

**Response to Change - Changing the Response:  
Increasing Donor Involvement in the Spectrum from Prevention to  
Care for HIV and AIDS**

**European Foundation Centre (EFC)  
GrantMakers East Group (GEG)  
Tenth Annual Meeting**

**Response to Change  
20 and 21 October, 2005**

**Kyiv, Ukraine**

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## ***Introduction***

One of the recent goals of the European Foundation Centre has been to engage more of its members in addressing health issues, including HIV and AIDS. Two relatively new groups within EFC have been formed. In 2002-3, EFC formed the HIV and AIDS Donor Group, convened by the Bernard van Leer Foundation. The goals of this donor group are, for example, to encourage new donor activity and exchange of best practices (<http://www.efc.be/projects/aids/default.asp>). Yet increasing the number of members has progressed at a relatively slow pace. It is thought that donors struggle to find a fit with their missions; experience their own feelings of stigma with the topic; do not perceive HIV and AIDS to be a significant threat in Europe; and label HIV and AIDS a health rather than a societal problem and the responsibility of the health sector.

The second group, created in the summer of 2005 at the EFC meeting in Budapest, is the European Partnership for Global Health (<http://www.efc.be/projects/health>). This Partnership plans to advocate for and shape a European voice and strategy on global health, based on European values and experience and an understanding of health as a basic human right. One of the features guiding this agenda will be the European commitment to the Millennium Development Goals (MDGs). MDG Goal #6, to be met by 2015, is to “Halt and begin to reverse the spread of HIV/AIDS”.

Clearly there is a need to address health and HIV across Europe. There are an estimated 1.4 million cases of persons living with the virus in Eastern Europe and Central Asia (UNAIDS, 2004). This number is considered to be highly underestimated. The rate of spread is the fastest growing in the world ([http://www.thebody.com/tpan/novdec\\_03](http://www.thebody.com/tpan/novdec_03)). Overall, more than 80% of people who are HIV positive in this region have not yet turned 30, in contrast to 30% of HIV positive residents of Western Europe. The epidemic is fueled by drug use among young people and unprotected sexual activity. Fewer than 5% of these young people have access to programs reducing risk. If protection against transmission is neglected in these high risk groups, HIV spread to the general population is likely to accelerate at an alarming rate in this decade ([Http://www.avert.org](http://www.avert.org)).

Rates of HIV infection in Eastern Europe may seem relatively low compared to those in African countries, such as Botswana, which has one of the world’s highest rates, close to 37%. But the time to act is before a country reaches the tipping point, which is considered to be a 5 % prevalence rate. After the rate climbs higher than 5%, containing further spread is very difficult. “The tipping point is not a hypothetical construct,” Peter Piot of UNAIDS has commented. “In South Africa, it took five years for prevalence rates to move from 0.5 % to 1 %. Then, in only seven years, it jumped from 1 % to 20 %.” (<http://www.washingtonpost.com/wp-dyn/articles/A23417-2004Nov30.html>).

In Eastern Europe, the Ukraine has made significant advances in handling the epidemic. For example, Alliance Ukraine, funded by USAID and the Global Fund, has procured anti-retroviral drugs for patients with AIDS as well as medications to treat opportunistic infections.

Ukraine has also been very successful in preventing transmission of HIV from mothers to newborns. More than 90% of HIV+ pregnant women now receive anti-retroviral treatment (compared to 0 before 1995) (AIDS Alliance Ukraine). This type of intervention is happening and achieving success because HIV/AIDS among pregnant women is the more visible epidemic; these women come into contact with HIV testing programmes at pre-natal clinics.

Despite these recent successes, scientists are concerned that the epidemic continues to grow among intravenous drug users, sex workers, and other marginalized groups, including homosexual men. In Ukraine young people have limited access to services; marginalized groups like young injecting drug users and sex workers are especially without access. A UNICEF poll discovered that fewer than 70% of Ukrainian teenagers were aware that condoms reduce the spread of AIDS, but do they have access to and use them? The social exclusion, stigmatization, and even incarceration these young people experience lead to more suffering and silently fuel the spread of disease ([www.unicef.org](http://www.unicef.org)).

To respond to Millennium Development Goal #6, there is a tremendous need for EFC-GEG donors to take on a much more comprehensive, multi-sectoral response, especially to address the underlying problems placing young people at risk

The goals of this paper are to engage the EFC-GEG donor community in considering:

- I. The interdependence of health with all aspects of our lives and institutions in society, which means that many sectors beyond health must be involved in the response to HIV and AIDS from prevention to voluntary counseling and testing to treatment, bereavement and care of children, who are affected and infected.
- II. The necessity of overcoming the barrier of stigma and discrimination in combating further spread of the virus and the effectiveness of involving associations of persons living with AIDS (PLWA) as a means to do so.
- III. Why and how schools, community agencies and Persons Living with HIV and AIDS, working together, can and must do more to implement effective strategies.
- IV. The broad range of foundation missions that can fit with the spectrum of prevention to care, across sectors, and the need for more donor involvement.

Recognizing the root causes of HIV and AIDS in the broader society and in many facets of our lives and society's institutions provides countless opportunities for donors of EFC and GEG to change the response and become involved. While HIV and AIDS are health problems, typically labeled as the responsibility of the health sector, there is an urgency to mount a much broader societal response that includes ---education, public health, mental health and social services, law enforcement, information and communications technologies (ICT), media, and all of civil society.

## ***Interdependence of Health with Society's Institutions***

In our work as a WHO Collaboration Centre, EDC subscribes to the World Health Organization's (WHO) definition of health (1946) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (<http://www.who.int/about/definition/en/>). As elaborated furthered in the Ottawa Charter, 1986, "health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Good health is a major resource for social, economic and personal development and an important dimension of quality of life". Our societies are complex and interrelated. Health cannot be separated from other goals. This broad definition of health should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. ([http://64.233.167.104/search?q=cache:irg6SycmObkJ:www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf+ottawa+charter+health+promotion+who&hl=en](http://64.233.167.104/search?q=cache:irg6SycmObkJ:www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf+ottawa+charter+health+promotion+who&hl=en)).

The updated WHO charter recognizes the need for multi-sectoral involvement if health goals across the world are to be achieved. The WHO Health Promotion Charter (Bangkok, August 2005), identifies "actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion and strong political action, broad participation and sustained advocacy" (<http://www.who.int/healthpromotion/conferences/>).

Over the last decade, a growing body of research illustrates the relationship between health and academic performance, workforce productivity, family and community stability and ultimately economic development (<http://www.unesco.org/education/efa/index.shtml>). Reciprocally, these issues and their institutions affect people's health. For example, numerous studies have documented the impact of child nutrition on cognitive development and test scores. Children lacking social emotional skills are more likely to be in conflict with their peers, which affects their performance as students. Children who experience emotional strife in families are less able to perform well in school. In turn, school failure and dropout can affect a young person's health. And, school failure and drop out are serious risk factors for substance abuse and victimization (Whitman *et al*, 2000).

The health of the workforce, including teachers as a workforce, affects productivity and economic development. Teacher absenteeism affects the quality of education and student learning. Economically, for example, a study in the Caribbean countries of Trinidad, Tobago and Jamaica described the impact of HIV/AIDS on the reduction of human capital for the labour force, the added cost to treat people, and the decline in GDP for the tourism industry (<http://64.233.167.104/search?q=cache:PD7-X7WpneMJ:www.iaen.org>). In turn, failed economic development, poverty and unemployment are also risk factors for drug abuse and sex work.

Therefore, HIV/AIDS is not an isolated disease caused by bad people, who engage in drug abuse and sex work. Although it has been primarily labeled a health problem, the

disease results in part from the failure of our many institutions ...family, schools, communities, employers. . . . which contribute to the problem and which increasingly will be affected by the results.

Given the ways in which all sectors of society may contribute to or stem HIV and the ways in which all society will be affected, the rapidly rising rates of prevalence in Eastern Europe should be a grave concern to all.

**The Need for a Multi-Sectoral, Comprehensive Approach:  
*Prevention, Intervention, Testing, Drug Treatment, Bereavement***

Consider how the factors in Figure I, “Societal Factors Contributing to Rising Rates of HIV and AIDS,” may be played out in one family. A child may be living in a family where one or both parents are un or underemployed. They are either living in poverty or on its margins. Such circumstances are often accompanied with parental abuse of alcohol, child neglect and/or physical abuse. The child suffers emotional and mental turmoil, cannot concentrate in school, gets poor grade scores, eventually dropping out. Having little access to counseling or services in the school or community, internalizing emotional pain and rejection, he/she resorts to drug use. For young men AND women, a primary source of income and their own self-victimization then leads to sex work. It is a vicious cycle from family poverty and dysfunction to mental health issues, school failure, and destructive behaviors, leading to HIV, now poised to spread through the general population.

**Figure I: Societal Factors Contributing to Rising Rates of HIV and AIDS**

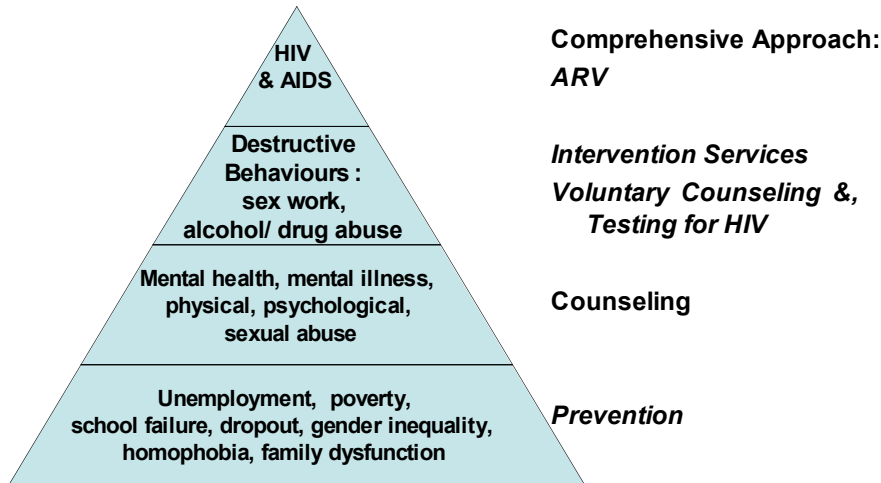


Figure II presents many of these same factors from the perspective of the individual, family, school and community that place a young person at risk of abusing alcohol and drugs.

**Figure II: Risk Factors for Self - Destructive Behaviours**

Individual	Family	School	Community
Friends who use	Chaotic home	Academic failure	Availability substances
Early problem behaviours	Poor family relations	Peer rejection	Exposure to violence
Hopelessness	Parents/family members who use alcohol and drugs	Low degree of commitment to school	Lenient laws, no enforcement
Genetic pre - disposition		Highly authoritarian; harsh punishments	Neighborhood Deterioration
Poor social adjustment & coping skills	Abuse/neglect		Lack of recreational activities and employment

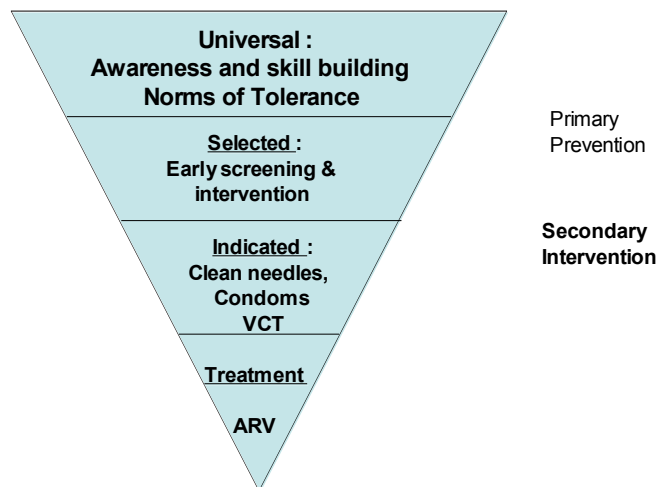
Yet society in general, disassociating itself with people in these circumstances, isolates and ignores the problem, to feel immune from risk. As research in Southeast Asia has shown, the epidemic, ignored over a decade, spreads silently to emerge, too late, as a full-blown epidemic in the general population (World Bank, 1997). Stopping HIV/AIDS before it spreads into the general population by intervening immediately with intravenous drug users and sex workers is essential. However, due to discrimination against these groups, few societies tolerate, let alone support, the policies for clean needles, rehabilitation, free condoms and other means that have shown to be effective. And intervention this late in the cycle of factors that contribute to the problem can hardly be called prevention. Prevention and early intervention sooner, with policies and programs that meet the needs of young people and families earlier in this cycle, are essential and ultimately will be more constructive and less costly and harmful to individuals and to society as a whole.

Figure III presents the elements of this broader response with *Universal* programs for all society, beginning with prevention by increasing awareness, knowledge and skill, cultivating societal norms of support and tolerance for policies and programs for those at highest risk and access to basic quality education and jobs. *Selected* programs are for those youngsters and adults indicating symptoms of risk, for example, the child in an abusive situation or who is at risk of school failure. Selected programs may need to be customized for children who are affected by HIV and AIDS, those who have lost one or both parents and who may be experiencing loneliness and depression from lack of

connection to caring adults. *Indicated* programs are for those people already engaged in high-risk or destructive behaviors, whose behavior threatens to spread the virus throughout the population. And finally, for those who are infected, access to drug treatment and trained professionals who can administer, counsel and provide further preventive strategies, are necessary to sustain life and prevent mother-to-child transmission and transmission to others.

Consistent with their values and mission, donors can contribute to stemming the HIV/AIDS pandemic at many different places in the spectrum from primary prevention to early intervention and care with *universal* programs that reach all, *selected* programs for people at high risk and *indicated* programs for those who are already engaging in behaviors that are destructive or likely to transmit the virus to others.

**Figure III: Spectrum of Response**



A comprehensive response to the HIV/AIDS epidemic includes all points on the continuum from prevention to intervention to care and bereavement. Interventions along the continuum are mutually reinforcing. For instance, antiretroviral medicines have been proven to reduce the number of new HIV infections (Blower & Farmer 2003). Increased care and treatment for people with HIV are linked to increased use of voluntary counseling and testing services. This means more people are aware of their HIV status and able to take preventive measures. Antiretroviral drugs reduce the viral load of patients on therapy, which thereby decreases the chance of transmission. Care and treatment also lead to the destigmatization of HIV and AIDS. (WHO ARV Care and Treatment: Haiti Case Study). According to WHO, the challenge ahead is to make the most of potential synergies between prevention and treatment.

Programs that integrate drug substitution treatment and ART with a range of preventive services reduce the risk of transmission in the young at-risk community and benefit drug users already infected, enabling them to protect their health. But Peter Piot, Executive Director, UNAIDS, believes that very few among the evaluated prevention programs have been proven effective in responding to the combined challenges of HIV and intravenous drug use in young people. Research into what makes these targeted programs work is urgently needed, and results must be shared across sites and countries where the epidemic conforms to this particular pattern ([www.unaids.org](http://www.unaids.org)).

### ***Effective Strategies to Overcome Stigma and Discrimination***

For donors to become more involved and for initiatives to gain broad public support, effective strategies to overcome the major barriers of stigma and discrimination must be used. AIDS-related stigma has been defined as prejudice, discounting, and discrimination directed at people with HIV/AIDS (Herek 2002). Stigma and discrimination against persons living with HIV and AIDS or engaging in risk behaviours that lead to HIV and AIDS stand in the way of prevention. Stigma and discrimination still remain the most poorly understood barriers to treatment (Brown et al. 2003)

Stigma seems to center on fear of contagion and moral assumptions about people who get the disease. Some people fear they will contract HIV through casual contact. The moral assumptions stem from people's attitudes about how those with HIV behaved—that they engaged in same sex or illicit sex and/or using drugs makes them bad people. Moreover, stigma surrounds injecting drug use because associated behaviors are secret, illegal, and shame-ridden. People tend to disassociate themselves from drug users or homosexuals, saying to themselves, “I do not do that, therefore I am safe.” They psychologically, through disassociation, then feel they can protect themselves and society in general. Although some of these archaic attitudes may explain its sources, stigma is inherently illogical (Brown et al. 2003).

Beyond causing emotional pain and suffering, AIDS stigma negatively affects preventive behaviors like condom use, pursuit of diagnosis, pursuit of care, and treatment of persons living with HIV/AIDS (Brown et al. 2003). Family members of people with AIDS also suffer the effects of stigma, which limits their opportunities and constrains their options. Keeping people disenfranchised and in the dark can fuel the epidemic.

Reduction in AIDS-related stigma is vital to stemming the epidemic (Cameron 2000). A review of 22 studies to decrease AIDS stigma in developed and developing countries reported: “some stigma reduction interventions appear to work, at least on a small scale and in the short term, but many gaps remain especially in relation to scale and duration of impact” (Brown et al. 2003). This review suggests that contact with PLWA might be one of the most promising approaches, though it clearly is not sufficient without improved understanding of the disease (i.e., together with information approaches). Contact with PLWA alone had a short-term impact among high school students, but had greater (though not statistically significant impact) when combined with information. Similarly, the positive impact of the contact method has shown the significant effect of educational

sessions given by someone who has disclosed his/her status, compared with the same person giving the same session but not disclosing their HIV-positive status (Scollay et al. 1992). Nonetheless, Brown et al. conclude that there have been too few anti-stigma interventions targeting the young (only 2 out of 22), and that experiments and programs that scale up efforts to combat stigma are essential (Brown et al. 2003).

People living with HIV and AIDS are recognized by WHO as having an essential role to play as partners in preventing new infections. Greater Involvement of People Living with or Affected by HIV and AIDS (GIPA) is a major weapon against stigma and discrimination. Involving PLWA encourages positive perceptions of those who are infected and enables them to be recognized as having rights and needs. GIPA ensures that the knowledge and expertise of people infected with and affected by the epidemic are involved in decision making at all levels and that needs and insights are reflected in policy and programs. ([www.unaids.org](http://www.unaids.org))

***Why and how schools, community agencies and Persons Living with HIV and AIDS, working together, can and must do more to implement effective strategies.***

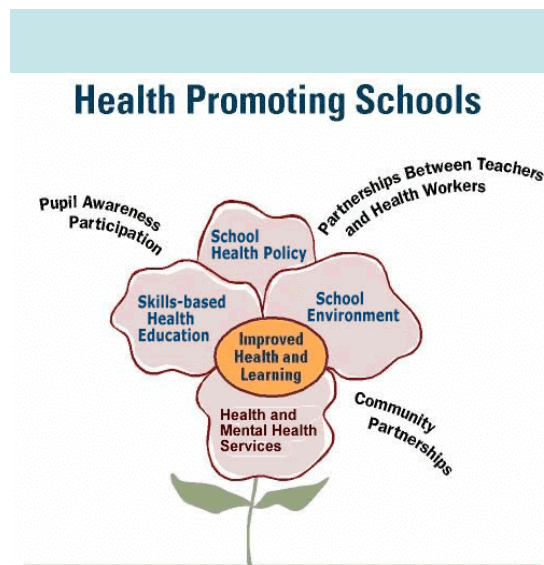
One way to work more effectively is to strengthen the role and response of the education sector, in collaboration with other players in society. Why advocate that the education sector play more of a leadership role? The education sector is especially important as the population in Eastern Europe disproportionately affected with HIV is so young, and schools can address many of the underlying factors that place young people at risk. Some reasons for greater leadership and involvement of the education sector.....

1. Education sector leaders, ministers of education and department heads, need to consider the impact of HIV and AIDS on schools and teachers and set norms for tolerance, and for communicating essential information and skills to young people;
2. Education sector policies, through example, by accepting teachers and students who are HIV positive, combat stigma and discrimination. Beyond the traditional curriculum, in the hallways and in the school yard, schools are places that transmit societal values of tolerance and gender equity.
3. Schools are workplaces for thousands of staff, who need to know essential information and where to find access to services; teachers themselves and school staff often are on the margins of living in poverty themselves.
4. Education and schools need strategies for young people to succeed. School success and completion alone are major preventive factors; schools also need services to identify and refer those at greatest risk of HIV and AIDS due to family dysfunction to mental health counseling and other services as early as ages seven and eight, thereby reducing the likelihood of their becoming involved with drugs and other self-destructive behaviors.
5. Schools are often the gathering place in the community and can serve as the major coordinating mechanism with other sectors; they can offer ways for parents and community leaders to come together and participate in solving social problems.

The concept of the Health Promoting School, which originated with the European Commission and Council of Europe, is a powerful one in the healthy development of teachers and staff and in combating HIV and AIDS. Drawing on the Ottawa Charter and WHO definitions of health, the HPS applies concepts of public health in education and community settings, also regarding school as a workplace.

The concept of the Health Promoting School is simply that schools will use all means at their disposal to promote the health of staff and students. This concept goes well beyond health and HIV and AIDS information in the curriculum. A Health Promoting School, as illustrated in Figure IV, combines policy, curriculum, services (counseling, mental health and health) and a healthy psycho-social and physical environment for working and learning. Such an environment would be free of stigma and discrimination, sexual harassment, homophobia and bullying. Most importantly, the HPS involves community and family participation. Strategies employed by Health Promoting Schools include designing programs based on local data and advocacy.

**Figure IV: Schools, Community, PWLA and Civil Society Working Together**



Policy, curriculum, services and environment are all involved in protecting health. In recent years, where possible, use of information and communications technologies also can play a key role. The HPS is well established in Eastern Europe and became so in the last decade because it offered parents ways to participate in democratic decision-making and taking action on behalf of their children at the community level. How can this powerful concept be applied for a strengthened response to HIV and AIDS?

## Education Sector Policies

The policies related to HIV/AIDS adopted by this visible and influential sector make a significant difference. These policies can include:

- Information about the epidemic and its patterns of transmission;
- Mechanisms for cooperation with civil society and PLWA;
- Emphasis on prevention education with staff training;
- Confidentiality about students and staff who are HIV positive;
- Universal precautions for handling potentially infectious situations;
- Access to counseling, mental health, testing and treatment services;
- Code of ethics that is tolerant of gender, race, ethnic and sexual differences (ILO AIDS).

In 2004, the University of Natal in South Africa conducted the '*Global Readiness Survey*' for the Interagency Task Team on AIDS in the Education Sector (IATT), convened by UNESCO. The group surveyed the policies in ministries of education in 71 countries ranging from high, medium and low prevalence of HIV and AIDS. Highlights of results from the seven Eastern Europe countries that responded to the survey appear in Figures V below (Armenia, Belarus, Estonia, Latvia, Moldova, Russian Federation and Ukraine). All are low prevalence countries with rates of one percent or less. The full survey report can be found at <http://portal.unesco.org/en/ev.php>.

**Figure V: Highlights of Global Readiness Survey: 7 Eastern European Countries**

Question	Eastern European Countries	
	Yes	No/NA
<i>Has any research been commissioned that informs the education sector response to HIV/AIDS?</i>	57%	43%
<i>Does the education sector have a shared strategy for the fight against AIDS?</i>	0%	100%
<i>The Ministry of Education has a specific HIV/AIDS policy</i>	28.5%	71.5%
<i>The Ministry of Education has a workplace policy relating to HIV/AIDS.</i>	43% (In process)	57%
<i>Have guidelines for implementing universal precautions been developed for use by all staff?</i>	0%	100%
<i>Do you enforce confidentiality of information about Ministry employees affected by HIV/AIDS?</i>	100%	0%

These highlights indicate there is much more to be done through a public health approach, using data to inform the education sector response. More than half of the countries have no data to inform their plans. HIV- and AIDS-specific and workplace policies have been adopted in fewer than 30% of the Eastern European countries. None has a workplace policy in place, but three countries are in the process of developing such a policy. All of these countries report that they respect confidentiality, but not one has guidelines for universal precautions for handling potentially infectious situations. Moreover, the education sector is typically not part of multi-sectoral planning for a shared strategy, and it needs to be.

## **Community and Parental Involvement**

The engagement of the community and parents as stakeholders can have many benefits. Community and parental participation can result in buy-in and support as well as the collection of informal data about the challenges family and community members face with young people, their patterns of behavior and access to harmful substances. Community involvement provides the opportunity for broader education of parents to combat stigma and discrimination and the opportunity for leadership development in civil society. Given the research on the effectiveness of involving persons living with HIV and AIDS, the importance of contact with PLWA and their credibility in delivering education messages, greater efforts must be made to work with organizations representing those affected in the community. Clear and straightforward education about how HIV is transmitted can help erode fears of casual transmission.

EDC is developing the New Wave Project with students in the Ukraine to fight stigma using information technologies. Partners include the Ukrainian Institute of Social Science Research, the Ministry of Education, EDC Europe, Alice O, iEARN. The New Wave project is a 3-year international effort using Information and Communication Technology (ICT) to involve high schools in advocacy and action research projects in the community into stigma and discrimination, which are doubly entrenched against drug users. As Dr. Cherednichenko states, “One of the goals of the New Wave project is for students never again to ‘think about HIV and AIDS as a problem which is very far away.’” Interviewing authentic sources, PLWA, students will be designing anti-stigma and discrimination projects. Where direct contact is forbidden, technology can be a great connector. Connecting students with PLWA can lead to interest in possible careers in nursing, medicine and health, filling needs of the future workforce. It is hoped that the broader community will be engaged to change norms and provide longer-term support.

Many of EDC’s projects have discovered there is a steep learning curve for community members to understand health issues and then apply research principles. This takes time. Working *with* the community in participatory ways and not *on* the community is an important element of the approach. Other strategies, such as providing a skilled coordinator/facilitator and assessing the stage of community readiness at the launch, are most helpful. (<http://main.edc.org/>)

## **Curriculum**

Evaluations have shown clearly that to be effective in reducing students' risk behaviors, curriculum must move beyond information only delivered in lecture format to engage and involve students in learning skills to protect themselves in specific situations. In the safety of the classroom, they not only learn lifesaving information, but also have the opportunity to practice skills before they are in a situation of risk. Unfortunately, worldwide, traditional lectures and individual counseling predominate. They do not include skills development or involve students in solving real-life problems.

## **Services**

Services may include counseling for early identification and referral to health (including reproductive health) and mental health services. At the high school level, partnerships with the business community and employers who offer internships and possibilities for young people to gain job-related skills can also offer hope for the future.

Given that drug use and unsafe sex are fueling the epidemic in Eastern Europe, strengthening counseling services in schools is an important part of early prevention. Teachers and nurses often say that they can identify youngsters with a propensity for high-risk behaviours as early as ages seven and eight. Students' inability to focus, conduct disorders, and learning disabilities are telling signs. Improved ways to identify and treat students' mental and emotional health early on can prevent future loss of lives. Guidance counselors should have training and professional development opportunities to help them address the broad range of psychosocial issues that those students affected by HIV and AIDS may face in their lives.

By partnering with the health care community, the health sector can bring knowledge and hope to those who for so long have not known where to turn. The sector can be involved in training education personnel about HIV testing and counseling, including where to seek services, how to prepare, what testing entails, and what is encompassed in post-test counseling.

## **Environment**

Finally, the school environment is the place where young people spend at least five or more hours each day. The psycho-social quality of that environment is all-important in reducing risk behaviours. One study in the United States found that the most important factor in reducing student risk behavior was the degree to which they felt connected to the school as a community and the caring adults there. (Blum, 2002) School environments also transmit values of the culture of tolerance or non-tolerance, of compassion and care. Environments free of sexual harassment, bullying and ridicule about differences set the stage for young people's lifelong attitudes. In this way, all schools have a powerful role to play in prevention.

## **Conclusion**

Although usually considered as a disease with particular patterns of morbidity and mortality, largely the domain of the health sector, HIV and AIDS clearly have their roots in much broader societal factors. Health affects many facets of life from academic success to workforce productivity and economic development. Ignoring and isolating intravenous drug users and sex workers will not contain the problem. Prevention, voluntary counseling and care are all necessary for mutual reinforcement. With the range of strategies required, many sectors of society must be involved.

One sector that can take much more of a leadership role and serve to coordinate with others, especially at the local community level, is education. And the Health Promoting School model, used quite extensively in Eastern Europe, can and should be expanded to combat HIV, using techniques to fight stigma and mitigate the risk of drug use in young people. By working with associations of PLWA, the health sector and civil society, schools and community agencies can do more to halt and reverse the spread of HIV and AIDS before it exceeds the tipping point, with irreversible consequences for all society.

Given the urgency of the problem and the range of needs, there are opportunities for many more donors in EFC and GEG to respond to HIV and AIDS in a way that directly corresponds with a variety of missions. Response may take the shape of creating programs to combat stigma, greater involvement of PLWA, strengthening what ministries of education can do, involving young people, using technology to engage students in community action research projects, conducting research about effective interventions and gaps, building the leadership capacity of civil society, tracking and monitoring needed capacity building, and much more. At this historical moment when citizens are gaining greater participation in democratic processes for social change, countries in Eastern Europe, *with help from EFC and GEG donors*, can base their response on we have learned about the course of the epidemic from around the world. A concerted response is our best hope of stopping HIV and AIDS in the region before it is too late.

A beautiful poem, written by a Ukrainian student who wished to remain anonymous, provides a poignant summary. This student was involved in one of our partnership projects using technology in the classroom to extend his understanding of the AIDS epidemic beyond the school walls.

*I wish to share this poem with all countries.  
AIDS is not a disease, although the virus has killed millions.  
AIDS is not a set of statistics, although the numbers are horrific.  
AIDS is not a conference in Durban.  
AIDS is not a presidential PR problem.  
AIDS is not advertisements and education programmes, although these help.  
AIDS is a feeling of hopelessness and despair.  
AIDS is young people who believe they're immortal.  
AIDS is a secret known by everyone. AIDS is not knowing what'll happen to your children when you're gone.*

*AIDS is people who are part of families.  
AIDS is everyday life carrying on against the odds.  
---a student from iEARN--Ukraine*

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