation of Health and Family Life Education Programmes • To Integrate HIV and STI issues into adolescent programmes including reproductive health programmes • To promote the development of HIV/AIDS prevention programmes for young people, including condom distribution • To advocate for the provision of youth-oriented health services and facilities • To promote and support innovative peer counselling models for youth, parents and teachers • To ensure the access of out of school youth to HIV/AIDS prevention and services
PRIORITY AREA #4: Prevention of HIV Transmission among Especially Vulnerable Groups
Drug and Substance Abusers • To strengthen understanding of role of substance abuse and drug use in regional epidemiology of HIV/STIs and to use information in appropriate prevention and care strategies ***Mobile Populations*** • To identity and address policy issues affecting mobile populations at regional level ***People in the Workplace*** • To mobilize and support key employers at regional and national levels to assess HIV/AIDS in their workplaces and to introduce appropriate prevention and support programmes for employees
PRIORITY AREA #5: Prevention of Mother to Child Transmission
• To strengthen primary prevention among women
PRIORITY AREA #6: Strengthen National and Regional Capacities for Analysis, Programme Design, Implementation, Management and Evaluation
• To build analytical and management capacity in key regional institutions such as UWI • To expand and improve the quality of information available to programme managers and policy makers on the course, causes and consequences of the epidemic at national and regional levels • To promote information exchange, coordination and formation of strategic alliance in the region
PRIORTIY AREA #7: Resource Mobilization
• To identify resource needs and gaps • To ensure access to the Global Fund for HIV/AIDS, TB and Malaria

References

Blum, R. W., & Rinehart, P. M. (2001). *Reducing the risk: Connections that make a difference in the lives of youth*. Minneapolis, MN: Division of General Pediatrics and Adolescent Health, University of Minnesota.

CARICOM/ Health and Family Life Education Project, & UNICEF, Caribbean Area Office, (2001) *Health and Family Life Education, Empowering Young People with Skills for Healthy Living.* Barbados: CARICOM/UNICEF.

CARICOM/UNICEF. (forthcoming). *HFLE Regional Curriculum Framework.* (publisher pending).

Dacey, J. & Travers, J. (1991). *Human Development Across the Lifespan.* Madison, WI: WCB Brown and Benchmark.

Dash, K., Vince Whitman, C., Harding, W., Goddard, C. & Adler, M. (2003). *Applying effective strategies for school violence and substance abuse prevention*. Newton, MA: Education Development Center, Inc.

Education Development Center, Inc. (1991). *Teenage Health Teaching Modules. Teacher's Guide for Grades 9 and 10.* Newton, MA: Education Development Center, Inc.

Education Development Center, Inc. (2003 Draft). *HIV/AIDS: Indicators for Capacity Building in the Education Sector.* Newton, MA: Education Development Center, Inc.

Education Development Center, Inc. (1991). *Teenage Health Teaching Modules. Teacher's Guide for Grades 9 and 10.* Newton, MA: Education Development Center, Inc. Adapted from Gold, R. (1982). "The Iceberg of Risk-related Outcomes." College Park, Maryland: University of Maryland.

Government of Namibia, Ministry of Basic Education, Sport and Culture, & Ministry of Higher Education, Training and Employment Creation. (n.d.) *Draft National Policy on HIV/AIDS for the Education Sector*. http://www2.ncsu.edu/ncsu/aern/aidpol.html

Economic and Social Commission for Asia and the Pacific [ESCAP]/ United Nations Office on Drugs and Crime [UNODC]. (2003). *Adolescent substance use: risk and protection*. New York: United Nations.

Education International [EI] & World Health Organization [WHO]. (2001). *Training and Resource Manual on School Health and HIV/AIDS Prevention.* http://www.ei-ie.org/educ/aids/eepublication.htm

Halcon, L., Beuhring, T. & Blum, R.W. (2000). *A portrait of adolescent health in the Caribbean 2000.* Minneapolis: WHO Collaborating Centre on Adolescent Health, University of Minnesota & PAHO.

Havighurst, R. (1972). *Developmental tasks and education.* New York: McKay.

HIV/AIDS, Theme Groups in the Caribbean et al. (2003). *Education & HIV/AIDS, Quarterly Report to United Nations*, Issue 4, December.

IATT. (2003). *Global HIV/AIDS, Education Sector Readiness Report, Project Proposal and Pilot Survey Results (HEARD)*. University of Natal, Gabon Workshop.

Inter American Development Bank [IADB]. (2004, final draft). *Caribbean HIV/AIDS Training Package for Teachers—Part I, Advocacy and Instructional Materials for Teachers' Training Institutions in the Caribbean*.

International Bureau of Education (2002). *Curriculum Development for Learning to Live Together: The Caribbean Sub-Region*; The Final Report of the Sub-Regional Seminar Held in Havana, Cuba, 15–18 May 2001. Geneva: International Bureau of Education.

International Institute for Educational Planning [IIEP]/UNESCO. (2002). *HIV/AIDS & Education. A strategic approach*. Paris: IIEP. http://www.unicef.org/lifeskills/StrategyFrameworkonHIVAIDSandEducation.pdf

International Labour Organization [ILO]. (2002). *Implementing the ILO code of practice on HIV/AIDS and the world of work: an education and training manual*. Geneva: ILO. http://www.ilo.org/public/english/protection/trav/aids/code/manualen/complete.pdf

Jamaican Ministry of Education, Youth and Culture, *National policy for HIV/AIDS management in schools.* Kingston, Jamaica, 2003. http://www.moec.gov.jm/divisions/ed/guidance/MOEYC%20HIVAIDS%20Policy%20for%20Schools%20Most%20Final.pdf

Karcher, M. J. (forthcoming). Connectedness and School Violence: A Framework for Developmental Inter-ventions. *Handbook of School Violence.* Hansworth Press.

Kelly, M. J. & Bain, B. (2003). *Education and HIV/AIDS in the Caribbean,* Paris: UNESCO Office for the Caribbean, International Institute for Educational Planning.

Kirby, D. (2001a). *Emerging Answers: New Research findings on programs to reduce teen pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy. Summary available online: http://www.teenpregnancy.org/resources/data/pdf/emeranswsum.pdf

Kirby, D. (2001b). Understanding what works and what doesn't in reducing adolescent risk-taking. *Family Planning Perspectives, 33*(6), 276–281.

Mangrulkar, L., Vince Whitman, C., & Posner, M. (2001). *Life Skills Approach to Child and Adolescent Healthy Human Development*. Washington, DC: Pan American Health Organization.

McNeely, C. A., Nonnemaker, J. M., & Blum, R.W. (2002) Promoting school connectedness: Evidence from the National Longitudinal Study of Adolescent Health. *Journal of School Health*, 72, 4: 138–146.

McNeely, C., & Whitlock, J. (2003). *Voice, visibility, place and power: Correlates of school and community connectedness among 8th, 10th, and 12th grade youth*. Unpublished doctoral dissertation, Cornell University.

Nonnemaker, J. M., & Blum, R. W. (2002). Promoting School Connectedness: evidence from the National Longitudinal Study of Adolescent Health. *Journal of School Health 72*(4), 138–146.

Pan-Caribbean Partnership on HIV/AIDS. (2002). *The Caribbean Regional Strategic Framework for HIV/AIDS, 2002–2006*. Georgetown: CARICOM.

PAHO. (2002). *Proceedings of the First Meeting and Creation of the Caribbean Network of Health Promoting Schools*. Washington, DC: Pan American Health Organization, Regional Office of the World Health Organization.

PAHO. (2003). *Press release. PAHO prepared to help Caribbean reduce high cervical cancer rate.* www.paho.org/English/DD/PIN/pr031211.htm.

Peterson, C. E. (1998). *HIV/AIDS Model Policy for Wyoming Public Schools*. Cheyenne, WY: Wyoming Department of Education.
http://www.k12.wy.us/ao/hs/Programs/hivpolicy.pdf

Sen, A. (1999). *Development as Freedom*. New York: Alfred A. Knopf/ Random House, Inc.

UNAIDS. (1997a). *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update*. UNAIDS/97.4.
http://www.unaids.org/publications/documents/children/schools/grunskme.pdf.

UNAIDS. (1997b). *Integrating HIV/ATD prevention in the school setting: a position paper.* Geneva: UNAIDS.

UNESCO Office for the Caribbean (2003). *Education & HIV/AIDS, a report to UN Theme Groups on HIV/AIDS in the Caribbean.* Kingston, Jamaica: UNESCO.

UNESCO, *Thematic Studies, School Health and Nutrition. World Education Forum,* Dakar Senegal 26-18 April 2000. Paris: UNESCO.

UNESCO Office for the Caribbean. (2002). *United Nations Support for HIV/AIDS Prevention and mitigation in the Caribbean through the Education Sector*. Kingston, Jamaica: UNESCO.

UNESCO. (2003). *Understanding HIV/AIDS and Drug Abuse,* Literacy and Life Skills Series, Workbook 1, Morton Publishing Company, Trinidad and Tobago.

UNESCO & IIEP. (2003). *HIV/AIDS and Education: A Strategic Approach*. Paris: International Institute for Education Planning, UNESCO, IIEP.

UNESCO, UNICEF, WHO & World Bank. (2000). *Focusing Resources on Effective School Health: a FRESH start to enhancing the quality and equity of education*.

UNICEF, WHO et al. (2002 Draft). *Briefing Package: Skills for Health. Skills-based health education, including life skills: An important component of a child-friendly/health-promoting school.*

University of Natal Aids Committee. (2002). *University of Natal. HIV/AIDS Policy*. http://www.hivan.org.za/campussupport/NU_downloads/aidspolicy.pdf

Vince Whitman, C., Aldinger, C., Levinger, B., & Birdthistle, I. (2001). *World Education Forum, Education for All 2000 Assessment. Thematic Studies: School Health and Nutrition*. Paris: UNESCO.

Vince Whitman, C. (2002). Rapid Assessment and Action Planning Process to Promote Health Through Schools. In *Proceedings of the First Meeting and Creation of the Caribbean Network of Health Promoting Schools*. Washington, DC: Pan American Health Organization, Regional Office of the World Health Organization.

Whitlock, J. (2003). *Fostering school Connectedness*. Cornell University, New York: ACT for Youth Upstate Center of Excellence Newsletter. http://www.human.cornell.edu/actforyouth

World Bank. (1993). *World Development Report 1993: Investing in Health.* New York: Oxford University Press.

World Bank. (2001). *HIV/AIDS in the Caribbean, Issues and Options.* Washington, D.C.: World Bank.

World Bank. (2002). *Education and HIV/AIDS. A window of hope.* Washington, D.C.: World Bank.

WHO, UNICEF, UNESCO, World Bank, EI, EDC, & PCD. (2003). Focusing Resources on Effective School Health: A FRESH start to improving the quality and equity of education. http://www.freshschools.org/whatisFRESH.htm

World Health Organization [WHO]. (1986). *Ottawa Charter for health promotion*. Geneva: WHO.

World Health Organization [WHO]. (1997). *Promoting Health Through Schools: Report of a WHO Expert Committee on Comprehensive School Health Education and Promotion,* Geneva, WHO. (WHO Technical Report Series 870.) Geneva: WHO.

World Health Organization [WHO], (2003). *WHO Information Series on School Health, Document Ten. Creating an Environment for Emotional and Social Well-Being: An Important Responsibility of a Health Promoting and Child-Friendly School.* Geneva: WHO

World Health Organization [WHO]. (1998). *WHO's Global School Health Initiative. Health-Promoting Schools. A healthy setting for living, learning and working*. WHO/HPR/HEP/98.4. Geneva: WHO.

World Health Organization [WHO]. (1999). *WHO Information Series on School Health, Document Six. Preventing HIV/AIDS/STI and Related Discrimination: An Important Responsibility of Health Promoting Schools.* Geneva: WHO.

World Health Organization [WHO]. (2000). *Local Action: Creating Health-Promoting Schools.* WHO/NMH/HPS/004. Geneva: WHO.

World Health Organization [WHO]. (2003a). *The World Health Organization's Information Series on School Health, Document 9. Skills for Health: Skills-based Health Education including life skills: An important component of a Child/Friendly/Health Promoting School*. Geneva: WHO.

World Health Organization [WHO]. (2003b) *The World Health Organization's Information Series on School Health, Document 8. Family Life, Reproductive Health and Population Education, Key Elements of a Health Promoting School*. Geneva: WHO.