THE IMPACT OF HIV/AIDS ON PRIMARY AND SECONDARY SCHOOLING IN MALAWI:

DEVELOPING A COMPREHENSIVE STRATEGIC RESPONSE

Esme Chipo Kadzamira
Dixie Maluwa Banda
Augustin Kamlongera
Nicola Swainson

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[1] The % column in the table refers to Mortality rate calculated as the proportion of total teacher deaths in a school in one year over the total number of teachers in that school in that year.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapies
AWIP	AIDS in the Workplace
CBO	Community Based Organisation
CBOC	Community Based Orphan Care
CCAP	Church of Central Africa Presbyterian
CDSS	Community Day Secondary Schools
CIDA	Canadian International Development Agency
CONGOMA	Council for Non-Governmental Organisations in Malawi
CSS	Conventional Secondary Schools
DANIDA	Danish International Development Agency
DEO	District Education Office
DFID	Department for International Development
EMIS	Education Management Information Systems
FGD	Focus Group Discussion
FPE	Free Primary Education
G & C	Guidance and Counselling
GABLE	Girls' Attainment in Basic Literacy and Education
GoM	Government of Malawi
HIV	Human Immuno-virus
JICA	Japanese International Co-operation Agency
MANEB	Malawi National Examinations Board
MIITEP	Malawi Integrated Teacher Education Programme
MSSSP	Malawi School Support Systems Programme
MoESC	Ministry of Education, Sports and Culture
MoESC	Ministry of Education, Science and Technology
MoHP	Ministry of Health and Population
MoGYCS	Ministry of Gender, Youth and Community Services
MoWCASWCD	Ministry of Women and Children's Affairs, Social Welfare and Community Development
MSCE	Malawi School Certificate of Education
NACP	National Aids Control Programme
NEC	National Economic Council
NGO	Non-Governmental Organisations
NSO	National Statistical Office
PEA	Primary Education Advisers
PIF	Policy and Investment Framework
PPPI	Payroll, Personnel, Pension Integrated
PSLCE	Primary School Leaving Certificate of Education
PTA	Parents Teacher Association
STD	Sexually Transmitted Diseases
SSTEP	Secondary School Teacher Education Programme
TUM	Teachers Union of Malawi
UNDP	United Nations Development Programme
UNESCO	United Nations, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activity
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

CHAPTER 1

INTRODUCTION

This report presents the findings and recommendations of an impact assessment of the HIV/AIDS epidemic on primary and secondary schooling in Malawi. As is well known, sub-Saharan Africa is at the centre of this global epidemic. The region as a whole accounted for 74% of new infections and 78.5% of HIV and AIDS-related deaths in 1999 (UNAIDS/WHO, 2000). The epidemic is concentrated in the so-called 'AIDS belt' stretching from East through Central and Southern Africa where, typically, infection rates are now over 15% of the sexually active population. The bulk of new HIV/AIDS cases occur among young people aged 15-25 and females are disproportionately affected. Although the epidemic (particularly in southern Africa) has not yet peaked, population growth rates are beginning to fall. In Malawi results from the 1997 population census show that overall population growth rate is now only 1.9 per annum compared with a projected growth rate of 3.2% made in the 1987 census.

A variety of AIDS-related 'demand' and 'supply' factors have been identified, which are expected to have highly adverse impacts on the education sector, and schooling in particular. However, even at this late stage of the epidemic, relatively little detailed empirical research has been undertaken in Malawi and elsewhere that systematically investigates the actual and likely impacts of the epidemic on the education sector and, more important still, provides policymakers with a clear set of recommendations about what should be done.

The impact of the epidemic must be analysed in each of the four main 'institutional arenas' that collectively, determine the supply and demand for education, namely the household, community, school, and government. At present, only very anecdotal evidence is available about the impact of AIDS with respect to each of these arenas. Many of the predictions that are currently being made about the future impact of the epidemic on the education sector amount, therefore, to little more than unsubstantiated assertions.

Nevertheless, it is clear that in Malawi and the other high prevalence countries in the region, the AIDS scourge does threaten to undermine the substantial gains made in expanding educational participation during the past decade and thereby prevent the attainment of national education objectives, including Education For All. As this study will document in detail, teacher morbidity (illness) and mortality have increased and a rapidly growing number of children directly affected by AIDS (in particular orphans) are facing additional difficulties with respect to their education. Given the likely magnitude of the crisis facing the education system in Malawi, it is essential that a comprehensive strategy is developed by the Ministry of Education, Science, and Technology (MoEST) in order to mitigate as effectively and efficiently as possible the manifold impacts of the epidemic. Without such a strategy, the social equality and other goals of the current Policy and Investment Framework for the education sector are unlikely to be achieved.

1.1. STUDY OBJECTIVES

This study adopts a comprehensive analytical approach that systematically addresses all the key quantitative and qualitative impacts of the epidemic on primary and secondary education in Malawi. The main research questions are as follows:

- ❒ What has been the impact of HIV/AIDS to date on educational provision in primary and secondary schools?
- ❒ How has the Ministry of Education responded to the emerging HIV/AIDS epidemic? What are the key factors that have influenced this response to date? What information has been available to planners and policy-makers?
- ❒ What has been the involvement of key stakeholders, including teacher trade unions/organisations, NGOs, and other government ministries?
- ❒ Given current and projected rates of HIV prevalence, what are the likely impacts on education supply and demand during the next 10-15 years?
- ❒ What should be done by the MoEST and its partners in order to prevent further HIV infection among students and teaching staff and support student and staff who are directly affected by the scourge?

Given the limited time and resources available, the study focuses on primary and secondary schooling only. It forms part of a larger research project, which comprises two other country studies (Botswana and Uganda) and an overview of the impact of HIV/AIDS on the education sector in sub-Saharan Africa. Being able to draw on a variety of country experiences in this way is crucially important in understanding the nature of the actual and likely impact of the epidemic on the education sector in Malawi and in identifying appropriate policy and other interventions.

1.2 REPORT STRUCTURE

The report is divided in two main parts. The first assesses the impact of HIV/AIDS to date and what has so far been done to prevent and mitigate the impact of the epidemic in schools. The second part analyses how HIV/AIDS is likely to affect the provision of primary and secondary education during the next 10-15 years and then presents a comprehensive set of recommendations about what should be done to minimise the impact of the epidemic on both staff and students.

Three main areas of impact are analysed:

Prevention: The current efforts of the MoEST in relation to HIV prevention among students are reviewed, in parallel with the views of pupils and teachers on the effectiveness of these interventions.
Impact on students: Three groups of school children are most directly affected by HIV/AIDS, namely orphans, those who care for sick relatives, and children who are themselves ill and/or HIV positive.
Impact on teachers and other staff: This focuses on the impact of the epidemic on teaching and support staff in relation to mortality, morbidity, and overall morale and motivation.

1.3. THE STUDY TEAM

The study was undertaken by a team of researchers from the Ministry of Education Science and Technology and the University of Malawi. The team members were as follows:

Ms Esme Chipo Kadzamira, National Team Leader, Research Fellow, Centre for Educational Research and Training, University of Malawi, Zomba.
Dr Dixie Maluwa-Banda, Head, Department of Educational Foundations, Faculty of Education, University of Malawi, Zomba.
Dr Augustin Kamlongera, Principal Planning Officer, Planning Unit, Ministry of Education, Science and Technology, Lilongwe.
Dr Nicola Swainson, Study Co-ordinator, Centre for International Education, University of Sussex, Brighton, UK.

The following individuals also provided excellent research assistance with the school survey: Mr. L.C. Hauya, Mr. Mackie Kamowa, Ms. G. Ntambalika, Ms. Twambilire Sichale and Mr. G. Vilili.

Dr. Martin Palamuleni from the Demographic Unit, Chancellor College calculated projections of the school-age population.

1.4 REPORT DISSEMINATION

This final report will be presented and discussed by MoEST in September. Two dissemination workshops were held in Lilongwe and Blantyre on 2nd and 4th May 2001, respectively. On September 16th 2001, a third dissemination workshop will be held to involve those participants from our survey schools who were unable to attend the May workshops. The proceedings of the May workshops are in Appendix 1 of this report. The executive summary of the final report is available separately.

1.5 ACKNOWLEDGEMENTS

The study was jointly funded by the Rockefeller Foundation and the United States Agency for International Development (USAID) and was based at the Centre for Educational Research and Training (CERT), University of Malawi.

The team wishes to acknowledge and extend thanks to the school managers, teaching staff and students at the survey schools as well as the many other individuals in the MoEST and other organisations who kindly agreed to be interviewed.

We are also very grateful to Dr Paul Bennell for his detailed comments and editorial assistance in the preparation of this report.

PART I

IMPACT ASSESSMENT

The first part of this report assesses the impact to date of HIV/AIDS on the provision of primary and secondary education in Malawi. Chapter 2 provides key background information on the schooling system, government education policy, and the HIV/AIDS epidemic in Malawi. Chapter 3 describes how the study was undertaken, in particular the main instruments that were specially developed for the school survey. Chapter 4 assesses the extent to which schoolchildren have changed their sexual behaviour in the light of the AIDS epidemic and the impact of school-based sexual and reproductive health education. Chapter 5 discusses what impact the epidemic has had on the three groups of children most directly affected by HIV/AIDS and what support has been provided by schools and other organisations in effort to mitigate these impacts. And finally, Chapter 6 focuses on the impact of the epidemic on teaching and support staff.

CHAPTER 2

OVERVIEW: EDUCATION POLICY AND THE AIDS CRISIS

The first part of this chapter briefly describes the schooling system and the main objectives of government with respect to primary and secondary education in Malawi. The second part then goes on to describe the extent of the HIV/AIDS epidemic and the response of the Government of Malawi (GoM) to this crisis.

2.1 THE EDUCATION SYSTEM

MoEST is responsible for all formal education and teacher training in Malawi. The ministry is also involved at a policy level with all the other key areas of education, namely technical and vocational education, university and other higher education institutions, adult literacy, and pre-school learning.[2]

2.1.1 Structure

The formal education system is conventionally divided into three main levels: primary, secondary, and tertiary and follows an 8-4-4 structure. Primary education is from standards 1-8 and enrols children from the age of 6. The primary cycle is divided into infants (standards 1 and 2), junior (standards 3 to 5) and senior (standards 6 to 8). The secondary education cycle is four years in duration, and is sub-divided into junior and senior levels. Access to secondary education remains highly competitive and, in 1997, the transition rate to government funded and government-aided secondary schools was only 8%. A further 26% were admitted into the then Distance Education Centres (DECs), now Community Day Secondary Schools (CDSSs). However, GoM is seeking to increase the GER to 30%, which will require a very considerable expansion of capacity in the secondary sector. In 2000, approximately 60,000 students were enrolled in conventional secondary schools and another 150,000 in community day secondary schools (CDSSs).

2.1.2 Enrolments and learning outcomes

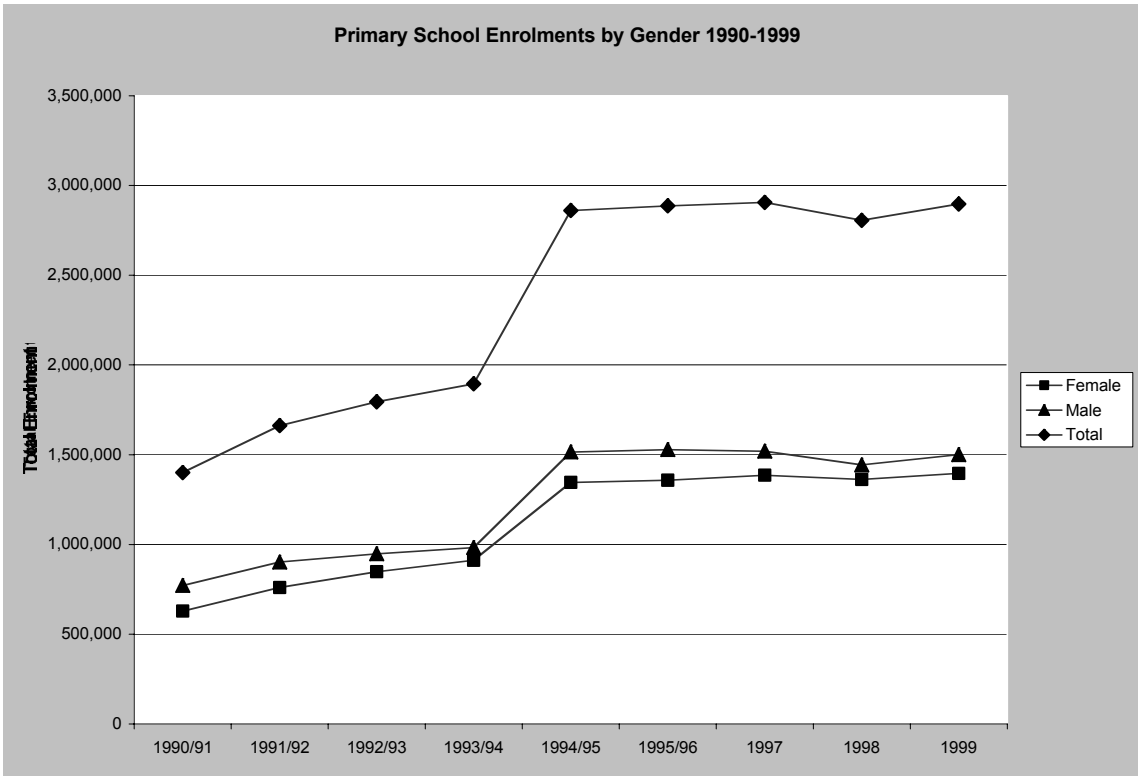
The rapid expansion of primary school enrolments from 1.9 million in 1992/93 to nearly three million in 1994/5 following the advent of Free Primary Education was a remarkable achievement. However, it is widely accepted that this rapid expansion of enrolments has been accompanied by some deterioration in the quality of teaching and learning.

By 1999, total enrolment at 4,481 primary schools was 2.9 million, slightly down from 1997 levels (see Figure 2.1). However, this fall in enrolments cannot be directly attributed to HIV/AIDS. Other factors, in particular increasing poverty, are almost certainly more significant factors.

[2] The Ministry of Gender, Youth and Community Services, (MoGYCS) is responsible for early childhood (pre-school) education and adult literacy and the Ministry of Labour and Vocational Training provides for technical and vocational education.

Since 1994, there have been chronic shortages of basic physical and human resources in the primary education sector, with the result that student:qualified teacher ratios are typically as high as 120:1 in most schools. Although the shortage of inputs is less severe at secondary and tertiary levels, with donor funds being increasingly directed towards primary education, there is a risk of further decline in secondary and tertiary sectors.

Figure 2.1: Primary School Enrolment Trends by Gender 1990/91-1999



Source: MoEST, EMIS 1997, 1998, 1999.

Although gender inequalities have been reduced over the past decade, far fewer girls than boys still manage to complete primary school (see Table 2.1). As a result, girls account for just fewer than 40% of secondary school enrolments. The gross and net enrolment rates for primary education in 1999 were 136% and 75% respectively. However, the GER for boys was 14 percentage points higher than that of girls, mainly because of the higher dropout rates among girls in the upper standards of primary school.

Primary education in Malawi also suffers from low rates of internal efficiency mainly because of high rates of repetition and dropout. Table 2.2 presents the main performance indicators for 1999. There are indications that performance indicators for primary education have improved from their 1997 levels, though it is perhaps too early to conclude that the system is improving because of the large variations in data collection errors between years[3]. The overall repetition rate for primary education fell from 16% in 1997 to 14% in 1999, although repetition rates are still unacceptably high in the first three standards as well as Standard 8.

[3] For example it is believed that the 1998 school census had a large margin of error which may have contributed to the improvements in key performance indicators for 1999.

Table 2.1: Primary school enrolments by standard and gender, 1993/4 - 1999

Std	1	2	3	4	5	6	7	8
1993/4								
Total	631,948	379,744	269,519	185,717	147,328	112,069	87,961	81,137
% girls	51.0	49.5	48.2	47.2	45.5	44.2	42.0	37.4
1994/5								
Total	1,006,194	517,652	409,220	277,473	215,543	162,580	129,367	142,651
% girls	49.4	47.6	47.3	46.1	45.3	44.3	43.3	38.5
1997								
Total	817,512	573,821	468,866	322,749	247,421	183,604	145,058	146,919
% girls	49.4	49.0	48.5	47.2	46.7	45.1	44.0	40.3
1998								
Total	772,481	548,606	443,688	325,953	245,823	188,772	145,529	134,933
% girls	50.3	50.4	49.2	48.3	47.2	46.3	44.2	39.9
1999								
Total	751,002	539,545	457,208	340,196	289,251	204,516	162,683	151,879
% girls	50.0	49.5	49.5	48.6	44.3	46.8	45.3	42.2

Source: MoEST: Basic Education Statistics 1994, 1995, 1997 and EMIS 1997, 1998, 1999

Dropout rates also remain very high, especially in Standard 1. Only half the children who start primary school reach Standard 4 and only one-quarter complete the full primary cycle. As will be discussed in Chapter 4, this has important implications concerning when HIV/AIDS reproductive health education should be introduced.

Table 2.2: Key performance indicators for primary education, 1999

Performance indicator	**Sex**	**Standard**							
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Promotion rate	Female	57.9	69.5	67.1	73.9	75.8	78.6	86.7	
	Male	59.2	72.0	68.5	87.8	77.2	81.8	92.0	
Repetition rate	Female	17.2	15.4	15.4	12.0	10.3	9.0	7.9	15.4
	Male	17.7	16.5	15.8	12.2	10.1	8.4	7.4	16.2
Dropout rate	Female	25.0	15.2	17.6	14.1	13.9	12.4	5.4	
	Male	23.0	11.5	15.7	0.0	12.6	9.9	0.7	
Survival rate	Female	100	69.5	56.4	44.0	36.3	30.2	25.6	23.7
	Male	100	71.6	61.0	48.7	47.8	40.4	35.5	34.7

Source: Calculated from EMIS: 1997, 1998, 1999.

Table 2.3: Key quality indicators, 1999

Indicator	Primary 1999	Conventional Secondary 1997	CDSS 1997
Percentage qualified teachers	60.0	91.2	0.85
Pupil:qualified teacher ratio	106:1	17:1	5183:1
Pupil:teacher ratio	63:1	15:1	44:1
Pupil per maths textbook	1.4:1		
Pupil per Chichewa textbook	1.3:1		
Pupil per permanent classroom	125:1		
Pupil per desk	19:1		

Source: Calculated from EMIS: 1997, 1998, 1999 and MoEST, Basic Education Statistics, 1997.

2.2 GOVERNMENT EDUCATION POLICY

The current Policy Investment Framework for the education sector (MoESC, 2000) has a number of ambitious objectives that relate to access, equity and quality as well as committing MoEST to a sector-wide approach. GoM is strongly commitment to the goals of Education for All. As a result, the education sector's share of public expenditure has risen to 28%, and a key PIF objective is that 65% of total education expenditure should be allocated to primary education. The PIF also shows a much greater concern with equity (social, gender and location) objectives than before, which relates to the government's overall strategy for poverty alleviation. The curriculum is to be revised so that it is more relevant to prevailing 'socio-economic and political realities'.

The development of secondary education has been seriously hampered by the availability of student places and user fees. Learning outcomes are also very poor. In 1999, only 17% of the 70,888 candidates who passed the Primary School Leaving Certificate of Education (PSLCE) were selected for secondary education. To improve the access of girls for secondary education, a non-selective scholarship scheme was introduced in 1994. This is currently being reviewed in order to provide support for needy boys as well as girls.

The government in conjunction with donors has responded to the increased demand for secondary education generated by FPE by introducing improvement and expansion plans for secondary education. In 1998, all Distance Education Centres were converted into Community Day Secondary Schools. However, improved cost recovery is also central to the government's overall strategy for both primary and secondary education. Increased private provision at the secondary level is also a key objective.[4] Free primary education has enabled eligible children, including orphans, to enrol in school. However, both primary and secondary students are expected to pay extra fees to cover the school costs that are not met by the government. As a result of these extra costs, many poor children (including orphans) continue to dropout of school. Furthermore, the growing privatisation of the secondary school sector will be a further obstacle to the participation of children from poor backgrounds

Pass rates for students sitting the Malawi School Certificate Examination (MSCE) have plummeted over the past five years. In 1997, the MSCE pass rate at government secondary schools was 36%, but by 1999 it had fallen to 13%. The Malawi National Examination Board (MANEB) believes that the low pass rate in 1998-2000 can be explained by a tightening up of marking due to extensive cheating (Swainson, 2000). However, the recent Presidential

[4] Fees for private schools are considerably higher than those in government secondary schools and are, therefore the preserve of the better off.

Commission of Inquiry into MSCE Results attributed declining examining performance to a number of other factors, most notably declining quality in teaching and learning. This is particularly the case at the Community Day Secondary Schools. Deteriorating student discipline and the validity of the MSCE examinations themselves are also highlighted.

2.3 THE AIDS EPIDEMIC IN MALAWI

Effective monitoring of the HIV/AIDS epidemic is critically important, not in order to assess the magnitude of the problem but also for the purposes of planning and designing appropriate interventions. There are currently 61 HIV surveillance sites (14 in the Northern Region, 21 in the Central Region, and 26 in the Southern Region.[5] Each site is required to report monthly the number of AIDS cases diagnosed at its centre to the National AIDS Control Programme secretariat in Lilongwe (NACP, 1997).

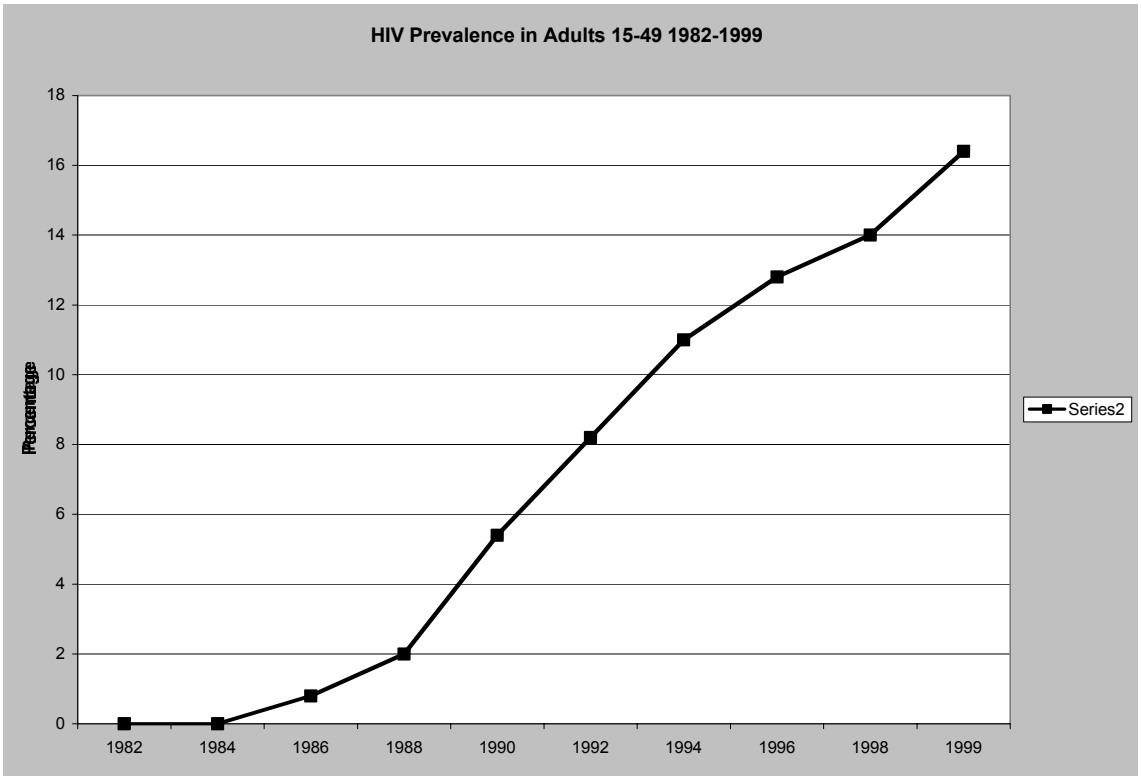
2.3.1 Prevalence

Since the first cases of AIDS were diagnosed and reported in Malawi in 1985, HIV-related diseases have precipitated an epidemic of unprecedented proportions (MacLachlan et al., 1997). A senior NACP official estimated that 50-70% of adult in-patients were suffering from AIDS-related illnesses in 2000.

Between 1985 and 1998, a cumulative total of 52,856 AIDS cases were officially reported to the NACP. However, since most cases are not reported, the NACP estimates that the actual figure for this period was over 265,000. The incidence of HIV as recorded through Sentinel Surveillance sites has risen rapidly in the 1990s (see Figure 2.2). Prevalence rates among pregnant women attending clinics in Blantyre rose from 3% in 1986 to 35% in 1996 (Kaluwa et al, 1996). Nationally, 16.4% of the population between the ages of 15 and 49 are infected with HIV. As students and teachers are included in this age band, there an urgent need to examine the impact of HIV/AIDS on these groups.

[5] Of the 61 reporting sites, 30 are government owned, the Christian Health Association of Malawi (CHAM) runs 27 and four are privately owned by the Army, Police, Dwangwa Sugar Company and the Sugar Company of Malawi (SUCOMA)

Figure 2.2: HIV prevalence rates for 15-49 adults, 1992 – 1999



Source: National AIDS Control Programme (2000) Malawi Response to HIV/AIDS for 2000-2004 (second edition) and NACP (1999) Sentinel Surveillance Report

Table 2.4: HIV prevalence rates, 1999

Age Group	Population Size	HIV Rate	No. HIV Positive
Less than 15 years	4,038,484	2.2%	88,847
15-49 Years	4,683,910	16.4%	768,161
50 or more years	846,112	1.1%	9,138
National Total	9,838,486	8.8%	865,786

Source: National AIDS Control Programme (1999) Sentinel Surveillance Report

Prevalence rates are much higher in urban areas and also in the Southern region (see Table 2.5).

The NACP estimates that 46% of all new infections in 1998 were among young people aged 15-24 and, of these, 60% were female. For the 15-19 age group, HIV infection rates are five times higher among female than males. Cumulative AIDS cases between 1995 and 1998 show that more females are infected in the 15-29 age group whereas more males are infected in the 30 and above age group. NACP projections of HIV indicate that the number of Malawians living with HIV is likely to increase to more than a million over the next ten years.

Table 2.5: HIV prevalence by location, 1999

Location	Total Population	Adults 15-49	HIV+	% Prevalence (15-49)
Urban	1,065,264	507,066	133,963	26.4
Semi-Urban	2,442,011	1,162,397	295,197	25.4
Rural	6,331,211	3,013,657	337,666	11.2
Northern region	1,229,360	585,175	78,980	13.5
Central region	4,041,636	1,923,819	236,333	12.3
Southern region	4,567,490	2,174,125	451,513	20.8
Total	9,838,486[6]	4,683,119	766,826	16.4

Source: Calculated from National AIDS Control Programme (1999) Sentinel Surveillance Report.

2.3.2 Government Policy and Practice

The initial response by government to the AIDS crisis was to develop a Medium Term Plan (MTP-I) 1989-1993 (Ministry of Health and Population, 1999). The overall focus was strongly biomedical in nature and was limited to blood screening and mass education. MTP-II (1993-1998) adopted a broader multi-sectoral approach, which took into account a range of social, psychological and economic issues.

Two major evaluations of MTP-I and II by UNDP and the World Bank concluded that:

- Although general awareness of the epidemic was over 90%, behavioural change has been limited and that the incidence of HIV has continued to increase;
- There has been an over-dependence on the health sector and that the focal points that have been established in various ministries have been ineffective;
- Technical leadership has been lacking at both central and peripheral (district) level (Ministry of Health and Population, 1999 and World Bank, 1998).

The main goal of the NACP National HIV/AIDS Strategic Framework 1999-2004 is to "reduce the incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS" (NACP, 1999:9). A comprehensive institutional framework for all sectors is to be established based on a clear elaboration of functions, roles and responsibilities. More specifically, "line ministries, departments and parastatal organisations will establish focal points for HIV/AIDS activities at all levels and in all sections of their institutions. In this regard each institution will assign personnel to deal with HIV/AIDS issues inside the institution and liase with the NACP and other private or public institutions in these activities. Line Ministries will mainstream HIV/AIDS through their focal point units by preparing… plans of activities on the basis the Strategic Framework and in collaboration with NACP….[and] will prepare budget lines for HIV/AIDS activities in their quarterly or annual submissions and will collaborate with the Ministry of Finance to consolidate and adopt those budgets" (MoHP, 1999, pp. 60-61).

[6] No explanation has been given by NACP for the lower total number of 15-49 age group and HIV positive people in comparison to Table 2.4

The overall objective of the strategy is to reduce sexual transmission of HIV/AIDS has been through IEC/social mobilisation messages concerning safer sex (i.e. mutual fidelity, non-penetrative sex, partner reduction, condom use, and avoidance of risk-conducive situations). Print media, radio, counselling, peer education and community mobilisation (through theatre for development, political rallies and National day of AIDS) will be used in a co-ordinated manner.

Prevention interventions are also targeted at youth (both in- and out-of-school) and the improvement of infection control standards through the regulation of blood transfusions. Voluntary testing and counselling facilities, which at the moment are predominantly urban based, will be expanded nationwide. With respect to mitigating the impact of the epidemic, the government plans to:

- Promote activities to strengthen community coping mechanisms in the case of chronic illness and orphan care.

- Assist with the development of coping mechanisms for private companies, the military, police, government departments and civic organisations. Improved support strategies for those affected by HIV/AIDS will be developed for both adults and children (UNAIDS/WHO, 1999:2-3).

To date, NGOs have spearheaded anti-AIDS activities in the community. However, greater co-ordination between government and NGOs is urgently needed. More generally, it is clear that a culture of silence still surrounds HIV/AIDS, which makes it difficult to implement constructive solutions. More senior politicians need, therefore, to be openly supportive of national anti-AIDS efforts.

2.3.3. Organisation and management

MoEST established an HIV/AIDS Steering Committee in 2000 with a mandate to design, co-ordinate, monitor, and approve HIV/AIDS interventions in the education sector. All heads of departments are members of the Committee as well as other senior officers from other key education institutions. The Planning Division acts as a secretariat. The Secretary for Education chairs meetings. The following technical committees have also been established: curriculum, teacher education, human resources, welfare, planning and budgeting, and guidance and counselling. To date, only the guidance and counselling committee has produced a strategic plan for HIV/AIDS.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

The challenge facing this study was to get students and staff to freely discuss issues concerning HIV/AIDS and its impact on education in a context where such issues are usually met with silence or denial. Consequently, a variety of research instruments were developed. It was particularly important to get the right balance of qualitative and quantitative data.

The principal methods employed in the data collection for the study included semi-structured interviews with key informants, focus group discussions and questionnaires. Permission to conduct the research was obtained from the relevant authorities in the Ministry of Education (including the District Education officials in Blantyre City and Chiradzulu District).

3.2. DATA COLLECTION

Three main types of data were collected:

- Primary data from a sample of primary and secondary schools in both rural and urban areas.
- Interviews with key informants in education, health, finance, labour and other ministries/sectors.
- Secondary data from a variety of sources (both formal and non-formal) including education and demographic statistics.

3.2.1 The school survey

A survey of 11 schools, (6 primary and 5 secondary) in two districts (one urban and one rural) in the Southern Region of Malawi was undertaken in order to assess the impact of HIV/AIDS at the school level[7]. The two districts, Chiradzulu and Blantyre City were chosen because they have relatively high HIV prevalence rates (24% and 15% respectively) and should, therefore, have been most affected by the AIDS epidemic.

Due to time and other resource constraints, it was not possible to visit more schools. Clearly, a larger survey is needed in order to have a truly representative sample of the total school population. Moreover, although Chiradzulu is classified as a rural district, it is within commuting distance of Blantyre City and is not, therefore, a typical rural location in the Southern Region. Despite this limitation, however, it is clear that the impacts of the epidemic are markedly different in the two locations.

[7] Three primary and two secondary schools were visited in Blantyre City and three secondary and two primary schools in Chiradzulu.

Three main sets of instruments were developed for the school survey: interviews, focus group discussions, and questionnaires.

- School data sheet: Key school performance indicators over the last five years (student enrolments, repetition and dropout, teachers numbers and characteristics, teacher and students deaths, school resources/facilities.
- Head teacher semi-structured interview. This focused on the overall impact of HIV/AIDS on the school, the management response to date, and what should be done in the future.
- School management team: As above.
- Individual teacher interviews: Ten teachers were randomly selected from each school.
- Teacher focus groups: Between 8-10 teachers were selected randomly at each school. The key areas that were discussed were HIV/AIDS education for students, impact of HIV/AIDS on students and staff, support for affected students, AIDS in the workplace policies and practices for teachers and other staff, and teacher sexual misconduct.
- Teacher questionnaire: Anonymous and self-administered to all teachers in each school. Two types of information were requested: personal and professional details and rating responses to 26 prepared statements covering all aspects of the impact of HIV/AIDS on schools.
- Student questionnaire: Anonymous but individually administered by research assistants in order to ensure full understanding of all questions. In addition to key background information (age, parental status, etc), the questionnaire assessed knowledge of causes and consequences of HIV/AIDS and the effectiveness of HIV/AIDS education. A similar set of statements was used as for the teacher questionnaire.
- Student focus groups: Separate groups of boys and girls from selected standards (6 and 8) and forms (2 and 4). Each group was asked to discuss and, if possible, reach consensus on a range of statements concerning HIV/AIDS and the school, from agree most to disagree most.
- School Committee focus groups.
- Orphan questionnaire. This was administered in the community surrounding each school. A similar set of similar questions as in the student's questionnaire was used. However, orphans were not asked to respond to the prepared statements and additional information was requested concerning support available to orphans and coping mechanisms. Local community leaders identified orphans.
- Orphan and orphan carer/parent focus groups were held in the community near to each survey school. Again, local leaders assisted in the selection of FGD participants.

FGD participants were asked not only about their views on the impacts of HIV/AIDS on education, but also to make suggestions about what should be done to prevent the spread of HIV and how to support those directly affected.

Table 3.1: School survey instruments and number of respondents

Type of Instrument	Primary	Secondary
School data sheet	6	5
School management team interview	9	6
School Committee focus group discussion	3	0
Teacher interview	63 (65% female)	34 (38% female)
Teacher questionnaire	151 (73% female)	54 (35% female)
Teacher focus group discussion	6	3
Student questionnaire	361 (49% female)	291 (49% female)
Student focus group discussion	12 (6 girls, 6 boys)	10 (5 girls, 5 boys)
Orphan questionnaire	111 (82 primary, 11 secondary, 18 dropouts)	
Orphan focus group discussion	7 (3 Blantyre, 4 Chiradzulu)	
Parents/carers focus group discussion	6 (2 Blantyre, 4 Chiradzulu)	

Interviews with management were generally conducted in English by the national researchers. Teacher interviews used a mixture of English and Chichewa. All student and orphan FGDs were conducted in Chichewa. The student questionnaires were drafted in English and administered in Chichewa. Interview notes were written up and shared with members of the team.

3.2.2 Stakeholder interviews

Fifty-five semi-structured, confidential interviews were conducted between February and November 2000. Individuals in the following institutions were interviewed:

- Senior managers and other professional officers in all key departments at MoEST headquarters in Lilongwe. These interviews focused on the impact of the epidemic to date, the Ministry's response and what should be done in the future?

- Other key ministries and public organisations, most notably the Ministry of Health, AIDS Secretariat, National AIDS Control Programme, Ministry of Gender, Youth and Community Services, National Statistical Office, Ministry of Labour, Department of Human Resource Development and Management, Ministry of Finance.

- Other MoEST officers including the Malawi Institute of Education, District Education Offices, South East Education Division Office.

- Non-Governmental Organisations and Community-Based Organisations in Lilongwe, Blantyre, and Zomba.

- Donor agencies including UNICEF, UNAIDS, UNDP, UNFPA, USAID, DANIDA, CIDA, JICA, DFID and the WORLD BANK.

- Academics and other researchers.

3.2.3 Secondary data

Secondary data was collected from the National Statistical Office, National Aids Control Programme, Department of Human Resource Management and Development, District Education Offices, the MoEST Educational Management Information System (EMIS) and the Payroll, Personnel Pension Integrated (PPPI) databases. Secondary data was used to strengthen the findings of the school survey as well as for modelling the impacts of the epidemic on the school-age population, enrolments and teacher attrition and future requirements.

3.3 MODELLING

The demographic impacts of the epidemic on the education system were analysed using a standard simulation model (see Al-Samarrai, 1997). MoEST enrolment data and enrolment PIF targets education sector were incorporated in the model. Assumptions about HIV prevalence and its demographic impacts are based upon data obtained from the NACP and the Demographic Unit at the University of Malawi provided the necessary population projections.

3.4 MAIN LESSONS LEARNED

In general, management, staff and students at the survey schools were extremely co-operative and helpful and most welcomed the opportunity to discuss how the epidemic was affecting their school. However, some secondary school teachers were reluctant to participate in the FGD and complete the questionnaire. As a result, it was only possible to hold eight teacher FGDs.

The main challenges were as follows:

- How to measure the impacts of the epidemic in the context of a paucity of good quality data.
- Sensitivity: silence and denial still surround HIV/AIDS.
- Identification of key areas within the education system where impact can be measured.

3.4.1 Data quality

- ✓ School records on key information such as pupil enrolments, repetition, dropouts, attendance, pupil deaths and the causes, teacher supply, absenteeism, teacher illness and deaths are poor or non-existent.
- ✓ At the national level, data on teacher mortality is not systematically collected or recorded by sex, age or years of service. This information would greatly assist the MoEST in understanding the precise impact of HIV related deaths on teacher supply.
- ✓ In countries such as Malawi where the quality of data is poor, longitudinal studies would be appropriate.

3.4.2 Sensitivity

The silence and denial that surrounds the issue of HIV/AIDS has been a major factor in explaining the very limited response of the MoEST to the epidemic.

Respondents at MoEST headquarters and in schools would claim that 'a lot of people are dying', but no attempts have been made to keep systematic records of teacher deaths. Similarly, many civil servants complained about the enormous financial burden that traditional practices relating to funerals and burials are placing on the state. However, because these practices are part of a local culture, they cannot easily be challenged. The widespread paralysis among senior decision makers concerning HIV/AIDS is a reflection of both fear and denial.

It is often thought that issues concerning HIV/AIDS are too sensitive to be openly discussed. Surprisingly, after an initial reluctance, participants were animated and prepared to tackle 'difficult' issues such as testing for HIV/AIDS. However, some respondents were more prepared to discuss the situations in other schools rather than their own.

3.4.3 Other issues

It is very difficult to make a robust assessment of the actual and likely impact of HIV/AIDS on the demand for education, especially when enrolments have been expanding so rapidly as they have done in Malawi during the last decade. It may well be another five years before any impacts become apparent. At the school level, it is hard to obtain data on dropout, repetition, and completion rates.

This study focused on children in rather than out of school. The opportunistic sampling procedure to capture orphans was only able to identify orphans who were attending school. For this reason, the school survey shows little difference between the participation rates of orphans and non-orphans. Sampling procedures in future should ensure that in school and out of school children are equally represented. Impact on demand could be captured more effectively using household listings or through snowballing sampling in which the researchers move into the community to identify respondents.

Any future studies of the impact of HIV/AIDS on education should use a bigger sample of schools and involve more participatory methods and action-oriented research. Action research could help mobilise schools and communities to respond to the AIDS crisis. Despite the limitations of size and time, our study did enable groups within the participating schools to debate the issues and discuss solutions. Both students and staff made a number of helpful suggestions regarding mitigation of the impacts of HIV/AIDS on the school. This concern could be widened out to the whole community.

CHAPTER 4

STUDENT PREVENTION

This chapter assesses the effectiveness of school-based HIV/AIDS education and other related activities in preventing the spread of HIV infection among young people in Malawi. The first part of the chapter focuses on the sexual behaviour of school-aged children in Malawi and, in particular, considers the extent to which they are at risk of contracting HIV. The second part of the chapter assesses the impact of school-based HIV prevention activities. Four types of intervention can be delineated: formal curriculum, other education activities (peer education, drama groups, etc.), guidance and counselling, and sexual misconduct of teachers.

4.1 STUDENT SEXUAL BEHAVIOUR

4.1.1 Overall level and trends

Young people in Malawi become sexually active at an early age. In McAuliffe's (1994) study, 46% of primary school and 66% of secondary students who were surveyed were sexually active and most had initiated sexual activity between 10 and 14 years of age. Almost 60% of secondary school students interviewed by Bandwe and Foster in 1996 said that they were sexually active with a mean age of first intercourse of 15 years old. Similarly, Bisika's 1996 study revealed that 78% of secondary school students and 42% of primary school students were sexually active. Phiri, et al (1997) reported that 65% and 26% of male and female secondary school students respectively declared themselves to be sexually active. The corresponding figures for primary school respondents are 46% male and 29% female. While there is little good quality evidence, it also seems that adolescents in Malawi are becoming sexually active younger.

4.1.2 High-risk sexual activity

There is mounting concern about the spread of HIV infection among the adolescent population in Malawi. A significant percentage of youth have unprotected sex with multiple partners. Although very few AIDS cases have been reported among adolescents, many young adults become infected during their teenage years (Barnett & Blaikie, 1992; Bury, 1991; MacLaclan, Chimombo, & Mpemba, 1997). In the McAuliffe 1994 survey, two-thirds of adolescent respondents agreed with the statement that "monogamy is impossible among young people'.

Surveys conducted in the mid-1990s show that only around 35-55% of sexually active male youth had ever used condoms (see McAuliffe, 1994, McAuliffe and Ntata, 1994, Bisika 1996 and Phiri et al, 1997). Even smaller proportions used condoms consistently. For example, in a survey conducted in 1994 by McAuliffe, only 24% of male condom users reported using condoms consistently with their girlfriends and only 18.5% reported consistent use of condoms with casual sex partners. Occasional condom use with girlfriends was reported by 14% of males and occasional condom use with casual partners by 5% of respondents**.** A more recent study by Maluwa Banda (in 1999) found that 43% of sexually active students had used a condom during first sexual intercourse and 16% (18.5% of females and 14.9% of males) of these students admitted contracting an STD at least once. This is much higher than the ever-

had STD incidences of 10% and 8% among sexually active boys and girls respectively reported by Phiri et al only two years earlier in 1997.

Although condom sales increased through the social marketing programme - from 4.6 million in 1995 to 7.1 million in 1998 - overall use remains low in Malawi. In the national MKAPHS sample, only 3% of women and 6% of men reported condom use, unchanged since the Demographic and Health Survey in 1992. Nevertheless, condom use was reported to be higher with non-regular partners (41% among men and 24% of women in 1996). (UNAIDS/WHO, 1999:10). However, the preliminary report of the Malawi Demographic and Health Survey shows a slight improvement, with 5% of women and 14% of men reporting condom use during their last sexual encounter (NSO et al 2000). Condom use was found to be higher amongst younger than older respondents and higher amongst women and men with higher levels of education than those with less education.

The school survey also reveals high levels of sexual activity among school children. Around 60% of the primary school students and slightly over 70% of secondary school students agreed with the statement that 'love relationships among students are very common in this school'. Around one-quarter of respondents also agreed with the statement that 'love relationships between students and teachers are common in this school' (see below).

Table 4.1: Student responses to statements about sexual behaviour

STATEMENT	PRIMARY						SECONDARY					
	Male			Female			Male			Female		
	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree
Students have not changed their sexual behaviour as a result of HIV/AIDS education	41	14	46	40	14	46	30	13	57	29	10	61
Love relationships among students are common in this school	33	9	58	32	11	57	18	11	71	18	10	72
Love relationships between students and teachers are common in this school	74	7	20	67	11	23	58	20	22	52	20	28
Student pregnancy is a big problem in this school	57	10	33	52	7	40	30	17	52	34	12	54

It is clear from the student FGDs many students are engaging in casual sex regardless of the HIV/AIDS epidemic and its consequences. The following contributing factors were repeatedly mentioned by students in both primary and secondary schools:

- ❒ Peer pressure
- ❒ Poverty (particularly among girls)
- ❒ "Just for fun"
- ❒ To experiment
- ❒ "Aroused by pornographic material"
- ❒ Alcohol and drug abuse

- ❒ "Lack of advice from parents in the homes"
- ❒ Sugar daddies

In almost all the FGDs, students emphasised the tremendous pressures on them to have sexual intercourse. Most of this pressure comes from their friends, especially those with girlfriends or boyfriends. As one participant remarked, *"the guys who have girlfriends are seen as heroes."* Female students in the rural schools also indicated that they are subjected to sexual pressure from their male teachers, whereas in urban schools, sugar daddies are the main problem. This current trend of older men paying younger women for sex reflects the growing belief among adult males that the younger the woman, the more likely she is 'HIV free'. It is also widely believed that having sex with a virgin is a cure for HIV.

Even though students at the survey schools are generally well informed about behaviour that is likely to spread the HIV virus, many still indulge in high-risk sexual activity. Lack of restraint, desire to experiment, and expectations of easy monetary/material gain are crucial explanatory factors. Typical comments made by student FGD participants are as follows:

'*Some male students have sexual intercourse with either married women or prostitutes in the community*' (rural secondary school).

'*Girls at our school behave in a way that is likely to spread HIV in and out of school because there are many who are involved in love relationships with boys from outside this school, including street vendors who buy them rings, food and other goodies, and even much older men*' (male urban student).

'*Some girls have more sexual partners because they want to have more pocket money so that they can buy whatever they want, which their parents or guardians could not afford to give them*' (female secondary student).

'*I know some girls who indulge in sex for monetary gains… Who doesn't want money?*'

'*Boys give girls money to sleep with them, and girls go out with sugar daddies simply to get easy money*'.

'*Practice makes perfect*'.

The availability of condoms was cited by some FGD respondents as an important factor encouraging sexual activity among youth. However, not all students have easy access to condoms, especially in rural schools. As a result, many sexually active students are not using condoms at all or are not using them consistently. In addition, there is still considerable resistance to condoms among youth. Statements such as having protected sex is like *"eating a sweet in its cover"* or "*having a shower in a raincoat*" were commonly made by male students. This resistance is further compounded by the considerable stigma and widespread misconceptions attached to condoms. Youth in particular receive conflicting messages from different sources. As one secondary schoolteacher aptly put it *"students are torn between using condoms and church messages"***.** The following comment from a male secondary student also conveys the confusion and tensions surrounding condoms: *"Most magazines say that condoms are not 100% safe, while the radio programmes emphasise the use of condoms as if they are 100% safe"*.

In the 1990s, the widespread distribution of condoms by the Ministry of Health to students in the schools was deeply unpopular with most school managements and many teachers and parents. Current MoEST policy forbids the distribution of condoms in school students. While Ministry of Health workers promote condom use, teachers, parents and religious leaders continue to stress abstinence.

Another common observation is that some students believe that there is no way to avoid AIDS so there is no point in taking preventive action. This type of fatalism and denial is reflected in such views as:

'*Rabies for dogs, Newcastle is for chicken and AIDS is for people*'.

'*We have never seen or heard of students dying of AIDS….*'

'*We will all die sometime, so if it is through AIDS, that is what happens*'.

'*AIDS inabwerera anthu kumene osati nyama zakuthengo* (*AIDS came for people not animals… so why worry?)*'.

Teacher perceptions: Most teachers at the survey schools do not think that 'students are changing their sexual behaviour in response to HIV/AIDS' (see Table 4.2).

Table 4.2: Teacher response to statement that 'students are changing their sexual behaviour in response to HIV/AIDS' (percentages)

RESPONSE	PRIMARY		SECONDARY	
	Male	Female	Male	Female
Disagree	68	65	43	51
Not Sure	27	26	35	23
Agree	5	10	22	26

Teachers are clearly very concerned about the high levels of sexual activity among their students and the fact that increasing numbers of children are becoming sexually active at a very young age. A strong consensus exists that many students do not perceive themselves as being at risk and, consequently, they have unprotected sex, often with multiple partners. The following comments made by a male teacher at a rural primary school is typical:

"*The perception of students is that AIDS is not real. They are always thinking that it cannot happen to them. It is only bad and immoral people. They even say that 'Imfa inabwerera anthu' (Death came for people… we will all die one day)*"

4.1.3 Social, Cultural and Economic Factors

There has been very major social and cultural change in Malawi since the early 1990s. This has affected the education sector in a number of ways. In particular, there has been a marked decline in school discipline and moral responsibility among students. This is commonly attributed to serious 'misinterpretations' of the true meaning of multiparty democracy and a general weakening of the social control and guidance functions exercised by the family, the school, and religious institutions. Some youth have interpreted 'freedom' as a license to do whatever one pleases. Economic and cultural factors have also accelerated the trend towards multiple partners. In the context of the relaxation of social control as a result of multiparty

democracy, there has been an increase in casual sex, drugs and alcohol abuse, all of which have fuelled the AIDS epidemic.

There is an established tradition in Malawi of older men having sexual relations with younger women. The current form of this practice involves 'sugar daddies' who obtain sexual favours from younger women or girls in exchange for money or other 'gifts' to be used for school fees, clothes, etc. Girls are often attracted to this easy but very dangerous form of income-generation. Unfortunately, there is evidence that older men, including some male teachers are deliberately turning to schoolgirls, believing them to be free from HIV infection (MacLachlan et al., 1997). In another study, boys revealed having sex for the sake of pleasure while the girls had sex for money (Phiri et. al., 1997).

In rural Malawi, a recent survey found that 55% of girls had been forced to have sex (Gachuhi, 1999). Schoolgirl pregnancy is still commonplace in Malawi schools, and in secondary schools it is often the main reason for the drop out of female students. In our survey more than half of girls and boys at secondary school considered that 'student pregnancy is a big problem in this school' (see Table 4.1). However the number of girls dropping out due to pregnancy is not recorded by the MoEST, and the precise numbers of schoolgirl pregnancies is not known. The social and personal cost to girls who get pregnant at school are considerable as they are suspended from school for one year and are often forced into early marriages or unsafe abortions. Schoolgirls can, in theory enrol in school again after one year, in practice, many do not. Boys who impregnate girls generally avoid any adverse consequences and do not take responsibility for their actions (Ministry of Youth, Sports and Culture, 1996). In the context of transactional sex and rising levels of sexual abuse, girls in particular run a high risk of contracting STDs or HIV/AIDS either from relationships contracted inside or outside of the school.

4.1.4 Student Knowledge of HIV/AIDS

One possible reason why students are not changing their sexual behaviour is that they lack key information about the causes and consequences of HIV/AIDS. Student questionnaire respondents at the survey schools were requested therefore to give true or false answers to twelve statements concerning HIV transmission and prevention.

The percentages of students who incorrectly answered these statements are presented in Table 4.3. Generally speaking, both primary and secondary school students are well informed about all key aspects of the epidemic and there is a definite learning curve as students progress from primary to secondary schools. The main exceptions are the relatively large numbers of incorrect answers to the two statements 'only immoral people get the AIDS virus' and 'you can tell if a person is HIV infected simply by looking at them'. Also, a surprisingly high percentage of female Form 4 students do not believe that 'using a condom properly helps to reduce the risk of contracting HIV'. This is a serious cause for concern given the existing levels of sexual activity among this age group.

4.2 HIV/AIDS AND THE FORMAL CURRICULUM

Students at the school surveys were asked to respond to and discuss a number of statements about the impact of school-based HIV/AIDS education. Table 4.5 shows that only 30% of secondary school students believe that sexual behaviour has changed as a consequence of this education. Similarly, a large majority of teachers do not believe that this education has been effective.

Table 4.3: Student knowledge about HIV/AIDS: percentage of questionnaire respondents giving the wrong answers to statements

STATEMENT	PRIMARY				SECONDARY			
	Std 6		Std 8		Form 2		Form 4	
	Male	Female	Male	Female	Male	Female	Male	Female
Characteristics								
Only immoral people get the AIDS Virus	51	69	44	49	20	26	19	33
You can tell if a person is HIV Infected simply by looking at them	53	44	39	39	19	24	14	18
There is no cure for AIDS	20	8	9	3	15	11	10	9
Modes of transmission								
Pregnant women who are infected can pass the AIDS virus to their unborn baby	5	8	9	0	0	4	5	6
It is possible to get the AIDS virus from sharing a toilet seat with a person living with HIV/AIDS	18	10	9	7	4	4	1	6
The most common way for HIV to spread is through unprotected sex	8	2	7	0	3	4	3	5
One can get HIV by sharing writing materials with other pupils in class	5	5	3	1	4	1	1	0
One can get AIDS virus through witchcraft	8	6	5	3	1	8	0	8
Modes of prevention								
Some traditional healers can cure AIDS	7	3	2	2	1	4	0	5
Using a condom properly helps to reduce the risk of contracting HIV	13	8	8	15	12	18	11	26
Having sex with a virgin is one way to cure AIDS	8	9	2	7	0	0	0	0
If one drinks 'kachasu' he/she will be protected from AIDS virus	8	2	4	1	0	0	0	0

The following discussion first describes the approach and overall objectives that have underpinned HIV/AIDS education in schools in Malawi and then assesses the design and delivery of this curriculum.

4.2.1 Approach and overall objectives

In the late 1980s, the USAID-funded AIDS Control and Prevention Project developed a series of booklets on AIDS-related topics for primary and secondary school students. Over a quarter of a million booklets were distributed by the Ministry of Education. However, a preliminary evaluation in 1991 found that there was no noticeable improvement in knowledge about HIV/AIDS among students at primary schools mainly because teachers were not using the booklets. Many teachers acknowledged that they did not feel comfortable talking about sexual behaviour and HIV with their students.

The overall objective of the UNFPA-funded Population Education Project (which became the Population and Sexuality Education Project in 1993) is to encourage children to 'control' their emotions. The project is a response not only to the rising incidence of HIV/AIDS, but also to the increasing number of girls dropping out of school through pregnancy. A wide range of grade and age-specific learning and teaching materials has been developed. In the lower primary grades, AIDS-related topics are integrated into the social studies curriculum while, in the upper primary grades, health/science education is the main carrier subject. Since 1997, AIDS education has also been incorporated into social studies, biology, agriculture and home economics at all junior secondary schools.

HIV/AIDS education is also an important component of a major World Bank-funded education support project. This includes the adaptation of HIV/AIDS education materials originally developed for secondary schools in Zimbabwe.

Life Skills: The MoEST began to develop Life Skills Education under Youth Reproductive Health in conjunction with UNICEF in 1997, although this was not introduced into primary schools until early 2000. It was trial tested in 24 schools in 1998 for Standard 4 and thought to be of benefit to all primary classes. Life Skills is a stand-alone subject for one hour a week but, currently, is only offered in Standard 4. Its goal is to equip students with key competencies in problem solving, decision-making, stress and anxiety management, conflict resolution, interpersonal relationships, planning and entrepreneurship, self-esteem and assertiveness as well as AIDS prevention. Teaching and learning materials for Standards 5 to 8 are still being developed and will be introduced from 2002 onwards. The new secondary curriculum also recognises Life Skills as a core subject. The syllabus and appropriate materials for all grades are being prepared. The intention is also to provide some inputs into teacher training to enable to effective teaching of life skills.

The WHY WAIT educational programme (funded by a consortium of NGOs) is based on Christian principles and has been particularly influential in both the formal curriculum and in Anti-AIDS extra curricula activities. It was introduced in secondary schools in 1995 and primary schools in 1999. Its overall aim is to sensitise youth to abstain from premarital sex. It has trained around 600 teachers to deliver a four-year programme, which seeks to address the problems facing youth concerning sexual decision making.

- ✓ The first year focuses on the physical, socio-cultural and environmental factors that lead to premarital sex and explains the needs for a monogamous faithful marriage. The aim is to encourage youth to avoid 'harmful' behaviour.

- ✓ The second year involves a greater focus on psychological and emotional factors, which influence the sexual behaviour of youth.

- ✓ The third year demonstrates life principles and encourages students to follow a path informed by biblical principles.

- ✓ Acknowledging that many students come from homes that offer poor models of parenting, the fourth year is focuses on positive parenting.

4.2.2 Student interest

Unless students perceive HIV/AIDS as being an important issue, it is unlikely that they will take school-based education seriously, no matter how well designed and delivered this curriculum might be. Table 4.4 shows that only around one-third of students at the survey secondary schools think that 'HIV/AIDS is a big problem in this school'. Although somewhat higher, only one half of primary school students agreed with this statement. Convincing students that AIDS is a critically important issue poses a major challenge for educators in Malawi.

Table 4.4: Student responses to statements concerning the delivery of the HIV/AIDS curriculum (rounded percentages)

STATEMENT	PRIMARY						SECONDARY					
	Male			*Female*			Male			Female		
	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree
HIV/AIDS is a big problem in this school	33	10	58	37	11	52	38	26	36	30	31	38
Topics on HIV/AIDS are not taught well in this school	57	5	38	60	7	33	29	7	64	44	8	56
Students have not changed their sexual behaviour as a result of HIV/AIDS education	41	14	46	40	14	46	30	13	57	29	10	61
Students do not feel free to talk to teacher counsellors about HIV/AIDS	60	4	37	54	5	40	43	5	52	41	5	54
Students at this school do not get all the information they need about HIV/AIDS	54	11	35	51	7	43	46	10	44	38	8	53

4.2.3 Curriculum design

Student questionnaire respondents were asked to rate the usefulness of seven topics, which should be covered in HIV/AIDS education programmes. Table 4.5 shows that most primary and secondary school students indicated that these topics have been taught and rated them as 'useful'. However, nearly one-quarter indicated that they have never been taught anything about dealing with threats and harassment.

However, as with other issues, the focus group discussions raised a number of major concerns about the adequacy of the HIV/AIDS curriculum. Secondary school students complained that HIV/AIDS education is not effective because 'most of the information comes in piecemeal'. Most teachers also believed this to be the case. Students also pointed out that AIDS education can only be effective if it is formally examined like any other subject. However, teachers are concerned that merely studying HIV/AIDS topics in order to pass examinations is unlikely to lead to significant and sustained behavioural change.

Table 4.5: Usefulness of HIV/AIDS topics taught at school (percentages)

TOPICS	Never been taught	Not useful	Not sure	Useful
PRIMARY SCHOOLS				
Basic knowledge on HIV/AIDS/STDs	2	1	1	96
How to avoid AIDS: delaying sex	4	1	2	92
How to avoid AIDS: protected sex	5	5	7	84
Testing for HIV	11	2	6	82
Dealing with threats and harassment	25	1	11	64
Being assertive	10	1	9	80
Care and support for people living with AIDS	5	1	4	90
SECONDARY SCHOOLS				
Basic knowledge on HIV/AIDS/STDs	2	0	3	95
How to avoid AIDS: delaying sex	3	2	2	93
How to avoid AIDS: protected sex	3	14	3	80
Testing for HIV	7	2	2	89
Dealing with threats and harassment	24	5	5	61
Being assertive	10	1	1	80
Care and support for people living with AIDS	2	2	2	94

Most teachers have major concerns about both the design and delivery of the HIV/AIDS curriculum. Only 20% of primary and secondary school teachers agreed with the statement that this curriculum is well designed. Teachers have the following objections to the way in which the HIV/AIDS curriculum components have been designed:

- Teachers have not been involved in the development of the curriculum;
- Teachers have been given little or no orientation on HIV/AIDS;
- Teachers feel they need in-service training on how to deliver sensitive topics.

The following type of comments were frequently expressed by teachers in the FGDs:

'We lack training in AIDS education. As a result we have problems presenting the sensitive topics on AIDS and sexuality to our pupils.'
'The material on HIV/AIDS is very explicit. Some of the content is not appropriate to some children because of their age.. it is very difficult to teach sexuality-related issues to a mixed age group in one class'.

'With no training in AIDS education, we don't feel adequately prepared to handle the material we are being asked to teach our pupils'.

4.2.4 Curriculum delivery

There are major problems with how the HIV/AIDS curriculum is being delivered in most schools in Malawi. Most of these relate directly to the commitment and competence of teachers to teach what are sensitive and difficult topics.

Teacher commitment: It would appear that the HIV/AIDS curriculum is not taught in many schools in Malawi. Table 4.6 summarises student responses to the question 'is HIV/AIDS education offered in your school?' Only 41% of male and 24% of female student questionnaire respondents at secondary schools indicated that HIV/AIDS topics are being taught at their school. However, the situation appears to be considerably better at primary schools with over 60% of students indicating that they are taught about HIV/AIDS. This difference can be explained by the fact that at senior primary school, HIV/AIDS is infused into carrier subjects such as Health/Science Education which is a core subject in the Primary School Leaving Certificate exams (PSLCE). In Table 4.7, 90% of male and 94% of female students identified these subjects as those in which HIV/AIDS is taught.

In secondary schools the main carrier subject is biology and HIV/AIDS topics are only covered under the topic 'sexually transmitted diseases'. It is possible that a number of students do not even take this subject. Some teachers actually skip the HIV-related topic and ask the students to read on their own because they feel profoundly uncomfortable and unprepared to teach this subject. The only systematic training of teachers with regard to HIV/AIDS components in the secondary curriculum seems to be provided through the WHY WAIT programme.

Table 4.6: Student responses to question 'Is HIV/AIDS education taught in this school?'

RESPONSE	PRIMARY		SECONDARY	
	Male	Female	Male	Female
Yes	61	62	41	24
No	39	38	59	76

Students were also asked to identify the subjects where HIV/AIDS topics are being taught. As can be seen in Table 4.7, science and health education and biology are the main subjects in primary and secondary schools respectively. Interestingly, only one-fifth of secondary school students mentioned WHY WAIT? The overloading of the curriculum at both primary and secondary means that there is little time to deal adequately with AIDS education even if the teachers felt more confident to do so.

Table 4.7: Carrier subjects for HIV/AIDS topics (percentages)

SUBJECT	PRIMARY		SECONDARY	
	Male	Female	Male	Female
English	1	2	4	3
Chichewa	2	3	-	-
Social studies	9	4	-	-
Science/health education	90	94	-	-
Agriculture	-	1	-	-
Home economics	-	-	2	6
Biology	-	-	44	67
Music	-	-	2	-
Bible knowledge	-	-	6	-
WHY WAIT?			20	21

Teachers as a source of information: Student questionnaire respondents were asked to identify their most important sources of information concerning HIV/AIDS. Table 4.8 shows that only half of secondary school students included school/teachers as one of their top three information sources, which again suggests that school-based HIV/AIDS education is not having the desired impact. However, the corresponding percentage for primary school students is much higher – over 70%. Among these students (and especially girls), teachers are, in fact, the most important source of information, along with the radio.

Table 4.8: Most important sources of HIV/AIDS information (percentages)

INFORMATION SOURCE	PRIMARY		SECONDARY	
	Male	Female	Male	Female
Radio	73	58	87	73
School/teachers	71	70	50	50
Church	14	9	14	24
Home/parents	10	25	18	20
Hospital	16	23	18	26
School clubs	14	9	26	8
Magazines/newspapers	9	10	23	21
Friends	13	23	10	19
Relatives	10	2	4	8
TV/films	5	3	11	9
Posters/leaflets	5	7	9	8
Drama/music	16	5	12	7
Organisations	7	4	8	5
Visiting officials	2	10	0	3

The Malawi Broadcasting Corporation has several HIV/AIDS radio programmes, which target specific audiences. The main programmes for youth are *Straight Talk*, *Teen Line*, and *Tinkanena*. *Straight Talk (*which is sponsored by UNICEF) is presented by young people and deals with day-to-day issues and concerns that directly affect young people in Malawi. *Teen Line* offers radio counselling in response to listeners' questions. *Tinkanena* is a radio drama programme. Compared to other sources, radio is far less personal, more acceptable, and does not put the individuals on the spot.

Teacher competence: Most teachers are ill prepared to teach the HIV/AIDS curriculum. Only 18% of primary and 25% of secondary teachers agreed with the statement that 'teachers are sufficiently confident to teach the HIV/AIDS curriculum' and almost 90% of secondary

school teachers said they were not properly trained (see Table 4.9). While student assessments of teacher competence are somewhat more positive, there is still considerable cause for concern. At secondary schools in particular, only 29% of male and 44% of female students agreed with the statement that 'HIV/AIDS topics are well taught in this school'. Again, it appears that primary school teachers are doing a better job, with 60% of student respondents agreeing with this statement. However, 40-50% of students in both types of school do not feel free to talk to their teachers about personal problems. This is symptomatic of the failure of most schools to create the child-friendly environments, which are essential for effective HIV/AIDS education programmes.

A large evaluation of school-based HIV/AIDS education (which was undertaken in 1997) also found that, while some AIDS-related education was being taught in the majority of schools, nearly three-quarters of teachers had not received any training on the content and delivery of this new curriculum. Furthermore, more than 25% of the secondary school teachers were too embarrassed to talk about AIDS-related issues and were put off by both students' laughter and lack of material. Even when teachers had attended orientation seminars, they still felt uncomfortable talking about sexual issues (see Mazloum et al, 1997).

Table 4.9 Teacher views on the design and delivery of HIV/AIDS curriculum

STATEMENT Teachers	PRIMARY			SECONDARY		
	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree
The curriculum on reproductive health and sexual behaviour is well designed	55	24	21	48	33	20
Teachers are properly trained to deliver sexual and reproductive health messages	77	11	11	89	6	5
Teachers feel confident teaching HIV/AIDS topics	65	16	18	48	27	25
In-service training for HIV/AIDS has been adequate	84	9	8	76	3	11

There are important differences concerning the delivery of the HIV/AIDS curriculum in rural and urban areas. In urban schools, students are generally more satisfied with both the content and delivery of HIV/AIDS education. They reported that they are taught about the existence and dangers of HIV/AIDS as well as STDs and they are also aware of means of preventing the transmission of HIV. From time to time, these schools invite outside speakers from either the local hospital or non-governmental organisations to talk to students about HIV/AIDS. However, student assessments of HIV/AIDS education tend to be a lot less positive in the rural areas. The taboos around discussing sexuality are stronger in rural areas, where communities are smaller and closer knit with the result that teachers are particularly reluctant to cause offence.

The following comment by a female primary school teacher is typical:

'*Topics on HIV/AIDS are not well taught in the school because the issues are covered as a minor lesson which slightly mentions HIV/AIDS in health/science education without going into details*'.

The school survey confirmed that most teachers (particularly females) felt uncomfortable teaching sexuality related components in the curriculum. Teachers themselves feel strongly

that they have not been adequately trained and prepared to teach about issues of sexuality and AIDS education. From the point of view of both teachers and students, the 'integration' of AIDS in the curriculum has not been successful. In the FGDs, many students and teachers stated that AIDS should be introduced as a subject on its own. This point was also made by a senior official of the NACP. Teachers also suggested that HIV/AIDS should be more explicitly and consistently taught in their pre-service training courses.

Typical comments from teachers concerning training are as follows:

'Teachers should be given orientation on how to tackle HIV/AIDS topics in the curriculum'.

'All teaching staff should be exposed to HIV/AIDS education and be oriented on how to teach it'.

'HIV/AIDS education is not sensitised to all staff. It is restricted to one or two teachers in sciences and yet the expectation is that we should all teach it'.

Resource availability: The 1997 evaluation found that 70% of the 100 schools that were surveyed had no resource materials on HIV/AIDS. Furthermore, a higher proportion of secondary than primary school students had read the AIDS information booklets (Mazloum et al, 1997). From the school survey undertaken as part of this study**,** it is also clear from both teacher and student FGDs that most schools lack materials to support both formal teaching and extra curricula activities. Nor do most schools have access to resource centres where they can consult materials on HIV/AIDS.

'The school lacks relevant literature on HIV/AIDS' (Student).

'Whenever the MOE is putting new topics on the syllabus, there should be books made available to schools' (Teacher).

'Provision of reading materials on HIV/AIDS to all pupils in form of leaflets' (Teacher).

'Books, posters, leaflets and pamphlets on updated information should be made available to all schools' (Teacher).

*'There is a need for instructional materials on HIV/AIDS in schools' (*Teacher*).*

DFID is currently supporting teacher resource centres in its community schools and UNFPA is producing materials for teachers and associated training. Also, CIDA is spending C$10 million on textbooks for the new life skills component of the curriculum. Hopefully these programmes will improve access to HIV/AIDS materials and resources.

4.3 OTHER EDUCATION INTERVENTIONS

There are a number of other school-based activities, which also have HIV prevention as their principal objective.

4.3.1 AIDS TOTO Clubs

AIDS TOTO clubs are the main extra-curricula anti-AIDS activity directed at school students in Malawi. There are also Bible clubs with a more limited scope as well as UNESCO-supported clubs that focus more on life skills and family life education.

UNICEF helped to establish AIDS TOTO clubs in the late 1980s through the provision of learning materials and guidelines for action. The clubs operate in both primary (Standards 6-8) and secondary schools. The original intention was that teenagers should discuss with their peers the dangers of 'indulging in multiple partners, drugs, and alcohol' (UNICEF, undated). Club activities are centred on empowering students by providing them with all the necessary information and knowledge about HIV/AIDS to enable them to make informed decisions about their sexual relationships. .

The school survey found marked variations in terms of staff commitment and levels of activity from one AIDS TOTO club to another. Depending on resources and student/staff commitment, students organise outings for inter-school discussions, drama, choir competitions, and invite guest speakers. Also a number of CBOs and NGOs make occasional visits to schools in order to talk about AIDS to students, usually during assembly but sometimes on a class by class basis. Many of the teachers and some of the heads interviewed in the survey had little or no knowledge of club activities and most of them showed little commitment to supporting the clubs.

Students were asked whether there was the AIDS TOTO club in their school. While most students are aware of the existence of the club, very few of them are active members, particularly at primary schools (see Table 4.10). Secondary school students have a relatively large number of clubs to choose from.

Table 4.10: Student knowledge and participation in AIDS TOTO clubs (percentage affirmative answers)

	PRIMARY		SECONDARY	
	Male	**Female**	**Male**	**Female**
Do you have an AIDS TOTO club?	66	73	93	97
Are you a member?	16	27	32	34

Every student club has a teacher who is its 'patron'. A teacher can either be appointed or volunteer to be the patron of a particular club. In most schools, the head teacher appoints the patrons of AIDS TOTO clubs. It is usually teachers who are teaching subjects with HIV/AIDS-related topics who are assigned this responsibility. Teacher involvement in the clubs tends to be quite limited mainly because teachers feel overloaded with work and there are no incentives. Some teachers also mentioned that they are not prepared to handle issues, concerns and questions of students around HIV/AIDS. Mazloum et al (1997) found that there was a direct correlation between teachers' attendance at HIV/AIDS orientation seminars and their participation in AIDS Club activities.

Although AIDS TOTO clubs were originally intended as peer education, club patrons (teachers) have tended to determine the direction of the clubs. In our school survey, only two primary heads and two secondary heads reported having peer educators in their schools. With waning enthusiasm on the part of overburdened teachers and a diminishing supply of materials from UNICEF, the clubs seem to have 'run out of steam' and they have not been successful in mobilising a large number of schoolchildren in the struggle against AIDS. They lack initiative and are in urgent need of revitalisation.

Students also complained of being 'lectured at' without anyone asking for their response. Students in the FGDs were only positive about AIDS TOTO clubs when their activities involved drama and making visits outside the school. A clear message emerging from students and staff is that anti-AIDS activities can only be effective if they are based on fully interactive and participatory approaches. This applies to both formal teaching and extra curricula AIDS activities.

As we have seen, the WHY WAIT initiative is an abstinence based programme which emphasises moral ethics in the formation of 'healthy' relationships among male and female students, the aim being to help young people make informed decisions regarding their future. As well as the formal inputs into the curriculum, WHY WAIT puts on extra-curricula sessions in school assemblies and sometimes in individual classes. These sessions cover the same set of issues as the formal curriculum inputs with a focus on the following: building friendships, peer pressures, true love versus lust, choice and consequences, STDs, HIV/AIDS, sexual abuse, self-awareness, getting to know the opposite sex, preparing for marriage: customs and beliefs.

4.4 GUIDANCE AND COUNSELING

Formal guidance and counselling in Malawi schools dates back to 1983 when the MOE appointed an acting career guidance officer at ministry headquarters to co-ordinate career guidance programmes in secondary schools. The main goal of guidance and counselling then was to prepare students for national examinations as well as make appropriate choices for higher education. In response to growing social and psychological problems among secondary school students, it was extended to provide personal counselling.

All schools in Malawi are supposed to offer guidance and counselling services. Formal guidance and counselling services should include the following: vocational/career guidance, educational guidance, personal and social guidance, individual counselling, group guidance and counselling, learning resource centres, enterprise education and orientation service. However, over the past few years this service has not been provided and the MoEST has yet to appoint an overall coordinator for the programme. Not surprisingly, therefore, one-third of girls and one-half of boys at both the primary and secondary survey schools indicated that guidance and counselling is not offered by their schools. Between 20-30% of teachers also responded negatively to this question (see Table 4.11).

Table 4.11: Student and teacher responses to the question 'Are guidance and counselling services offered at your school?' (percentages).

Group	PRIMARY		SECONDARY	
	Male	Female	Male	Female
STUDENTS				
Yes	50	63	45	64
No	49	30	52	32
Not sure	1	7	3	5
TEACHERS				
Yes	71	33	71	69
No	29	67	21	30

Teachers' perceptions of guidance and counselling services provided at the survey schools are presented in Table 4.12. Although more than half indicate that 'counselling' is offered, it is clear from teacher interviews and FGDs that this amounts to little more than 'advice-giving' rather than professional counselling. According to traditional customs, nearly every adult person at one time or another plays the role of a counsellor to young people. Once again, fewer female primary school teachers than other teachers appear to be confident that counselling is provided in their schools. Nor are AIDS TOTO clubs considered to be an important source of counselling by most teachers (see below).

School managers enumerated the following G&C activities at the survey schools: disciplinary committee and class teachers (three schools); career counselling and guidance (two schools); addressing 'immoral' behaviour of students and early marriages (two schools); school committee members counselling students on HIV/AIDS issues (two schools); anti-AIDS clubs/drama (one school); and outside organisations provide counselling on HIV/AIDS to students (one school).

Table 4.12: Teacher perceptions of G&C services provided by their schools (percentages)

Type of counselling service	PRIMARY		SECONDARY	
	Male	Female	Male	Female
AIDS TOTO Club	24	39	18	45
Talks by outside CBOs and NGOs	6	8	9	0
Time-tabled lessons	18	23	12	5
Individual counselling	53	30	61	50

'*All the students' matters are resolved through the discipline committee. It is only when the issue is relatively simple that teachers are encouraged to resolve them. This discipline procedure is fine and working properly*' (Primary school head, urban).

When the heads were asked directly whether the G&C programme had an HIV/AIDS component, all six primary heads and two secondary heads agreed that it did. Brief talks during school assembly, generally delivered by the head or deputy, are also seen as guidance and counselling.

'*In my school, the only counselling that students get is when they are warned by the headmaster during the school assembly. If that student does not change, then the matter is taken to the disciplinary committee*' (Primary school head, rural).

It is clear that primary schools do not offer professional, formalised guidance and counselling services. All primary head teachers acknowledged that their schools had adopted a variety of *ad hoc* solutions, but mainly relied on the disciplinary committee and pastoral care by class teachers. Secondary schools, on the other hand, are expected to provide formalised G&C services. At the survey secondary schools, one or two teachers have been appointed as school counsellors**.** However, due to heavy teaching loads and other responsibilities, they have very little time to counsel individual students, Nor have they received any appropriate training, which means they have great difficulty dealing effectively with student problems, especially in relation to complex problems such as HIV/AIDS.

It seems many heads do not have a clear understanding of the role and rationale of G&C in their schools. In particular, many cannot tell the difference between the functions of the G&C programme and the disciplinary committee. Teachers also have a very narrow of looking at guidance and counselling was also confirmed in teacher FGDs. The existing 'crisis management' system of school based counselling is highly reactive and, as such, it fails to adequately confront HIV/AIDS related issues.

4.5 SEXUAL HARASSMENT

Sexual misconduct by teachers is another way in which students can become infected with HIV. Students at the survey schools indicated that sexual harassment of female students by male teachers is pervasive, especially in rural schools where relatively more male teachers are employed. At the rural survey schools, most participants agreed with the statement that 'love relationships between teachers and students are common at this school'. This was also confirmed during focus group discussions with boys and girls, with participants in all but one rural school concurring that teacher-student love relationships existed in their schools. Only a few cases of sexual harassment by teachers at urban schools were cited. These incidents occur mainly at boarding secondary schools. Other studies have also shown that sexual relationships between students and teachers commonly occur in schools in Malawi and that the overall incidence of teacher sexual misconduct is considerably higher in all but one rural school (see, Kadzamira and Chibwana, 2000).

Male teachers commonly exert pressure on female students to accept their 'love proposal'. Some instances of female students being made pregnant by male teachers in the schools were also reported.' However, it is hard to gauge accurately the extent of sexual harassment in schools since most cases go unreported. In all but one rural schools, both boys and girls in separate group discussions were aware of the occurrence of teacher-student relationships at their school.

While most teachers at the survey schools do not believe that sexual misconduct is a big problem in their schools, a relatively large number of secondary school students stated that this is a serious problem (see Tables 4.1 and 4.13).

'*Some teachers are known to harass girls who refuse to have sexual relationships with them in such ways as being refused exit permits, punished for petty offence or no clear reason at all, ill-treated in class*'.

'*When a girl refuses to get involved with the teacher, she is punished severely for no apparent reason, sent out of class while others are learning and sometimes she is even failed teacher-made tests*'.

'Likewise a female student who had a relationship with a male teacher could drastically improve her grades… These relationships become more prevalent during examination period as teachers promise to reveal examination paper to girls who accept to sleep with them.'

'*We do not do anything because if we choose to report or expose the teachers we can be punished severely or be chased from school for no proper reason.*'

'*These teacher/pupil relationships are so popular at this school in such a way that even the headmaster himself is also involved. There have been many incidences where teachers including the headmaster have impregnated school -girls. How do you expect the headmaster to help?*'

Female students easily submit to the teachers' sexual demands for fear of being punished in various ways. Girls who have transactional sex with male teachers do so both for money and other gains (for example, private tuition or leaking of examination papers). While girls at urban schools tend to gravitate towards older men who have higher incomes than teachers, teachers in rural areas belong to a relatively very small group of people who enjoy regular wage incomes. As one female student commented: "*Some girls go out with teachers because of poverty, they do this with the intention that the teachers should be giving them lots of money.*" One urban head described male teachers in rural areas as 'shining stars'. Teachers frequently give private lessons after school in the afternoons to supplement their incomes. Several student focus groups mentioned that girls often pay 'in kind' when they cannot afford these lessons.[8]

More recent teacher graduates from the university and colleges are generally quite young, which increases the likelihood that they will have 'love relationships' with students. Some MoEST officials indicated that sexual misconduct has increased with the rapid growth of temporary and young teachers in schools. Temporary teachers are poorly informed about MoEST rules and regulations due to the nature of their training. PEAs are now briefing temporary teachers on this issue. However, many teachers going out with female students are married and likely to have multiple partners thus increasing the risk of infecting the female students they have sexual relationships with.

MoEST regulations clearly stipulate that any teacher found having sexual relations with a student in their own or any other school, should be interdicted immediately pending investigations and, if found guilty, permanently expelled. However, most incidents are either unreported or school management fails to follow proper procedures. A major problem is that most school managers are not decisive enough in gathering the necessary evidence with the result that very few cases reach court. The most common practice is for offending teachers to be transferred to another school. Very few cases, therefore, result in dismissal and/or criminal prosecution.

Most communities are also uncertain about how to deal with teacher-student sexual relationships. This is particularly the case where school committees collude with the teachers and school management and do not report cases to the authorities. School committees are also frequently inactive, leaving the community with no representation to take up the issues with DEOs. At rural primary schools, teacher-student sexual relationships are often covered-

[8] Such lessons are common now due to the declining standards linked to large class sizes and lack of resources.

up because the student's parents frequently collude with the teacher concerned for economic reasons. Even if the student becomes pregnant, she simply withdraws from school without identifying the teacher responsible. The high proportion of male teachers in the senior standards of rural primary schools is also said to be a major factor contributing to the relatively higher incidences of sexual abuse of girls in rural schools.

The majority of students at the survey schools believe that teachers who have sexual relationships with (in most cases, under-age students) should be dealt with firmly by the MoEST and that, more generally, all teachers should provide positive role models both in and out of school. Students also want teachers to more actively participate in school-based anti-AIDS activities. Most of the students also reported that though they are aware sexual misconduct on the part of teachers in their schools, they are powerless to take any action such as reporting cases to the head for fear of reprisals.

Table 4.13. Teacher responses to statements concerning sexual misconduct in schools

STATEMENT	PRIMARY						SECONDARY					
	Female			Male			Female			Male		
	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree
Sexual harassment of students by teachers is a big problem in this school	85	9	6	92	8	-	68	37	-	82	15	3
Sexual harassment by teachers at this school has got worse in recent years	89	8	3	72	26	3	89	6	6	83	11	6
School management deals effectively with sexual harassment by teachers	54	15	32	34	18	47	53	13	33	27	50	24

In the past, there has also been much denial at all levels of management in the MoEST concerning the extent of teacher sexual misconduct. In a few of the survey schools however, some teachers have been reported for sexual harassment of one kind or another:

'In 1999, one of the boarding masters took advantage of girls who had come to him to discuss their problems…as he was of retiring age he was encouraged to leave…girls are now advised to take their problems to female teachers or boarding mistress only' (urban secondary school).[9]

'Two, three years ago male teachers were going out with pupils' (rural primary school).

'There were incidences of sexual harassment of female pupils by male teachers' (rural primary school).

[9] However, quite a few female students mentioned that they do not find most female teachers particularly approachable.

'Sexual harassment is there but it is not obvious because the girls are colluding with it' (rural secondary school).

'Sexual harassment between teachers and students is there but many such cases go unreported' (rural secondary school).

There is also considerable confusion among head teachers and teachers about what behaviour constitutes sexual misconduct and sexual harassment. For example, the head teacher at one of the rural secondary schools commented that:

'No sexual harassment has been reported. However, it has been rumoured that some teachers are having affairs with girls but this leads to consensual sex…these are normal discipline issues rather than sexual harassment'.

Half of the female teachers at both primary and secondary schools and one-third of male teachers at primary and one-quarter of male teachers at secondary schools disagreed with the statement that management deals effectively with sexual misconduct by teachers.

To date, teacher relationships with students have not been taken seriously by either by management, teachers or the community. When the school student having a relationship with an older teacher is under-age, this behaviour constitutes child abuse. Regardless of whether such relationships are 'consensual', young females are being exposed to the deadly HIV virus. Relationships between teachers and students should not be tolerated on moral or ethical grounds.

Sexual relations between students are not seen as a particular problem, since boy-girl relations are seen as being 'normal'. However, student FGD participants at the survey secondary schools did point to incidents where older male students sexually coerce female students in lower forms.

Table 4.14. Student responses to statements concerning the school environment (percentages)

STATEMENT	PRIMARY						SECONDARY					
	Female			Male			Female			Male		
	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree	Dis-agree	Not sure	Agree
Fighting and bullying are common in this school	60	6	35	57	1	42	76	10	14	81	7	12
Girls in this school are fearful and anxious about their safety	73	1	27	65	2	33	61	9	30	60	13	28
Boys in this school are fearful and anxious about their safety	78	2	20	65	3	32	67	16	17	64	10	27

Table 4.14 shows that fighting and bullying are more common in primary than secondary schools, which can probably be explained by the very large numbers of children at some of the urban schools as well as high student:staff ratio. Girls are slightly more anxious than boys about their safety at school. In such difficult conditions, various forms of harassment (sexual or otherwise) can go unchecked.

CHAPTER 5

IMPACT ON STUDENTS

This chapter first assesses whether repetition and dropout rates have increased as a consequence of the AIDS epidemic. It then examines the impact of the HIV/AIDS epidemic on the education of children who are most directly affected, namely orphans, children with sick family members, and children living with AIDS. An assessment is made of the educational problems that these children have to contend with and the support which has been provided by the school and other agencies in order to mitigate the impacts of the epidemic.

5.1 REPETITION AND DROPOUT RATES

It is widely anticipated that the AIDS epidemic will result in large increases in repetition and dropout rates (see Carr-Hill et al., 2000, Kelly 2000). However, there is no evidence to suggest that this has happened so far in Malawi. Table 5.1 shows that, repetition and dropout rates have declined slightly since 1993 (the year before the introduction of FPE) with the dropout rates having fallen very significantly in the last 4-5 years of primary school for both male and female students. Whether these declines would have been larger still in the absence of AIDS (the counter-factual scenario) is impossible to tell, but what is clear is that they have not increased.

Table 5.1: Change in repetition and dropout rates for primary schools students, 1993-1999 (percentages)

GRADE	REPETITION				DROPOUT			
	1999		Change since 1993		1999		Change since 1993	
	Female	Male	Female	Male	Female	Male	Female	Male
1	17.2	17.7	-4.7	-3.2	25.0	23.0	1	0.5
2	15.4	16.5	-4.8	-4.1	15.2	11.5	0	-4.0
3	15.4	15.8	-2.2	-2.5	17.6	15.7	0.3	-0.2
4	12.0	12.2	1	0.1	14.1	0	-2.9	-14.3
5	10.3	10.1	-1.9	-2.6	13.9	12.6	-6.0	-3.1
6	9.0	8.4	-0.9	-2.1	12.4	9.9	-8.1	-3.5
7	7.9	7.4	-1.2	-2.6	5.4	0.7	-18.8	-14.3
8	15.4	16.2	0.6	-1.2	NA	NA	NA	NA

5.2 ORPHANS

One of the most profound impacts of the AIDS epidemic is the growing number of orphaned children without parental care and support who are often vulnerable and abused. It is widely believed that orphans are at far greater risk of malnutrition and early withdrawal from school than students with two parents.

5.2.1 Definitions and estimates

Orphans are defined in a variety of ways. UNICEF estimates that 6% of children under 15 years old in Malawi are double and maternal orphans (UNICEF, 1999). The number of these orphans has grown exponentially in recent years – from 210,000 in 1998 to 500,000 in 2000 (NACP 2000). The government defines an orphan as someone who has lost one or both parents because of death and is under the age of 18 years. On the basis of this definition, the total orphan population was around 1.2 million in 2000. However, in the Malawi context, both the UNICEF and the government definitions of orphans are too restrictive. This is because nearly 10% of school students are over 15 years old and continue to be heavily dependent on adult support. It is important, therefore, that these young people are not excluded in any discussion of the orphan problem. Consequently, for the purposes of this study, any student who has lost one or both parents, irrespective of age, is considered to be an orphan.

5.2.2 The orphan sample

A total of 312 orphans were interviewed for this study, 111 of whom were identified through community contacts using an opportunistic sampling procedure. These children completed a separate orphan questionnaire. The remaining orphans were part of the overall student samples who were randomly selected from the targeted classes at each survey school. These children completed the standard student questionnaire.

Gender breakdown: The gender breakdown of these orphans is shown in Table 5.1[10]. 48% of the orphans who responded to both the orphan and the student questionnaires at the primary level were female and 52% were males. At the secondary school level, an equal number of female and male orphans were interviewed.

Table 5.2: Student sample size by parental status and level of schooling

Status	PRIMARY				SECONDARY				OUT OF SCHOOL	
	Orphans		Non-orphans		Orphans		Non-orphans		Orphans	
	N	%	N	%	N	%	N	%	N	%
Female	89	47.6	118	46.3	54	50.0	95	48.7	7	38.9
Male	98	52.4	137	53.7	54	50.0	100	51.3	11	61.1
Total	187	42.3	255	57.7	108	35.6	195	64.4	18	100.0

Almost all the orphans interviewed were attending school at the time of the study. We only managed to interview 18 out-of-school orphans, all of whom were dropouts. This could be attributed to the sampling procedure adopted as orphans from the community were identified with the assistance of local leaders[11]. Of the orphans currently attending school, 63% were in primary with the rest at secondary school.

[10] It was possible to merge the orphan and student questionnaires because the first part of each questionnaire contained identical questions.

[11] Local leaders and community based orphan care groups assisted with the identification of orphans who were asked to assemble in one place for the interviews and FGDs. Because the focus of our research was on education, it is possible that this might have influenced attendance in the sense that the community might have perceived our mission as assisting orphans in school hence the small number of out of school orphans who turned up. Moreover, out of school children are more likely to be heavily involved in the economic survival of their families making it difficult for them to attend the meetings.

Age profiles: The age range of orphan interviewees in primary school was 7 to 21 years old with a mean age of 13.7 years and 14 to 23 years at the survey secondary schools with a mean age of 17.6 years. The age profiles of these orphans do not differ significantly from those of non-orphans. There is a sizeable mismatch between standard and age, but this is a common feature of the education system in Malawi (see Kadzamira and Chibwana, 2000). The majority of orphans are older than their respective standard, which means that most did not start until after the age of six or they repeated. About a third of the orphans and non-orphans in the survey primary schools and 90% in the secondary schools are over 15 years old.

Table 5.3: Distribution of students by standard/form, mean age, and parental status

Std/ form	ORPHAN								NON-ORPHAN							
	Female				Male				Female				Male			
	N	mean	sd	range	N	mean	sd	range	N	mean	sd	range	N	mean	sd	range
1	1	8.0			2	16.5	0.7	16-17								
2	1	7.0			2	12.5	0.7	12-13								
3	8	10.9	0.8	10-12	6	11.7	2.9	7-15								
4	8	10.8	1.4	9-13	11	12.6	1.3	10-14								
5	6	12.8	1.7	11-16	6	12.5	1.4	11-15								
6	31	13.3	1.7	11-18	24	13.5	1.4	11-17	62	12.9	1.6	10-18	72	13.3	1.9	10-19
7	3	15.0	1.0	14-16	5	14.8	2.2	13-18								
8	40	13.4	2.2	12-17	32	15.6	2.2	13-21	56	14.9	1.8	12-20	65	15.1	1.7	10-19
F1	1	14.0	-		3	17.3	3.1	12-17	-				-			
F2	29	16.3	1.3	14-19	29	16.9	1.6	15-21	52	16.2	1.3	14-20	48	16.9	1.6	14-21
F3	-				-				-				-			
F4	24	18.5	1.8	14-22	22	19.4	1.8	15-23	42	18.5	1.4	16-25	52	19.7	1.5	18-23
Total	152				142				212				237			
15+ prim	32.7%				33.7				37.9%				33.9%			
15+ sec	94.4%				98.1%				94.7%				98%			

Educational attainment of parents and guardians: The level of educational attainment of parents and guardians is high by national standards for both orphans and non-orphans (Table 5.4). The majority of parents have more than four years of schooling (80% fathers and 60% mothers). A significant proportion also have some secondary education – among secondary school students 61% for non-orphans and 65% for paternal orphans and for primary school students, 53% and 46% respectively. According to the Integrated Household Survey (IHS) of 1997-98, 53% of males and 29% of females had completed at least four years of primary schooling and only 10% of males and 3% females had some secondary education (GoM, 2000).

Educational attainment varies by the gender of the parents. Generally, mothers of both orphans and non-orphans are less well educated. At the primary level, a higher proportion of fathers and mothers of male orphans and non-orphans have attended secondary school than parents of female orphan and non-orphans. However, at secondary level, the opposite seems to be the case- a higher proportion of parents of female orphans and non- orphans had received some secondary education. The proportion of mothers who have reached secondary level was higher among secondary school children (36% non-orphan mothers and 32% of orphan mothers) than among primary school children (30% non-orphans and 23% orphans). Though the samples are small, the results are broadly consistent with other studies that show that educational levels of parents of children in school tend to be higher than those of children

out of school**,** suggesting that the higher the educational attainment levels of parents the more likely that children will complete school.

Table 5.4: Parental educational attainment by parental status (percentages)

FATHER	**PRIMARY**				**SECONDARY**			
Parental status	**Both parents alive**		**maternal orphan**		**Both parents alive**		**Maternal orphan**	
Educational level	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
None/non formal	2	5	0	8	3	4	0	14
Primary 1-4	1	6	7	0	4	10	0	0
Primary 5-8	26	20	20	15	15	30	0	29
Secondary &above	50	67	40	54	73	50	70	57
Don't know	22	13	33	23	5	6	30	0

MOTHER	**PRIMARY**				**SECONDARY**			
Parental status	**Both parents alive**		**paternal orphan**		**Both parents alive**		**Paternal orphan**	
Educational level	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
None/non formal	7	12	8	8	13	23	4	22
Primary 1-4	8	10	14	26	7	11	8	17
Primary 5-8	43	33	41	26	27	36	32	33
Secondary & higher	27	32	20	26	47	26	32	28
Don't know	14	13	18	14	5	4	13	0
Total								

Occupational Status: The parental occupation profiles of orphans and non-orphans are shown in Table 5.5. The most common occupation for both fathers and mothers among both primary and secondary school children is farming. Generally, there is considerable variation in the occupation of father for both the orphans group and the non-orphans group. There are also variations in fathers' occupation by parental status and by level of schooling of the children. Farming is the most common occupation amongst male orphans and non-orphans at primary school, non- orphans at secondary school and female orphans in secondary school. The main occupation of the female non-orphan father is in the unskilled category whilst the main occupation for fathers of female orphans is trading. At secondary school level, a higher proportion of females (both orphan and non-orphan) mentioned farming as the main occupation of their fathers than males (i.e. 40% versus 17 for orphans and 33% and 25% for non-orphans). The proportion of fathers of both orphans and non-orphans in the professional/managerial category is higher than national average. This is the most cited occupation for father in the case of female orphans at primary and male and female orphans at secondary level. The proportion of orphans' fathers in this category is much higher among secondary school orphans than primary school orphans which supports observations from earlier research that children from high socio-economic status families have a higher probability of attending secondary education than children from poor families.

Farming is the main occupation of orphans' mothers irrespective of the level of schooling or gender of the respondent - a higher proportion of mothers than fathers were reported to be in this category. Primary school orphans were however, more likely to indicate that farming was their mothers' occupation than secondary school orphans. The proportion of mothers of orphans engaged in farming is much higher than the proportion of mothers of non-orphans and of orphans' fathers particularly at primary. Engaging in petty trading or business is the

second most frequently cited occupation of mothers for about a third of both female and male orphans in primary school and a third of males in secondary. Thus, half the mothers of female orphans and over two-thirds of mothers of male orphans are in occupations that can generally be classified as low income. This suggests that households of maternal orphans are more likely to be impoverished. The most frequently cited occupation for non-orphans mother is housewife with a third of the students mentioning this. This is followed by trading and then farming and professional/managerial categories. Secondary school children are more likely to report have mothers in the professional category than their counterparts in primary school, and this is more pronounced for female non-orphans at secondary than at primary, again implying that socio-economic status might be linked to secondary school attendance.

Table 5.5: Parental occupation by parental status (percentages)

FATHER	PRIMARY				SECONDARY			
	Both parents alive		Maternal orphan		Both parents alive		Maternal orphan	
Occupation status	Female	Male	Female	Male	Female	Male	Female	Male
Farming	15	18	13	22	33	25	40	17
Skilled worker	19	17	13	19	8	17	0	33
Trading	11	17	19	11	8	25	0	0
Clerical	13	17	10	10	25	8	20	17
Unskilled	23	8	17	10	0	8	0	0
Professional/ managerial	11	18	30	19	8	0	40	33
Other	9	6	4	8	17	17	0	0

MOTHER	PRIMARY				SECONDARY			
	Both parents alive		Paternal orphan		Both parents alive		Paternal orphan	
Occupation status	Female	Male	Female	Male	Female	Male	Female	Male
Farming	21	20	41	41	16	31	33	36
Skilled worker	2	1	2	2	3	-	4	0
Trading	24	20	37	33	23	17	17	33
Clerical	7	7	2	0	5	-	13	3
Unskilled	4	2	6	6	1	2	4	6
Professional/ managerial	4	12	2	6	16	13	8	8
Housewife	37	37	8	8	36	32	21	8
Other	1	2	2	4	0	5	0	6

Household composition and size: The mean household size reported in the school survey is higher than the national average (6.4 compared to 4.3). Table 5.5 shows that mean household size is slightly smaller for orphans (6.7 for females and 6.9 for males) than non-orphans (6.1 females and 5.5 males). This is probably because, when parents die, siblings are often separated and taken in by different members of the immediate and extended family. Carers are most often grandparents or siblings who may be just slightly older than them. Children from larger families may have a better chance of completing school than children from smaller families, because workloads can be shared by a larger number of household members (see Rose and Al-Samarrai, 1998, and Kadzamira and Chibwana, 2000). As a result, the demands for labour in small households can be very high. For example, a secondary school headteacher commented that:

'We had a case of a male student who asked for a transfer because he lost both parents and was staying with grandparents. He had to take care of his grandparents and therefore had less time for studies. He wanted to be transferred to a boarding school to lessen the work burden that was on him and have more time for studying.'

Some MoEST officials also stated that they have had frequent transfer requests among secondary school students after the death of parents.

Table 5.6: Mean household size by status and sex

Status	FEMALE			MALE		
	Mean	SD	N	mean	SD	N
Orphan	6.1	2.3	150	5.5	2.3	144
Non-orphan	6.7	2.4	194	6.9	2.4	241
All	6.4	2.4	344	6.4	2.4	385

Orphan and non-orphan households have similar age profiles (see Table 5.7). Almost two-thirds of the children are of school going age (i.e. between 6 and 17 years) in both the types of household. Less than 10% of the household members are under six years of age and about a quarter are over 18.[12] After taking into account the missing cases**,** dependants account for one half of household members, which is in line with the proportion (51%) of those under 18 years old reported in the 1998 Population and Housing census (NSO, 2000).

Table 5.7: Age distribution of household members (rounded percentages)

Age cohort	ORPHANS			NON-ORPHANS		
	Female	Male	Total	Female	Male	Total
0-5	9	10	9	10	10	10
6-13	39	35	36	37	37	37
14-17	28	26	27	29	23	25
18-21	17	20	18	5	21	19
22-64	7	10	9	8	9	9
65+	0	0	0	0	0	0

Schooling status of household members: Table 5.8 shows that over 90% of the (primary and secondary) school aged children (i.e. 6-17 year olds) from both orphan and non-orphan households were enrolled at school. This may not be surprising perhaps, since other studies have reported that siblings of pupils in school are also most likely to enrol and complete their schooling than siblings of dropouts (Kadzamira et al, 2000). As indicated earlier, most of the respondents in this study were currently attending school hence the high enrolment rates observed. The proportion of orphans aged between 14-21 years enrolled in school is slightly lower for orphans than non-orphans.

[12] The proportion of household members who are 18 years or older could be higher than reported here because of the large number of missing cases. The particulars of household members were obtained from the respondents and the majority of them did not know the ages of older members of the households, particularly adults and their parents or guardians.

Table 5.8: Schooling status of household members

Schooling Status	ORPHANS				NON-ORPHANS			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
Percent ever enrolled 6-13 years	217	96.9	210	98.1	345	96.9	410	96.7
Percent in school 6-13 years	217	96.9	207	95.8	341	95.8	404	95.3
Percent ever enrolled 6-17 years	381	98.2	367	98.1	617	97.6	666	97.8
Percent in school 6-17 years	365	94.1	349	93.3	600	94.9	653	95.9
Percent ever enrolled 14-21yrs	260	98.9	279	98.2	416	98.3	495	99.0
Percent in school 14-21 years	196	74.5	224	78.9	351	83.0	428	85.6

Respondents were asked to indicate the highest educational level reached by members of their household who were not currently in school. The results are presented in Table 5.9. Educational levels of household members out of school are very high, with over 50% with some secondary education. School completion rates are considerably higher in non-orphan than in orphan homes. Well over 90% of members of non-orphan households had completed at least more than five years of schooling compared to 84% for members from orphan households.

The results suggest that orphans attending school tend to come from households where most other members are also in school and which have relatively high educational attainment levels. It will be difficult therefore, to measure and estimate the impact of HIV/AIDS on household demand for schooling given these high participation levels amongst our survey samples and the absence of out of school children from our analysis.

Table 5.9: Educational attainment of household members not currently in school

Highest Education Attained	ORPHAN		NON-ORPHAN	
	Female	Male	Female	Male
Std 1-4	14	17	4	6
Std 5-8	26	28	33	20
Secondary and higher	59	54	63	74

5.2.3 Characteristics of Orphans

Number and enrolment*:* Despite the fact that orphan care is high on the national agenda, none of the survey schools had adequate information about these children. Many classroom teachers did not know how many orphans they had in their classes**.** However, from interviews and questionnaires, the orphan profile of each school could be established. Nearly two-thirds of teacher interviewees reported that they had orphans in their classes. Table 5.10 shows the number of orphans in each of the schools visited as reported by the head teacher.

Table 5.10: Orphans as a proportion of total enrolment

Level/ school	FEMALES			MALES		
	Total Enrolment	No of Orphans	% orphans	Total Enrolment	No of Orphans	% orphans
Primary						
1- urban	947	148	15.6	932	117	12.6
2- urban	2085	688	33.0	2089	648	31.0
3- rural	737	116	15.7	876	132	15.1
4- rural	1023	216	21.1	1004	202	20.1
5- rural	518	31	6.0	540	21	3.9
Secondary						
6-rural	220	27	12.3	136	21	15.4

Only six head teachers were able to give estimates, and these are probably underestimates. It is clear, however, that orphans account for a large share of enrolments at all but one of these schools. Data from the student questionnaires also show that at the survey primary schools, 25% of the males and 33% of the female student are orphans. One-third of both male and female student samples at the survey secondary schools are orphans.

It appears that access to primary schooling is not a major problem for most of these orphans. The household data presented earlier indicate**s** that orphans who are attending school come from households where other children are also likely to be in school. Both students and parents also stated that most orphans are in school. It seems, therefore, that the alleged correlation between dropping out and orphan-hood is more apparent than real, although school attendance does not mean that orphans are able to complete their schooling. It is clear that the policy of free primary education has made it possible for many orphans to attend primary school. However, access is a major problem for orphans at secondary school level, mainly because of school fees.

Parental status of students in school: Student and orphan questionnaire respondents were asked to indicate if their father and mother were alive and also where they lived during school term. The majority of students both at primary and secondary level reported that both their parents are alive. Slightly more boys than girls are orphans (44% against 38% at the survey primary schools and 37% against 35% at the survey secondary schools).

Table 5.11: Parental status of students (percentages)

Parental status	PRIMARY			SECONDARY		
	Female	Male	Total	Female	Male	Total
	%	%	%	%	%	%
Both alive	55.7	61.7	59.0	63.5	65.4	64.5
Maternal orphan	6.6	5.9	6.3	6.8	4.6	5.1
Paternal orphan	23.1	21.6	22.5	16.2	23.5	19.9
Double	14.6	10.8	12.7	13.5	6.5	10.0
All orphan	44.3	38.3	41.4	36.5	34.6	35.6

The majority of orphans have lost their father only. Around 20% of students are paternal orphans. It is not clear from the data we have whether those who have already lost mothers or both parents are most likely to drop out of school hence the lower proportion of maternal and double orphans in school. Although this data suggest that death rates are higher amongst men than women, it is likely that the mother will die soon after the father if his illness was HIV related.

Around 6% of primary and 5% of secondary school students are maternal orphans. The proportion of double orphans- those who have lost both parents- is much higher at 12% and 10 % of primary and secondary students respectively.

Living arrangements: Table 5.12 shows that 75% of primary school students who have two parents live with both parents. The corresponding figure for secondary school students is probably about the same (assuming that most of the 36% of students who board also live with their parents). Relatively few students whose parents are both alive live with close relatives (15% primary and 16% secondary).

In the past, the extended family system has taken care of orphans**.** However, two recent studies show that traditional safety nets are deteriorating rapidly as a result of increased AIDS-related mortality and the worsening economic situation (see MoWCACDSW, 1996). Another important finding of these studies is that, after the death of their parents, most orphans are placed in different households with relatives. An increasing number of orphans are now being cared for by grandparents and siblings who are themselves very often in need of support and care.

Table 5.12: Living arrangements during school term by parental status

LIVING WITH	BOTH ALIVE		PATERNAL ORPHAN		MATERNAL ORPHAN		DOUBLE ORPHAN	
	Prim	Sec	Prim	Sec	Prim	Sec	Prim	Sec
Both parents	77.1	41.0	0	0	0	0	0	0
Mother only	7.2	5.6	68.0	33.3	0	0	0	0
Father only	0.4	0.5	0	0	19.2	0	0	0
Mother &stepfather	0.8	1.0	2.9	5.0	0	0	0	0
Father &stepmother	0	1.5	0	0	15.4	0	0	0
Grandparents	4.4	1.5	12.6	3.3	23.1	5.9	22.6	16.7
Siblings	3.2	6.2	7.8	5.0	11.5	11.8	15.1	16.7
Other relatives	6.4	5.1	5.8	8.3	23.1	11.8	30.2	26.7
Orphanage/institution	0.4	0.5	0	0	7.7	0	20.8	0
Boarding	0	35.9	0	41.7	0	58.8	0	30.0
Self boarding	0	1.0	0	3.3	0	5.9	0	0
Child- headed	0	0	1.9	0	0	5.9	5.7	6.7

Orphans are more likely to live with their mother if she is alive, but less likely to live with their father if he is the only surviving parent. Two-thirds of paternal orphans at primary and one-third at secondary school are living with their mothers.

Slightly under one-half of all maternal orphans at primary school are living with grandparents and another 8% are in orphanages. Nearly 60% of maternal orphans at secondary schools are boarders. Another 6% are living in child-headed households and 6% rent their own accommodation near their school.

Most double orphans at primary school are living with other relatives, grandparents and siblings. However, a fifth are in orphanages and 6% are living in child-headed households. Relatively far fewer double orphans at secondary school are boarders, which is probably due to financial factors.

When a mother dies, her children become particularly vulnerable because most are placed under the care of other vulnerable groups (in particular grandparents) or are left to fend on their own in child-headed households. Living with members of the extended family system and step-parents also increases the likelihood that they will be discriminated against and marginalised in their new households. Some of the typical problems pointed out during focus group discussions with parents and orphan carers are as follows:

Orphans face many problems, which also affect their school life. Some of the problems faced are lack of food because their guardians are very old, they cannot cultivate enough crops to feed the orphans as a result many do not go to school regularly.

We encounter many problems in supporting these orphans. It is hard because of poverty and because we are also very old, so the support we offer is not adequate.

Orphans are, in most cases, left in the custody of very old people or with siblings who are themselves just children who cannot take care of them properly.

In one village, it was said that these households face severe food shortages throughout the year because the carers are either too old to grow enough food or lack of money to buy fertilisers. Poverty in Malawi is widespread with 65% of the Malawian population estimated to live below the poverty line with the incidence of poverty being higher in rural areas (67%) than urban areas (55%) (NEC 2000). Caring for orphans is, therefore, a major burden for the majority of households, especially in rural areas.

Orphans living in child-headed households are probably the most at risk. Most of these children live in appalling conditions with inadequate food and poor accommodation. The manager of a church-based NGO, which is running a community home care orphan programme in a high density suburb of Blantyre, noted that the number of child-headed households in the city is growing very rapidly. Furthermore, children in this situation often 'switch days to go to school while others are trying to find money or food'.

5.3 ATTENDANCE AND EDUCATIONAL ATTAINMENT

Studies conducted in Malawi have shown that school attendance is strongly affected by household demand for child labour (see Chimombo and Chonzi, 2000, Kadzamira and Chibwana, 2000). It is widely believed that orphans are more likely to dropout of school because of lack of support and care.

The school survey collected both qualitative and quantitative information on absenteeism, repetition and dropout for each orphan group and non-orphans. The perceptions of most students, teachers, school managers, and the community is that orphans do face additional problems in attending school, mainly because of lack of financial, material and moral support.

5.3.1 Absenteeism

Poor and irregular attendance is a significant problem particularly at primary levels with an average daily attendance ratio of 60% in 1999 (MoESC 2000). Most school managers stated that absenteeism has increased over the past few years because many students lack adequate support. This is particularly the case for orphans**.** The data from the student questionnaire

confirms widely held contention that absenteeism is much higher among orphans than non-orphans (see Table 5.13). More than half of both female and male orphans in the survey primary schools had been absent from schools in the previous two weeks compared to less than half of the non-orphans. Similarly, about 40% of the orphans in the survey secondary schools had been absent from school compared to about a third of the non-orphans.

Table 5.13: Student absenteeism, repetition and dropout by type of school and parental status

Parental Status	Ever absent during the last two weeks?				Ever repeated a grade?				Ever stopped attending school?			
	Primary		Secondary		Primary		Secondary		Primary		Secondary	
	F	M	F	M	F	M	F	M	F	M	F	M
Both parents are alive												
Live with both parents	48.8	47.2	44.4	25.7	74.7	68.6	45.2	35.6	2.3	7.6	4.5	5.7
Mother only	42.9	72.7	100.0	66.7	71.4	81.8	50.0	44.4	14.3	0.0	0.0	33.3
Grandparents	62.5	33.3	0.0	33.3	62.5	66.7	-	100.0	12.5	0.0	-	0.0
Siblings	33.3	20.0	0.0	100.0	33.3	80.0	50.0	33.3	0.0	0.0	0	16.7
Other relatives	45.5	66.7	0.0	20.0	72.7	66.7	60.0	60.0	0.0	33.0	20.0	0.0
Boarding	0.0	0.0	22.9	17.1	0.0	0.0	74.3	60.0	0.0	0.0	2.9	8.6
N	117	133	95	100	117	132	62	59	117	132	93	100
Non-orphans	47.5	49.3	32.6	32.0	67.8	70.1	65.3	59.0	3.4	7.3	4.3	10.0
All orphans	59.2	53.9	42.6	38.9	72.4	64.0	55.6	61.1	16.3	13.5	3.7	15.1
Paternal orphans	62.7	54.9	37.5	44.4	74.5	64.7	70.8	61.1	19.6	13.7	4.2	11.1
Maternal orphans	46.7	53.8	30.0	42.9	73.3	61.5	40.0	57.1	13.3	23.1	0.0	14.3
Double orphans	61.3	50.0	55.3	10.0	67.7	66.7	45.0	60.0	12.9	8.3	5.0	33.3
Total (N)	215	226	149	153	215	225	149	153	215	225	147	152

There are also some interesting gender differences in absenteeism rates. For non-orphans at primary level, females are more likely to be absent than male students if they are living with grandparents whilst males are more likely to be absent if they are living with their mother only and other relatives. This may imply that household demand for labour is higher for females living with grandparents and for males living in a female-headed household. At the secondary level, relatively more females than males living with both parents and mother only were absent from school while more males than females in the other living arrangements were absent from school.

Students in the FGDs also noted that absenteeism is high at the beginning of school terms because children are sent home because they have not paid their school fees. There was a general feeling that boys tend to be more affected than girls. However, it is important to recognise that the GABLE sponsored scholarship scheme for girls does not cover all the costs of schooling and, in some schools, parents still have to pay extra money for boarding and other schooling expenses.

Among female orphans, absenteeism is higher amongst paternal and double orphans while for male orphans absenteeism is higher for paternal and maternal orphans both at primary and secondary level. These results indicate that the absence of the father may increase household demand for male child labour, which is what one would expect given the very marked gendered division of labour in households. Upon the death of the father, boys are frequently called upon to take up their father's roles. Gender differences in absenteeism are very noticeable amongst double orphans, with female students at primary and secondary schools more likely to miss classes than male students. Female double orphans are also more likely to be living with their grandparents and other relatives. It has been suggested that orphans living with other relatives might face higher levels discrimination and lack of support than children living with members of their immediate family (i.e. siblings or grandparents). On the other hand, the demand for child labour might be particularly high in grandparent-headed households because dependency ratios are relatively high.

Students at the survey schools were asked to give the main reason for any absence from school during the last two weeks. There is little difference in the reasons given by orphans and non-orphans. Illness of the self is the main reason for absenteeism among all groups of primary and secondary students (see Table 5.14). 'Death in the family' and 'needed at home' were also frequently given as reasons for absenteeism, again regardless of where the students lived and parental status. At one of the urban survey secondary schools, school management noted that two to three students go to funerals every week and that they can be away for up to a week.

The reasons given by teachers for student absenteeism are broadly the same as those given by students. Both primary and secondary teachers most frequently cited 'illness of self' as the main reason. The low ranking of 'needed at home' among secondary students is because nearly 40% of the students interviewed are boarders. There are, however, some noticeable gender differences in the reasons given for absenteeism. While labour demands seem to be higher for paternal and non-orphan male students, maternal and double orphan female students are more likely to miss school in order to assist with household activities than their male counterparts. This suggests that the death of a mother may increase the demand for female child labour and the death of a father increases the demand for male child labour.

Table 5.14: Main reason for absenteeism by type of schooling and student living arrangements (percentages)

LIVING WITH	Both parents		Mother only		Siblings		Grand-Parents		Other relatives		Boarding school	
PRIMARY	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Illness of self	51	60	38	52	100	50	47	50	46	40	0	0
Death in the family	17	8	14	0	0	13	11	10	27	10	0	0
Attend to sick family members	7	8	7	4	0	0	11	0	0	0	0	0
Needed at home	14	14	14	30	0	13	16	20	9	30	0	0
Sent back by school/ school fees	5	0	5	0	0	25	0	0	0	0	0	0
Lack of clothes	0	6	14	6	0	0	11	10	0	20	0	0
Other	4	4	7	4	0	0	5	0	0	0	0	0
SECONDARY												
Illness of self	40	11	42	17	0	11	67	0	0	0	71	47
Death in the family	20	11	29	8	0	22	0	0	0	0	6	13
Attend to sick family members	10	0	0	8	0	11	33	0	0	0	18	0
Needed at home	5	33	0	8	0	11	0	0	0	50	0	0
Sent back by school/ school fees	20	44	29	42	100	45	0	100	0	50	6	27
Lack of clothes	5	0	0	0	0	0	0	0	0	0	0	0
Other	5	0	0	0	0	0	0	0	0	0	0	13

Table 5.15: Main reason for student absenteeism by type of school and parental status (percentages)

Reason for being absent	PRIMARY								SECONDARY							
	Non-orphan		Paternal orphan		Maternal orphan		Double orphan		Non-orphan		Paternal orphan		maternal orphan		Double orphan	
	F	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Illness of self	51	56	39	56	57	29	44	17	52	19	44	44	67	33	46	0
Death in the family	18	9	1	0	14	14	17	54	16	9	11	13	33	33	0	0
Illness in family	7	8	9	7	0	0	17	8	10	6	11	0	0	0	27	0
Needed at home	12	17	12	19	29	14	7	0	3	13	0	6	0	0	0	100
Sent home/fees	9	0	0	11	0	14	0	23	16	47	33	25	0	33	18	0
Lack of clothes	0	6	18	7	0	29	11	8	3	0	0	0	0	0	9	0
Other	4	5	6	0	0	0	6	8	3	3	0	13	0	0	0	0
Number	57	66	33	27	7	7	18	13	31	32	9	16	3	3	11	1

The rising number of deaths and illness due to HIV/AIDS might account for the high proportion of all students who are absent from school because of attending funerals of family members and looking after sick family members. Table 5.15 shows that these two reasons combined accounted for 34% and 62% of absenteeism among female and male double orphans respectively at the survey primary schools. More female than male maternal orphans are absent due to illness of self. However, non-orphans are equally affected, which suggests that the devastating impacts of the AIDS epidemic may be felt well before students become orphaned.

Focus group discussions with orphans revealed that lack of decent clothes and money to buy detergent for washing clothes are the most common reasons for absenteeism amongst orphans.

‘ We lack clothes to change so that sometimes we absent ourselves from school waiting for washed clothes to dry’.

Other major factors are inadequate food and learning materials, lack of money for school fees and other school contributions and school uniform, and the demand for labour at home. Lack of basic needs, particularly food, were repeatedly mentioned during discussions with orphans and their carers.

‘Lack of food and money to buy food forces us to not go to school because we are often hungry and there is no way we can listen and concentrate in class. We live like birds and this affects our schooling. When we come back home from school there is no food for us to eat’ (orphans, urban community).

Some of these problems were more pronounced at secondary schools. It was widely reported that most orphans are absent from school at the beginning of the term because of non-payment of school fees. Being sent home for not having the proper school uniform also accounts for a sizeable proportion of student absenteeism at secondary schools.

School managers and teachers stated that student absenteeism has increased because most orphans lack proper support from their guardians. Many orphans are forced to undertake income-generating activities (known as ‘ganyu’) so that they can buy basic necessities. This results in frequent absenteeism: “*Doing ‘ganyu’ affects our attendance and performance as we lack concentration because of tiredness.*” It is also alleged that orphans (and especially girl orphans) are allocated a disproportionately large share of household activities.

5.3.2 Repetition

Repetition is relatively high in primary schools in Malawi. Poor student performance is the result of a myriad of factors including irregular attendance and generally very poor quality schooling.

The difference in ever-repeated rates between orphan students and non-orphan students are very small at both primary and secondary. Among orphan students at primary, the ‘ever repeated’ rates are slightly higher among females than males (see Table 5.13). Absenteeism is however, higher amongst male students with both parents alive but living with mother only and other siblings.

Amongst female orphans ever-repeated rates are highest amongst paternal and maternal orphans, both at primary and secondary schools than among double orphans, suggesting that female double orphans are less likely to persist in school in the face of poor performance. On the other hand, ever-repeat rates are higher among paternal and double orphans in the case of males.

5.3.3 Dropouts

Given that very few of the orphan interviewees were out of school, dropout rates may not be particularly high among orphans. In a number of the FGDs, students felt that there is no obvious link between being an orphan and dropping out of school. However, as stated earlier, the sampling procedure that was employed to select orphans may have excluded many dropouts. In addition, most of the orphans interviewed are living in households where other

children are also likely to be in school. Consequently, it is possible that the orphans targeted in this study are not representative of the orphan population as a whole. Nonetheless information on school attendance among orphans and other students was obtained from individual interviews and FGDs with students, orphans, teachers and parents.

Students and orphans were asked to indicate if they had ever stopped attending school for any reason. In overall terms, school interruption was not a problem among the students interviewed - fewer than 10% of the students at both primary and secondary schools indicated that they had ever stopped attending. Given the much higher dropout rates at the national level, this would suggest that those who drop out of school are unlikely ever to return.

Ever-stopped attending rates are again much higher among orphan students than non-orphan students and this is more pronounced in the case of primary school students (see Table 5.13). Among orphans in primary school, female paternal and male maternal orphans are the most likely to have ever left school before. The lower ever stopped attending rates for double orphans is perhaps, an indication that they are very unlikely to return to school once they drop out. This is perhaps, not surprising given that double orphans are often more vulnerable than the other types of orphans. Relatively more females than male students with both parents alive living with their mothers only and grandparents have had their schooling interrupted. This may be because of the greater household demand on girls to carry out domestic chores.

There are some notable gender differences in ever-stopped attending rates among orphans. Female double orphans at primary level are, for example, more likely to have ever dropped out of school than their male counterparts. The proportion is also higher for female paternal students. On the other hand, male maternal orphans are more likely to have ever stopped attending school than their female counterparts.

There are a number of important findings that emerge from the FGDs. Firstly, the most common reason for dropping out of school is the financial burden of sending children to school. Inability to meet school expenditures was mentioned by the majority of non-orphans, paternal and double orphans whose schooling has been interrupted. Other reasons are parental influence/pressure, lack of interest, transfers, illness of self and family members, death in the family, needed at home, lack of clothes, pregnancy and poor performance.

Secondly, lack of support and guidance is a key reason why dropout rates tend to be higher among orphans than non-orphans. Thirdly, female orphans are more at risk of not completing schooling because of the higher household demand for their labour and also, according to male students they 'lack perseverance when faced with hardships'. Male orphans, on the other hand, generally have more options open to them because they can earn income through *ganyu*. However, when income-earning opportunities of this kind are hard to come by, they are also likely to dropout of school. Some are even forced onto the streets to beg. Others resort to drug and alcohol abuse. One FGD was conducted with male orphans who are 'street children', but who are receiving assistance from an NGO in the form of skills training and accommodation.

One orphan FGD mentioned that female orphans are often taken to town to be employed as nannies and male orphans are employed as house servants. One urban NGO mentioned that poor guardians from the rural areas often force orphans in their care to go to town and earn money, which is then taken away from them.

And fourthly, female orphans often get married very young in order to get assistance. Some even venture into prostitution.

"*Most female orphans who lack support indulge in sexual activities to source financial support but eventually they drop out of school because of pregnancy*" (Female FGD rural secondary school).

Poor guardians who find it difficult to support orphans in their households also frequently encourage early marriages.

5.4 SOCIAL EXCLUSION

Orphans, particularly AIDS orphans, suffer from social and economic exclusion. The problems faced by orphans are compounded because of the absence of formal social safety nets and inadequate basic social services such as education and health. As a result, many orphans lack adequate support and are the most likely to leave school prematurely. As indicated earlier, many of the children who have lost one or both parents end up living in households that are already impoverished and vulnerable.

5.4.1 Problems faced by orphans

As a result of the AIDS epidemic, many more children are being orphaned, which is adding to the already large pool of existing orphans. Guardians interviewed in one village stated that many of them have up to four orphans in their households. In another village, one carer reported that she is responsible for six orphans in addition to nine children of her own. There was also a case of two young mothers, each with one child**,** having taken into their custody eight and seven orphans respectively. According to the carers, taking in orphans tends to compound the problems already faced by households. For example, food security worsens because many of them have only small farms. Hunger is a key factor affecting orphan attendance and performance at school.

Orphans interviewed identified the 'lack of basic needs' as the most important problem that they faced. Over 80% of orphan respondents mentioned lack of food, clothing, shelter, and bedding (see Table 5.16). However, fewer than 10% of orphans singled out discrimination as a particular issue.

Table 5.16: Orphan perceptions of their main problems

Main problem	N	%
Discrimination/mistreatment by carers	9	8.1
Food, clothing, shelter and bedding	92	82.9
Lack of money to buy school materials	8	7.2
Illness of self	1	0.9
No problem	8	7.2
N	111	100.0

Source: Orphan survey

When asked about the problems they face with their education, nearly one-third of orphans mentioned lack of money to meet schooling expenses. Other factors are lack of basic needs and lack of support from guardians. Only 11% of orphans cited lack of support from the school, which highlights the relatively limited role of schools themselves in ensuring that orphans are properly educated. Teachers, on the other, tend to have different perception of the problems faced by orphans. Poor attendance and absenteeism were mentioned by most teachers as the main problem faced by orphans followed by poor performance, psychological trauma, and lack of basic needs (see Table 5.17). This suggests that teachers are less aware than they should be of the underlying causes of absenteeism and poor performance among orphans.

Table 5.17: Orphan and teacher perceptions of the main problems among orphan students

Problems with schooling	Orphans		Teachers	
	N	%	N	%
Lack of basic needs: food, clothing	20	18.0	15	15.5
Poor attendance and absenteeism	5	4.5	40	41.2
Lack of money to pay for schooling expenses	36	32.4	7	7.2
Lack of support and care from guardians	12	10.8	8	8.2
Poor performance	2	1.8	21	21.6
Lack of support from teachers/ school	12	10.8	0	0.0
Lack of interest in school	0	0.0	12	12.4
Psychological trauma/ depression	0	0.0	17	17.5
No problems	16	14.4	4	4.1
Totals	111		97	

5.4.2 Discrimination

There is little or no overt discrimination against orphans or other children who are directly affected by AIDS by either students or teachers at the survey schools. Most teachers disagreed with the statements that students who are affected by HIV/AIDS are discriminated against by teachers and by fellow students (see Table 5.18). However, teachers do not believe that school managers have taken firm action to counter AIDS-related discrimination when this has arisen. Most students, both orphans and non-orphans, also stated that orphans are treated no differently than other students.

Table 5.18: Teachers views concerning discrimination against students affected by HIV/AIDS

Statement	Primary			Secondary		
	D	NS	A	D	NS	A
Students whose family members have HIV/AIDS related illnesses are discriminated against by teachers	76	13	6	78	20	2
Students whose family members have HIV/AIDS related illnesses are discriminated against by other students	76	13	4	72	24	2
School management has taken firm action to counter discrimination against teachers and students who have AIDS	61	22	17	53	32	15

While overt discriminate against orphans is not common in the survey schools, subtler forms of discrimination do exist. In particular, some school rules and regulations unintentionally exclude orphans. For example, it is common practice for schools to send children back if their clothes are dirty. As noted earlier, lack of soap and poor clothing seriously affect school attendance among orphans. Similarly, the 'no fees, no school' policy at secondary schools has badly affected orphans and contributed to absenteeism. Despite the very rapid increase in the orphan population in Malawi, most schools have seriously failed to respond to their needs. For example, none of the survey schools have exempted orphans from wearing school uniforms.

Some schools also demand money for development work (e.g. costs of new classrooms). Students, including orphans, who are unable to pay these levies are punished by either not providing them with the free learning materials supplied by government or by not allowing them to attend classes (further contributing to their absenteeism). During interviews with members of a community orphan care group in Zomba, an elderly grandmother caring for her four grandchildren said that one of them was not allowed to write an end of term test because she had not made the requisite contribution to the school development fund.

These adverse impacts, which are the direct consequence of acute poverty, were frequently mentioned by orphans themselves.

'If a pupil does not have uniform, he or she is sent back home by the school and, if they don't have anybody to buy the uniform for them, it means that they will be absent from school until they get one....If we don't have soap to wash our clothes, we don't come to school...When we go to school in dirty clothes, our friends laugh at us which affects our concentration in class.'

'We are never discriminated by teachers and other students. We are treated equally by teachers and the other children regard us as part of them. It is only when our teachers send us back home from school to look for school fees that our friends laugh at us, but this is not serious.'

'Lack of adequate clothes to change coupled with lack of soap forces us to wear dirty clothes. When we go to school in such attire we are sent back home.'

'Our well-to-do friends do not want to associate with us. Our friends don't want to hang around with us because we don't have nice clothes or bring any pocket money to school.'

The insensitivity of schools to the special problems and needs of orphans has, therefore, contributed to the social exclusion of orphans within the school system. However, to reiterate, the problems faced by orphans do not relate directly to their status as orphans, but affect all children from impoverished backgrounds.

There also appears to be much less overt discrimination against orphans in the wider community than is commonly suggested. Some orphans, however, did complain of discrimination and ill treatment by guardians at home.

'Orphans in some households are made to work as servants… they are forced to work even when they are ill…they are asked to stop going to school…everything that was left behind by their parents is snatched away from them by relatives. At times this makes the orphan break down and some of them just deteriorate and eventually die.'

Some carers are also reluctant to attend to the health needs of orphans because they assume they are already infected with HIV. A few complained that about the time that is wasted looking after sick orphans, which could be spent tending their gardens and the cost of medical treatment.

5.5 SUPPORT FOR ORPHANS

5.5.1 The National Orphan Care Programme

The growing number of AIDS orphans has overwhelmed the already very limited capacity of government-run social welfare agencies in Malawi. However, the need to provide support for orphans has been recognised by government. The proposed National Safety Nets Programme has identified orphans who are not in households or are in very poor households as the second most important target group (NEC, 2000).

Malawi was one of the first countries to develop a comprehensive orphan care programme in response to the AIDS epidemic. A multi-sectoral National Task Force on Orphans was established in 1991 and, by 1992, the Ministry of Gender, Youth and Community Services had issued policy guidelines for the care of orphans and co-ordination of assistance.

Given the very limited public funding for social welfare activities, the main policy thrust of the orphan care programme is community-based care. The responsibility of government is to ensure that appropriate assistance is given to the extended family and to the community in order to meet the basic needs of orphans (MoWCACDSW, 1996). With NGOs, CBOs and religious groups taking the lead in the provision of care for orphans, government has been mainly responsible for the co-ordination and regulation of the programme.

Organisations providing support for orphans have proliferated since the mid-1990s. By 1999, more than 20 NGOs had orphan-support programmes or activities (CONGOMA ,1999). A range of services is on offer, principally orphan care, advocacy, education, counselling, human rights, income generating activities, skills training and HIV/AIDS education. In addition, numerous CBOs have been established, which also offer orphan care, counselling, skills training and HIV/AIDS education. These CBOs work in close collaboration with either the Social Welfare Officers from the Ministry of Gender, Children Affairs and Community Development or NGOs. Community-based orphan care (CBOC) programmes, which are

managed by elected committees have been established and are operational in all the communities covered by the school survey.

MoGYCS also runs several programmes that target orphans namely, foster care, adoption services, public assistance and institutional care (MoWCACDSW 1996). Orphans and other children in need of care are placed with foster families, who are paid a monthly honorarium. The Ministry also facilitates the legal adoption of children and provides limited short-term relief and public assistance (e.g. food, shelter, clothes and transport) to destitute children including orphans and their families. Lastly, the Ministry has responsibility for the registration and supervision of orphanages by NGOs and private individuals.

There are a number of weaknesses in the current support programmes for orphans. In an interview with a senior social welfare official, she noted that *"there is a pressing need to review the current welfare laws for the disadvantaged and develop a consistent policy to help orphaned children with their education".* A major problem is the poor co-ordination among the various stakeholders in the delivery of orphan care programmes. A common complaint among Social Welfare Officers is that the MoEST does not work closely enough with officials from other key ministries, especially Health and Social Welfare. The survey schools themselves do not liase with their local Social Welfare Departments in order to obtain support for needy children including orphans. However, it is also the case that social workers rarely visit the schools, allegedly because of lack of transport.

5.5.2 Family Support

Orphans were asked to indicate the person who provides most of their material support. Mothers are clearly the most important group, with 40% of female and 36% of male orphans stating that their mothers are their main providers. In contrast, very few orphans are supported by their fathers – only 9% female orphans and none of the male orphans.

Orphans at the survey schools were also asked to specify who is paying for their schooling. Table 5.18 shows that, while surviving parents were most frequently identified, there are some notable gender differences. In particular, 28% of male orphans pay for their education compared to only 9% among female orphans**.** Aunts and uncles are a far more important source of funding for female orphans**.** The large majority (71% females and 83% males) of the orphans stated that the support that they receive from their immediate families is not adequate.

Table 5.19: Person who pays for orphan schooling costs

Person responsible	Female N= 42		Male N = 47	
	N	%	N	%
Mother/ father	17	40.5	18	38.3
Sister/brother	4	9.5	8	17.0
Aunt/uncle	9	21.4	3	6.4
Grandmother/father	9	21.4	5	10.6
Self	4	9.5	13	27.7
NGO/church/ bursary	6	14.3	8	17.0

5.5.3 NGO Support

NGOs, CBOs and religious organisations provide most support for orphans. NGOs are mainly involved in the following activities:

- provision of basic needs, mainly food and clothes;
- skills training (e.g. bricklaying, tailoring, carpentry etc);
- provision of credit facilities to orphan carers for income generating activities;
- provision of counselling services to both orphans and their carers;
- training on the care of orphans for carers;
- early childhood education and day care centres targeting orphans under eight years of age;
- meeting schooling costs through the provision of learning materials and payment of school fees.
- provision of residential care.

It is clear from the school survey that support services for orphans are very limited and the majority of orphans have not yet been reached. Most teachers (particularly at primary schools) see little or no evidence of concrete assistance to orphans in their classes. Some secondary schoolteachers were able to identify some orphans who receive bursaries or are assisted with their school fees. Carers stated that it is the cost of secondary schooling that is the most serious problem affecting the education of orphans. These costs are usually prohibitive for poor households because students are expected to contribute a large proportion of the overall costs of secondary schooling.

NGO activities also tend to be very localised and they are heavily concentrated in urban areas. All eleven NGOs interviewed for this study only operate in and around Blantyre City with a few out-reach activities in nearby rural communities. As one student from a rural secondary school observed, *'Orphans in rural areas also need help, which is mostly concentrated on orphans in urban schools'.*

With limited funding and staff, most NGOs are only able to assist small numbers of orphans. Given the magnitude of the orphan problem, many needy orphans are therefore slipping through the net. Furthermore, much of the assistance is food and clothing which, while obviously helping to meet immediate basic needs, does not address the underlying causes of the endemic poverty that affects orphans and their carers. Only a few NGOs provide training and/or credit to orphan carers in order to help them improve their livelihoods.

CBOs have also sprung up across the country in response to the growing orphan crisis. Community-based orphan groups have been established in most of the communities visited.

Most of these predominantly rural CBOs rely on funding from NGOs and other organisations. Funding is seriously inadequate and most are heavily reliant on ad hoc donations from religious and other charitable organisations.

Most of the communities indicated that orphans and carers in their area had received limited, one-off support, mainly food, clothing and payment of school fees. Only a handful of NGOs[13] provide more sustainable forms of assistance, which combine health and nutrition, education and training and other basic needs.

One parent FGD noted that, although one religious organisation assists orphans in their area, this support is very limited. For example, orphans are only given a small packet of maize flour which only lasts a few days or an item of clothing is donated once every one or two years. One group of orphans and another group of guardians said that they were unaware of any organisation supporting orphans and their carers that was operating in their area.

Nearly all teachers recognise that most orphans urgently need various kinds of assistance, most notably meeting the costs of schooling and the provision of basic needs. Other support measures were also mentioned including the provision of counselling services to orphans and training for AIDS carers. Similar suggestions were made by students, orphans and parents.

Both MoEST officials and teachers pointed out that collaboration between MoEST and NGOs was poor and there was little effective co-ordination of activities. Both school managers and teachers feel strongly that MoEST should provide much stronger leadership and liase closely with other ministries and NGOs in the provision of support to orphans in school.

5.5.4 School Support

Table 5.20 shows that very few teachers agreed with the statement that the Ministry of Education has an effective policy to support students who are affected by HIV/AIDS. MoEST has yet to come up with a comprehensive package of strategies to address orphans issues although the current PIF does include a policy on orphans. None of the survey schools has established programmes or guidelines for providing orphan support nor have they been proactive in soliciting support for orphans and other children affected by AIDS from organisations. This is perhaps not surprising given the lack of clear guidance from the Ministry.

[13] Most notably, the Samaritans and the Community Based Orphan Care Programme of the Blantyre Synod of the Church of Central Africa Presbyterian (CCAP).

Table 5.20: Teachers and students views on support to students affected by HIV/AIDS (percentages)

Statement	PRIMARY			SECONDARY		
	D	NS	A	D	NS	A
TEACHERS						
Students are able to discuss their problems with teachers.	29	16	55	23	19	58
The Ministry of Education has an effective policy to support students who are affected by HIV/AIDS	66	23	11	45	49	6
STUDENTS						
Orphans in this school receive a lot of support	55	5	40	64	14	22

Both teachers and students feel that their schools provide little or no support to children directly affected by HIV/AIDS. Only 40% of primary and 22% of secondary students agreed with the statement 'orphans in this school receive a lot of support'(see Table 5.20). Nearly two-thirds of primary school teachers also indicated that their school does not provide any kind of assistance to orphans or other students affected by AIDS. Similarly, around one-half of secondary school teachers were unaware of any support given to orphans by the school.

Table 5.21: Type of assistance offered by school to students directly affected by HIV/AIDS

Type of Assistance	PRIMARY				SECONDARY			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
Individual counselling	4	9.8	1	4.5	1	7.7	-	
Remedial/extra lessons	2	4.9	-		1	7.7	2	9.5
Mobilise support from community	5	12.2	1	4.5	1	7.7	-	
Assist through School fund	1	2.4	-		-		1	4.8
Moral support through visits and condolences	6	14.6	-		3	23.1	-	
Offer temporary employment	-		-		1	7.7	-	
No assistance given	26	63.4	14	63.6	6	46.2	12	57.1

Acute resource constraints clearly prevent schools offering any meaningful support to affected students. However, most orphans feel that school managers are unconcerned about their situation and welfare. As noted earlier, none of the survey schools have made any systematic efforts to identify students who are orphans and let alone assess their needs. Orphans from one of the rural communities visited noted that:

'They do not get any support from the school. The reason for this is that the schools do not recognise them as orphans. In addition, schools do not have the time and interest to find out how many children are orphaned and what it can do to assist them.'

However, the fact that the teachers and the school management teams are able to discuss the kind of problems faced by orphans suggests that they are not completely oblivious to their situation. Indeed, some of them may well be caring for orphans themselves.

Parents, guardians, and orphans themselves argue that the teaching staff is sometimes insensitive to orphans' needs. It was pointed out that some of the problems orphans are facing with their schooling are a direct result of the demands made by the schools. As has been pointed out earlier, some of the school policies and regulations are insensitive to the plight of orphans as demonstrated by the indiscriminate nature of the punitive actions taken

against orphans failing to meet the schools demands. In one focus group with the parents/guardians of orphans, it was noted that: *"there are some teachers who send back home orphans when they fail to meet some school requirements despite the children explaining to them their situation. Teachers do not seem to listen to orphan's complaints."*

Table 5.21 shows that some of the schools offered individual counselling to orphans and other affected children whilst others provided remedial or extra lessons to students affected falling behind their friends in class due to the high levels of absenteeism. But this is relatively uncommon at the survey schools and is dependent much more on the individual teachers and not on school policy. In some schools, teachers visit the families of students who have been directly affected by AIDS and in the case of bereavement also contribute to condolence funds to the student's family.

More generally, the silence and denial that surrounds AIDS might be contributing to the limited response of schools. At one of the rural primary schools, a teacher helps with AIDS education and counselling in the community but does nothing at school.

5.6 CHILDREN LIVING WITH AIDS

5.6.1 Overview

The silence, secrecy, and denial that surrounds HIV/AIDS makes it especially difficult for head teachers to obtain accurate information about teachers and students living with AIDS. 2.2% of children under 15 were estimated to be infected in 1999. However, most were infected from birth and do not, therefore, live long enough to attend school.

Eight out of the eleven schools provided statistics on student deaths during the last five years. However, these are likely to be under-estimates because it is known that not all deaths are recorded (including deaths that occur during school holidays).

Table 5.22: Students deaths at survey schools, 1994-mid 2000

Location of school	PRIMARY		SECONDARY			Total by Location
	Female	Male	Female	Male	Unknown	
Rural	2	5	4		3	14
Urban	15	12	-	-	2	29
Total by sex	17	17	4	-	5	
Total	34		9			43

Table 5.22 shows that considerably more deaths are reported in urban schools than in rural schools. The age of students who died ranged from 6 to 21 years old. Nearly two-thirds of the student deaths were in the high-risk group for HIV infection i.e. 15-21 years. The HIV prevalence rate for 15-49 adults in urban areas was over double that in rural areas in 1999, 25.6% versus 12.1% (NACP, 1999). However, given the paucity of data on prevalence rates among school students coupled with the erratic recording and reporting of deaths by most schools, it may not be the case that HIV prevalence rates are higher among children in urban areas.

Mortality rates among students at the survey schools are very low (around one death per thousand students in 1999). However, they do appear to increasing very rapidly, particularly among primary school students (see Table 5.23)**.**

Table 5.23: Number of student deaths and overall mortality rates at survey schools, 1996-1999

Year	PRIMARY		SECONDARY		TOTAL	
	Total deaths	MR	Total deaths	MR	Total deaths	MR
1996	2	0.02	1	0.05	3	0.02
1997	4	0.03	0	-	4	0.03
1998	6	0.04	1	0.03	7	0.04
1999	14	0.09	2	0.12	16	0.07

Mortality rates by gender

Year	PRIMARY				SECONDARY			
	Female		Male		Female		Male	
	N	MR	N	MR	N	MR	N	MR
1996	2	0.03	0	-	1	0.05	0	-
1997	2	0.03	2	0.03	0	-	0	-
1998	1	0.01	5	0.07	1	0.05	0	-
1999	8	0.11	6	0.08	0	-	2	0.13

Student deaths and mortality rates at rural and urban survey schools

Year	PRIMARY				SECONDARY			
	Rural		Urban		Rural		Urban	
	Female	Male	Female	Male	Female	Male	Female	Male
1996	0 -	0 -	2 0.05	0 -	1 0.2	0 -	0 -	0 -
1997	1 0.05	1 0.05	1 0.02	1 0.02	0 -	0 -	0 -	0 -
1998	0 -	2 0.08	1 0.02	3 0.06	1 0.13	0 -	0 -	0 -
1999	1 0.04	1 0.04	7 0.13	5 0.10	0 -	2 0.19	0 -	0 -

Time series data on students who are 'persistently ill' is the other indicator that can be used to assess and measure the impact the epidemic on students. Relatively large numbers of teachers (54% female and 41% male at primary and 46% female and 29% male at secondary) could identify at least one persistently ill student in their class. High rates of absenteeism lead to poor performance, frustration, and eventual dropout[14].

However, mainly as a result of poor nutrition, morbidity rates are relatively very high among school children in Malawi. For example, around one-third of the primary student questionnaire respondents had been ill in the previous two weeks. Among secondary students, 25% and 18% of female and male respondents had been ill during the same period.

5.7 STUDENTS WITH SICK FAMILY MEMBERS

The total number of children in Malawi living with parents or other household members who have clinical AIDS is not known. It is generally argued that the education of these children will be adversely affected. As with orphans, they often lack parental care and support as their

[14] A District Education Officer in an urban area stated that some children in the infant sections of primary schools are affected by HIV/AIDS and are seriously ill. He could not, however, estimate the numbers of children affected.

parents become ill and slowly die. Not only will they be seriously emotionally traumatised, but many will have to take responsibility for the care of the sick and other household duties that were previously undertaken by sick parents.

It was relatively easy to obtain information on children with sick family members who were enrolled at the survey schools. However, in most cases, the nature of the illness was not known.

Table 5.24 shows that fewer than one-third of teachers were able to identify a child in their class who is looking after a sick family member. The number of students identified varied from 1 to 4. However, most knew classmates who have sick family members. As with orphans, the major problem affecting the schooling of these children is absenteeism, which, in turn, leads to poor performance.

Table 5.24: Proportion of teachers who identified a student in their class with sick family members

	PRIMARY				SECONDARY			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
Yes	10	25.6	7	31.8	4	30.8	4	19.0
No	29	74.4	15	68.2	9	69.2	17	81.0

Given current prevalence rates, student absenteeism is likely to increase as a result of the increasing demand for child labour in households with sick family members. The main reasons for student absenteeism at the survey primary and secondary schools were, in order of importance: death in the family, needed at home, and family sickness (see Tables 5.14 and 5.15). As male students at a primary schools noted:

'*There are so many children who absent themselves these days because of the increase in the number of people suffering from HIV/AIDS related illnesses. Such children do not have time to study. The girls are the ones who fall victims, they are always doing a lot of work in the household. The boys are left to go to school and have time to do their work and study'.*

Students taking care of sick family members are often anxious and depressed and therefore find it difficult to concentrate in class. Students in one FGD recounted how a female student was continuously absent from school and finally dropped out because of her mother's illness. She subsequently became pregnant.

None of the survey schools make any effort to support children with sick family members. In a few instances, teachers offer remedial or extra lessons to these students and visits have been made to the student's home. In some of the schools, students stated that teachers are not sympathetic to the problems faced by children affected by HIV/AIDS**.**

CHAPTER 6

IMPACT ON TEACHING AND SUPPORT STAFF

6.1 INTRODUCTION

The AIDS epidemic in high prevalence countries such as Malawi is expected to have very serious impacts on the overall capacity of national education sectors to deliver high quality services. (see Kelly 1999, Carr-Hill & Oulai, 1993). Mortality rates among teaching and support staff are projected to increase very rapidly during the next decade. In addition, there will be much higher levels of morbidity (sickness) among education personnel with persistent absenteeism from work. More generally, there are also concerns that high levels of mortality and morbidity will lead to low morale and motivation among all staff.

In Malawi, teachers are reported to be already dying at faster rate than they can be replaced. However, reliable, up to date staffing data is very hard to come by. The current data systems do not collect many of the key indicators that are essential in order to assess the impact of the epidemic on human resources in the education sector and to make robust projections of teacher requirements and related recruitment targets. These missing data include date of birth of the teacher, marital status, and gender. Nor is information on staff deaths being collected and recorded in an accessible form[15].

This chapter first describes the staffing situation, both nationally and in the survey schools. The second section then pulls together the available data to assess current levels of mortality, morbidity and absenteeism among teaching staff. The third section reviews the efforts that have been made to prevent and mitigate the impact of the epidemic on staff.

6.2 STAFFING SITUATION

6.2.1 Overview

The MoEST employed a total of 50,752 teachers in 1999. Of these, 45,784 were deployed in 4,481 primary schools and 4,968 in 701 secondary schools (101 conventional and 600 Community Day Secondary Schools).

Forty percent of primary school teachers are female and 54% are qualified. Over 80% of teachers in urban primary schools are female while 67% of teachers in rural schools are male (see Tables 6.1 and 6.2).

[15] There are plans in the 2000 school census to include questions on teacher mortality. However, it remains to be seen whether other equally important indicators on teachers are going to be included such as age at death, gender, grade, marital status and date of death etc.

Table 6.1: Primary teachers by education division and sex, 1999

Division	Female	Male	Total	% female
Northern	2822	5383	8205	34.4
Central Eastern	2469	4858	7327	33.7
Central Western	5703	6695	12398	46.0
South Eastern	2208	3797	6005	36.8
Shire Highlands	1717	3717	5434	31.6
South Western	3401	3014	6415	53.0
Total	18320	27464	45784	40.0

Source: EMIS, 1999

Table 6.2: Distribution of primary teachers by location and qualification,1999

Characteristic	Female		Male		Total	
Total	18320	40%	27464	60%	45784	
Qualified	9159	37%	15356	63%	24515	54%
Urban	5005	83%	1019	17%	6024	13%
Rural	13315	32%	28271	68%	41586	87%
Rural qualified	5862	26%	16385	74%	22247	56%
Urban qualified	3297	81%	797	19%	4094	68%
% urban qualified within each sex		66%		78%		
% rural qualified within each sex		44%		58%		

Source: EMIS 1999

Good quality data on secondary school teachers is even scarcer. In particular, teachers at the Community Day Secondary Schools (CDSS) are not usually included in MoEST statistics. However, the picture at secondary level is similar to that at primary school. Overall, there are more male than female teachers and the few female teachers in the system are concentrated in urban areas. In 1997, for example, female teachers constituted about 20% of the total teaching force at secondary level. There are also wide discrepancies in provision between the conventional secondary schools (CSS) and the CDSS. As indicated in Table 6.2 the majority of CDSS teachers (99%) are unqualified whereas over 90% of teachers in CSSs are qualified.

Table 6.3: Secondary school teachers by school type and sex, 1997

Type	Female	Male	Total	% female	% qualified	% female qualified	% males qualified
CDSS	553	1917	2470	22.4	0.9	1.27	0.73
CSS	524	2401	2925	17.9	91.2	79.2	93.8
Total	1077	4318	5395	20.0	49.8	39.2	52.5

Source: MoEST, Basic Education Statistics 1997

6.2.2 Teaching staff at the survey schools

In the absence of a comprehensive national data set, the following analysis of the impact of HIV/AIDS on education personnel relies heavily on the school survey data. This included teacher interviews and questionnaires, which provide very useful information on key areas such as absenteeism and staff perceptions of the impact of HIV/AIDS in the workplace. However, it must again be emphasised that the 11 survey schools are not a representative sample of the school population.

Number by sex and location: A total of 342 school managers and teachers were employed at the 11 survey schools – 252 primary level and 90 secondary. The distribution of male and

female teachers in rural and urban areas closely reflects the national breakdown. Table 6.4 shows that almost 90% of teachers at the urban primary school were female, but only 44% in rural schools. At the secondary level only 15% of the teachers in rural schools were female compared to 42% for urban schools.

Table 6.4: Teaching staff at the survey schools by sex and location (percentages)

	PRIMARY		SECONDARY	
	Rural	**Urban**	**Rural**	**Urban**
Female	44.4	87.7	15.0	42.0
Male	55.8	12.3	85.0	58.0
N	81	171	40	50

Age profile: Over 80% of primary school teachers are below 40 years old. The age profile of secondary school teachers is broadly similar (see Table 6.5). Female teachers have a slightly older age profile than male teachers. This may be an indication that female teachers are more likely to remain in the system than their male counterparts.

Table 6.5: Age profile of teaching staff at the survey schools (nearest percentage)

Age cohort	**PRIMARY**		**SECONDARY**	
	Female	**Male**	**Female**	**Male**
20-24	1	5	14	5
25-29	29	26	22	30
30-34	33	39	22	30
35-39	19	12	11	18
40-44	7	11	11	14
45-49	7	2	11	2
50-54	2	2	7	2
55-59	2	3	0	0
60 +	0	2	0	0
N	186	66	27	63

Marital status: Most teachers at the survey schools are married. Eight female primary teachers were widowed, but none of the male teachers were. Relatively more male teachers have never been married (see Table 6.6).

Table 6.6: Marital status of teaching staff at the survey schools (percentages)

Marital status	**PRIMARY**		**SECONDARY**	
	Female	**Male**	**Female**	**Male**
Never married	4.5	12.2	0.0	17.1
Married	83.6	85.4	78.9	80.0
Divorced	3.6	0.0	5.3	0.0
Widowed	7.3	0.0	15.8	2.9
Separated	0.9	2.4	0.0	0.0

Academic and qualification profiles: Although a slightly higher proportion of female primary school teachers are professionally qualified, relatively more of their male colleagues have higher academic qualifications (57% of the male primary teachers have MSCE compared to only 38% among female teachers).

Table 6.7: Qualifications profile of teachers at the survey schools

Qualification level	PRIMARY		SECONDARY	
	%Female	%Male	%Female	%Male
Qualified	69.4	63.6	84.0	75.4
JCE	60.0	47.5	0	0
MSCE	37.8	57.4	8.0	14.8
Diploma	0	0	56.0	50.8
Degree	0	0	36.0	34.4

At the secondary schools, female teachers have slightly better academic and professional qualification profiles. Most of the unqualified male teachers are teaching at the Community Day Secondary School in the sample where the head teacher was the only qualified member of staff. The remainder comprised former primary schoolteachers whose highest educational level was MSCE.

Teacher deployment: Table 6.8 shows that female teachers are concentrated in the lower primary standards, especially in rural areas. It has been argued elsewhere that the concentration of male teachers in upper standards of rural schools robs girls in rural areas of female role models at a time when they need them most i.e. during their early adolescence. This pattern of teacher deployment has also been linked to the higher incidence of sexual harassment of girls by male teachers in rural schools and reluctance on the part of girls to participate in classroom activities. In the GAPS survey, for example, students showed same sex preferences when asked whether they would like to be taught by a male or female teacher (Kadzamira & Chibwana 2000).

Table 6.8: Distribution of teachers by standard at survey primary schools

Standard	RURAL		URBAN	
	%Female	Male	Female	Male
1	30.1	7.1	9.4	0.0
2	22.2	11.9	14.6	0.0
3	19.4	16.7	15.6	20.0
4	13.9	11.9	15.6	0.0
5	5.6	9.5	13.5	0.0
6	2.8	14.3	12.5	20.0
7	2.8	11.9	9.4	30.0
8	2.8	16.7	9.4	30.0
Total	36	45	96	10

6.3 TEACHER PERFORMANCE

6.3.1 Absenteeism

None of the survey schools keep systematic records on teacher absenteeism. Thus, it is not possible to analyse trends in teacher absenteeism since the mid-1990s. Data on current levels of teacher absenteeism was obtained through interviews and discussions with teachers and school management teams and the teacher questionnaire.

Absenteeism is higher amongst female teachers at both primary and secondary levels. Table 6.9 shows that nearly 80% of female teachers had been absent at least once compared to 60% among male teachers during the previous term. Higher female absenteeism is mainly because women in Malawi are responsible for the care of sick children and other family members. Teacher absenteeism was lower in the survey secondary schools.

Table 6.9: Teacher absenteeism during the previous term at the survey schools (percentages)

Days absent	0	1	2	3	4	5	6+	Total absent	N
Primary									
Female	14.7	10.8	19.6	19.6	4.9	8.8	13.7	84.0	102
Male	26.3	10.5	21.1	13.2	10.5	2.6	7.9	71.4	38
Both	17.9	10.7	20.0	17.9	6.4	7.1	12.1	80.6	140
Secondary									
Female	22.2	5.6	5.6	22.2	0.0	5.6	16.6	71.4	18
Male	50.0	11.8	5.9	11.8	2.9	8.8	5.9	48.5	34
Both	40.4	9.6	5.8	15.4	1.9	7.7	9.6	54.2	52

Although individual teacher absenteeism is low (on average, about three days per term), the overall impact on the learning process in each school can still be quite substantial[16]. Furthermore, sizeable proportions of teachers at the survey schools had been absent for more than a week during the previous term – 15% male and 17% female of primary teachers and 13% male and 27% of female secondary teachers. Excluding those on maternity leave, four teachers (2.1% of the total) were absent for more than 30 days (three were ill and one was looking after a sick family member).

Nonetheless, most school managers, teachers and students at the survey schools do not feel that teacher absenteeism is a major problem nor do they think that absenteeism has increased significantly as result of HIV/AIDS (see Table 6.10). Over 90% of primary and 84% of secondary school students disagreed with the statement that 'our teachers are often absent from school'.

[16] Another recently completed study has also shown that the absence of even one teacher can cause serious disruption within a school (see IEQ, undated).

Table 6.10: Teacher and students responses to teacher absenteeism and other performance statements (percentages)

STATEMENTS	PRIMARY						SECONDARY					
	Female			Male			Female			Male		
TEACHERS	**D**	**NS**	**A**	**D**	**NS**	**A**	**D**	**NS**	**A**	**D**	**NS**	**A**
Teacher morale at this school is high	49	19	32	38	24	38	44	13	44	27	32	41
Teacher absenteeism is a big problem at this school	88	9	4	93	5	2	94	-	6	91	3	6
Teacher absenteeism has risen significantly as a result of HIV/AIDS	86	8	5	87	10	3	78	6	17	60	29	11
STUDENTS												
Teachers at this school are not hardworking	88	2	10	92	-	8	73	11	14	76	6	18
Our teachers are often absent from school	95	2	3	92	1	8	84	6	10	84	8	8

Illness of self, attending to sickness in the family and funerals were the most common reasons given by the teachers for being absent from school (see Table 6.11). While these could be AIDS-related, most teachers did not think this was the case. The following kind of statements were commonly made:

'I have not noticed any effect of HIV/AIDS on the school although both teachers and non-teaching staff do take a lot of time off for funerals' (secondary deputy head teacher).

'Teaching standards have not been affected much as a result of HIV/AIDS' (secondary school head teacher).

'As far as we know we have not been able to notice how HIV/AIDS is affecting our work as teachers' (secondary school teachers).

'The only thing we know of is that the situation (outside the school) is very discouraging because a lot of people are dying of HIV/AIDS' (secondary school teacher).

Table 6.11: Reasons for teacher absenteeism at the survey schools (percentages).

Reason for being absent	PRIMARY		SECONDARY	
	Female	Male	Female	Male
Illness of self	53.9	56.7	40.0	55.6
Attending funerals	39.3	70.0	26.7	50.0
Other family sickness	25.8	16.7	6.7	22.2
On Maternity leave	5.6	0.0	13.3	0.0
School related (e.g. training)	2.2	6.7	13.3	5.6

Note: The percentages do not add up to 100 because respondents were allowed to mention more than one reason.

However, during focus group discussions, teachers repeatedly pointed out that that absenteeism is increasing:

'Teacher absenteeism is on the increase as teachers have to attend funerals, own sickness or attend to their families.'

'Teacher absenteeism has increased because of attending funerals in the neighbourhood and community.'

'Absenteeism of teachers is on the increase because more teachers are dying in the zone and teachers have to attend these funerals.'

These observations were supported by some of the DEO questionnaire respondents who noted that a growing proportion of the school week is being lost as a result of teachers attending funerals, which reduces contact hours in the classrooms.

6.3.2 AIDS-related Morbidity

While sickness accounts for around one half of all teacher absenteeism, only three teachers at the survey schools had long-term illnesses, which were likely to be AIDS-related and were also absent for long periods of time. In the FGDs, teachers were quick to point out that they did not know of any sick and/or HIV positive colleagues unless they had openly declared their HIV status.

However, there are teachers who are persistently ill but who are not absent for long periods of time. Most of them continue to work until they are too sick to do so. Though these teachers continue to teach, it is generally accepted that their performance is seriously affected.

6.3.3 Teacher motivation and morale

Teachers' motivation and morale is generally poor at the survey schools. Only about a third of the primary school teachers and just under one-half of the secondary school teachers agreed with the statement that 'teacher morale and motivation at this school is high' (see Table 6.11). Teacher FGDs revealed even higher levels of dissatisfaction. There is no evidence however, to indicate that low teacher morale and motivation can be directly attributed to the impact of HIV/AIDS. A possible link between the two was suggested at only two of the rural schools:

'A lot of teachers are dying and schools within the zone are affected because they attend these funerals. There are some teachers who are de-motivated because they think that maybe they are also infected'

'Teachers' morale and motivation is very low as they see people dying…'

'Many teachers are depressed having lost one or more members of their family in a row'.

Typically, other factors other than HIV/AIDS account for the low morale and motivation observed among teachers. Teachers in all the FGDs repeatedly mentioned low pay and poor conditions of service:

'The MoE should improve salaries and conditions of service for teachers...the whole issue of salaries should be addressed. If nothing is done ...the MoE should not expect much from teachers whose morale is very low' (urban primary school).

'Teachers are overloaded and have no time to provide extra lessons to those who are sick... Teacher salaries and conditions of service leave a lot to be desired. Teachers feel that their parent ministry does not care for them' (rural primary schools).

'*There are no personnel policies to improve teacher morale. Teachers have been demotivated by lack of incentives to boost their welfare'* (rural secondary school).

A frequent complaint is that the pay and conditions of service for teachers are worse than those enjoyed by similar professions in the civil service, which have the same educational qualifications.[17] In order to supplement their meagre salaries, many teachers spend a lot of their spare time trying to earn additional income from a range of activities. Private tutoring after school has finished is very common. Teachers at one of the rural secondary schools said that, at one time, private tutoring accounted for much of the teacher absenteeism at the school (although, with the introduction of stiffer penalties, this is now longer the case).

Most teachers feel that the ministry is doing very little to improve their welfare and that it does not care about them. They complain bitterly about the lack of incentives to boost their morale and also the lack of allowances when travelling on official duties. The following comment by a group of teachers at a rural primary school is typical:

'In AIDS TOTO seminars, teachers use their own money for transport and lunch as no allowances are provided…. Yet other educational staff like PEAs receive allowances…teachers are not given any incentives…. We are being misused and are taken as cheap labour by the ministry.'

6.4 TEACHER MORTALITY

The following discussion presents four sets of mortality data for teachers – from the school survey, a survey of Education Districts, and secondary data kept by the MoEST Department Human Resource Management and Development and the Payroll Personnel Pension Integrated database.

Apart from the school survey data none of these data sets is complete or comprehensive enough to carry out detailed analysis. Because of the way teacher data is captured within the system it highly probable that the numbers of deaths reported are underestimates of the actual magnitude of teacher mortality. However, with such a small number of schools in the sample coupled with a small number of deaths, great care must be taken in drawing conclusions about the overall level and patterns of mortality in education system as a whole.

6.4.1 Primary school teaching staff

School survey: A total of 36 teachers died between 1994 and June 2000 at the six primary survey schools. All six schools reported that they had lost at least one teacher through death. The average annual mortality rate at these schools was 2.4% between 1996 and 1999.

[17] The report of the presidential commission of inquiry into poor MSCE results also concluded that poor salaries have contributed to low morale in the teaching profession (see Presidential Commission of inquiry into MSCE results, 2000).

Gender and location: 28 (77.7%) of the 36 the primary school teachers who died were female. However, this is not disproportionately high because female teachers accounted for 74% of primary school teachers in the sample as a whole. Over 80% are in urban schools where prevalence rates are highest. Mortality rates for female teachers in the survey urban schools have been increasing rapidly in recent years - from 1.32 % in 1996 to 4.05% in 1999.

Five teachers died at three rural primary schools but six times as many died at the three urban primary schools. In 1997 the mortality rates in urban survey schools were comparable to those in the rural survey schools, however, by 1999 they were almost twice the mortality rates in the rural schools.

Table 6.12: Teacher deaths and mortality rates (MR)[18] at the primary survey schools, 1994-2000

School	1994	1995	1996		1997		1998		1999		2000*		Total
Primary	N	N	N	MR	N	MR	N	MR	N	MR	N	MR	N
1-urban	1	1	0	0.0	1	2.6	0	0.0	1	2.8	0	0.0	4
2-urban	0	2	0	0.0	1	1.2	5	6.1	3	3.8	1	1.4	12
3-urban	0	1	2	2.9	3	4.8	2	2.7	4	6.3	2	3.5	14
4-rural	0	0	0	0.0	0	0.0	0	0.0	1	3.9	0	0.0	1
5-rural	0	0	0	0.0	2	5.0	0	0.0	0	0.0	0	0.0	2
6-rural	0	1	0	0.0	0	0.0	0	0.0	1	5.3	0	0.0	2
Overall	1	5	2	0.7	7	2.6	7	2.5	10	3.8	3	1.2	35

Note: Data on the number of teachers per school for 1994 and 1995 was not available hence could not calculate mortality rates for these years.
* January to May only.

Age profile: Two-thirds of teachers who died were under 40 years old (see Table 6.13). Mortality was highest in the 30-34 age cohort (39% female teachers and 43% male teachers).

Table 6.13: Age profile of teacher deaths at the survey schools, 1995-2000 (percentages)

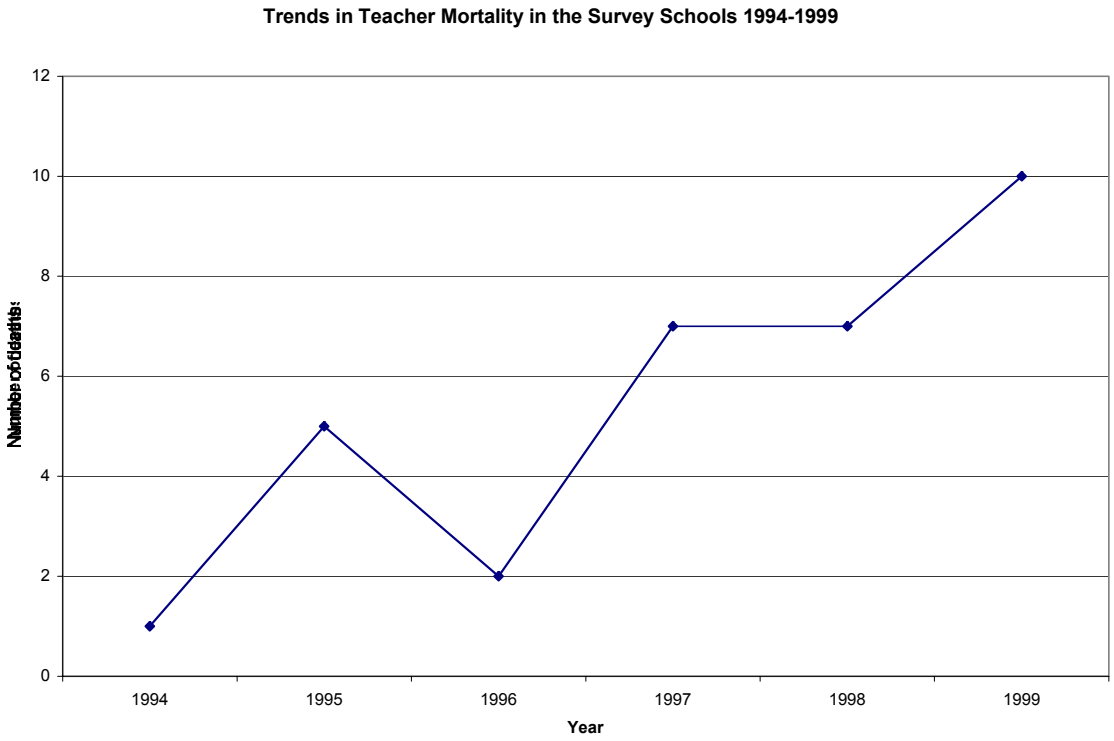
Age cohort	PRIMARY			SECONDARY		
	Both	Female	Male	Both	Female	Male
25-29	11.1	14.3	0.0	0.0	0.0	0.0
30-34	38.9	42.9	25.0	50.0	0.0	66.7
35-39	16.7	10.7	37.5	25.0	0.0	33.3
40-44	11.1	10.7	12.5	0.0	0.0	0.0
45-49	8.3	7.1	12.5	25.0	100.0	0.0
50-54	5.6	7.1	0.0	0.0	0.0	0.0
55-59	2.7	0.0	12.5	0.0	0.0	0.0
60+	2.7	3.6	0.0	0.0	0.0	0.0

Trends over time: Mortality rates increased very rapidly at urban primary schools – from 1.09% in 1996 to 4.60% in 1999. However, at rural primary and secondary schools there have been no significant increases in mortality rates since 1994. At the time of the survey in May 2000, three teaching staff at urban primary schools had died in the preceding five months, but there had been no deaths that year at either rural primary or secondary survey schools.

[18] The % column in the table refers to Mortality rate calculated as the proportion of total teacher deaths in a school in one year over the total number of teachers in that school in that year.

Overall impact: Over this six year period, increased teacher mortality is only likely to have had a significant impact at two of the 11 schools.

Figure 6.1: Number of teacher deaths at survey schools, 1994-1999



DEO survey: A total of 16 out of 31 education districts furnished some information on teacher deaths in primary schools. However, given the variability in the quality of this data, it is not possible to undertake a detailed analysis. For most districts, age at death is not available along with other key information including qualification, years of teaching experience, marital status and grade. Nonetheless, given that this data covers over half of all primary schools in the country, it is representative of the entire population of teachers.

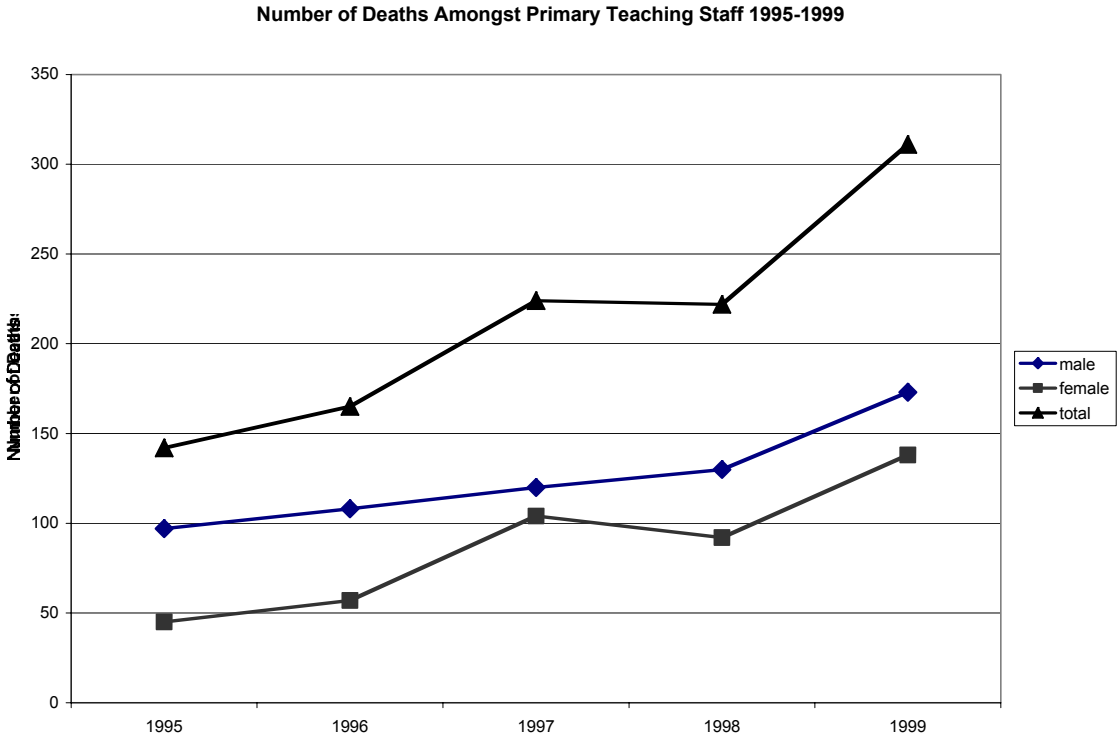
Table 6.14: Mortality rates among primary teaching staff in 16 Education Districts, 1995-1999 (percentages)

Year	Female	Male	Total
1995	0.43	0.68	0.57
1996	0.54	0.74	0.66
1997	0.83	0.83	0.83
1998	1.03	0.99	1.01
1999	1.32	1.32	1.32

Source: DEO survey for this study

Teacher mortality rates increased very rapidly - from 0.57% in 1995 to 1.32% in 1999 (see Table 6.14 and Figure 6.2). This is particularly the case for female teachers who are concentrated in urban areas where HIV prevalence rates are much higher than in rural areas.

Figure 6.2: Total deaths among teaching staff at primary schools in 16 DEOs, 1995-1999



Source: Data supplied by 16 DEOs from all the six education divisions

Table 6.15 shows that mortality is concentrated in the under 35 age cohorts. Among female and male teaching staff deaths peak in the 19-29 and 30-34 age cohorts respectively.

Table 6.15: Age at death among primary school teaching staff, 1995-1999 (percentages)

Age group	1995		1996		1997		1998		1999	
	F	M	F	M	F	M	F	M	F	M
19-24	6	2	20	0	20	2	17	1	0	0
25-29	71	34	30	27	40	36	31	24	5	23
30-34	0	32	20	21	11	30	24	32	47	38
35-39	12	9	10	21	17	16	7	20	26	19
40-44	6	6	0	12	6	5	14	12	13	8
45-49	0	6	10	9	3	7	5	9	6	7
50-54	6	9	10	9	3	5	2	1	3	2
55-59	0	2	0	0	0	0	0	0	0	2
60+	0	0	0	0	0	0	0	0	0	0
N	17	47	20	33	35	44	42	75	62	97

Source: Data supplied by 16 DEOs form all the six education divisions

There is widespread agreement among DEOs and other senior officers in the MoEST officials and DEOs interviewed that the number of AIDS-related deaths among primary school teaching staff is increasing very rapidly. One urban DEO indicated that at least one teacher is dying every fortnight in the district whilst the number of deaths at secondary level were more infrequent 1-2 deaths per term.

The PPPI Database: The most comprehensive data on primary teacher deaths (by sex, age and qualification) is contained in the PPPI database. According to this data, nearly one thousand primary school teachers died in 2000, 2.2% of the total employed in that year. Mortality rates appear to be considerably higher among female primary school teachers, which again is probably because relatively more female teachers are at schools in higher prevalence areas.

Table 6.16: Number of deaths and mortality rates among primary school teaching staff, August 1999 to December 2000

PERIOD	FEMALE		MALE		TOTAL	
	N	MR	N	MR	N	MR
Aug-Dec 1999	186	1.02	230	0.84	416	0.91
Jan-Jun 2000	307	1.68	329	1.20	636	1.39
Jul-Dec 2000	151	0.82	216	0.79	367	0.80
Jan-Dec 2000	458	2.50	545	1.98	1003	2.19

Source: PPPI database

Mortality rates among female teachers are highest in the 25-34 age cohorts and for male teachers they are highest in the 25-39 age cohorts (see Table 6.17).

It can also be observed in Table 6.17 that mortality rates for both male and female teachers fell considerably between the first and second halves of 2000. However, it is clearly too early to tell whether mortality rates have peaked among primary school teachers.

Table 6.17: Mortality rates for primary school teaching staff by age cohort (deaths/ '000)

Age cohort	Aug-Dec 1999		Jan-Jun 2000		Jul-Dec 2000		Jan-Dec 2000	
	Female	Male	Female	Male	Female	Male	Female	Male
Less than20	0.0	0.0	0.05	0.0	0.0	0.0	0.05	0.0
20-24	0.33	0.15	0.27	0.04	0.33	0.07	0.60	0.11
25-29	4.48	1.71	3.71	1.97	2.78	1.13	8.02	3.09
30-34	2.84	2.73	3.49	3.79	3.44	2.99	8.68	6.77
35-39	1.26	2.00	1.53	2.84	0.82	1.86	2.73	4.70
40-44	0.22	1.13	1.36	1.49	0.33	0.66	1.75	2.15
45-49	0.38	0.29	0.66	0.87	0.11	0.44	0.93	1.31
50-54	0.22	0.25	1.15	0.55	0.16	0.33	1.42	0.87
55-59	0.22	0.07	0.49	0.36	0.16	0.25	0.71	0.62
60 above	0.05	0.00	0.0	0.04	0.0	0.07	0.0	0.11
Overall	9.99	8.34	16.76	11.94	8.13	7.79	24.89	19.73

Source: PPPI database

6.4.2 Secondary school teaching staff

It is very difficult to obtain reliable, comprehensive data on teacher mortality for the secondary school system. Apart from the survey schools, the only other information that could be obtained on secondary teacher deaths was from the Department of Human Resources Management and Development (HRMD) and the PPPI database. However, only teachers in conventional secondary schools are covered by these databases. It is quite possible that mortality rates among teachers, most of whom are unqualified, at Community Day Secondary Schools, are not the same as generally better qualified teachers at conventional secondary schools.

Survey schools: At three of the five (60%) survey secondary schools, no teacher died during this period (see Table 6.18). The average annual mortality rate at these schools was 1.02% between 1996 and 1999.

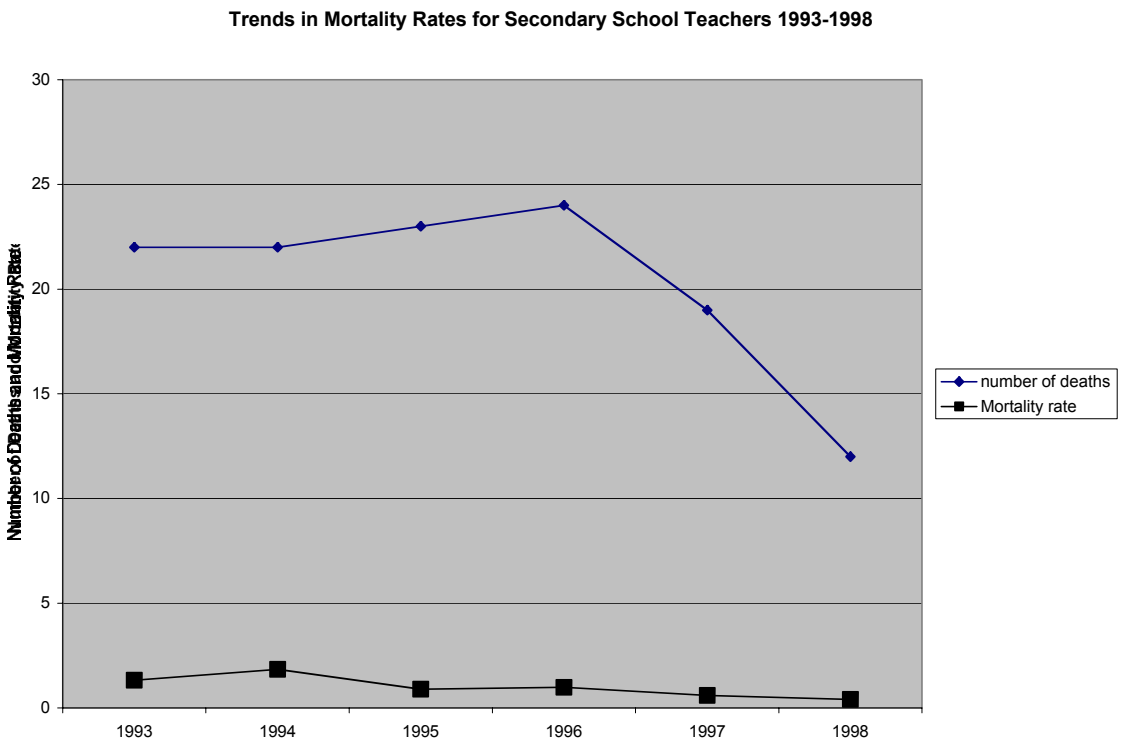
Table 6.18: Number of deaths and mortality rates at the survey secondary schools, 1994-2000

School	1994	1995	1996	1997	1998	1999	2000	Total
7-urban	0	0	0	0	0 0.0	0 0.0	0	0
8-urban	0	0	0	0	3 1.36	0 0.0	0	3
9-rural	0	0	0	0	0 0.0	1 0.9	0	1
10-rural	0	0	0	0	0 0.0	0 0.0	0	0
11-rural	0	0	0	0	0 0.0	0 0.0	0	0
Total	0	0	0	0	3 0.31	1 0.09	0	4

There was one report of death in the rural survey secondary schools between 1996 and 1999 compared to three deaths in the urban secondary schools during the same period. Given the rarity of death amongst secondary school teachers in both rural and urban survey schools it is difficult to reach conclusions about gender differences in mortality rates. Of the four deaths reported during the period only one was of a female teacher. There was no noticeable increase in deaths over time in both the rural and the urban survey schools.

HRMD database: Figure 6.3 shows that mortality rates among secondary teachers peaked at around 2.3% in 1996, but then fell very significantly to less than 1% in 1998. This is in marked contrast to the very rapid increase in mortality rates among primary school teachers during the same period. It is not immediately clear why this should be so, but there is some evidence from other countries, which does suggest that, in the later stages of the epidemic, higher levels of education are protective of HIV infection.

Figure 6.3: Mortality rates for secondary schoolteachers, 1993-1998



Source: Department of Human Resources Management and Development (HRMD)

PPPI Database: According to the PPPI database, 29 secondary teachers died in 2000, almost exactly 1% of the total (see Table 6.19). It would appear that overall mortality rates among secondary teachers have remained at around 1% since 1998. Mortality rates are slightly higher among male secondary teachers.

Table 6.19: Mortality rates among secondary school teaching staff, August 1999 to December 2000

Period	Female		Male		Total	
	N	MR	N	MR	N	MR
Aug-Dec 1999	4	0.79	11	1. 07	15	0.98
Jan-Jun 2000	6	0.62	12	0.61	18	0.62
Jul-Dec 2000	3	0.31	8	0.41	11	0.38
Jan-Dec 2000	9	0.93	20	1.02	29	0.99

Source: PPPI database

Age specific mortality rates for secondary school teachers are given in Table 6.20. The small number of deaths makes it difficult to establish patterns, but mortality rates are highest in the 30-49 age cohorts.

Table 6.20: Mortality rates among secondary schoolteachers by age cohort (death/ '000)

Age cohort	Aug-Dec 1999		Jan-Jun 2000		Jul-Dec 2000		Jan-Dec 2000	
Less than 20	Female	Male	Female	Male	Female	Male	Female	Male
20	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
20-24	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
25-29	0.0	1.95	1.04	1.02	0.0	0.51	0.0	0.0
30-34	3.95	0.0	2.07	0.0	1.04	1.02	1.04	1.53
35-39	0.0	4.87	0.0	1.53	0	1.53	3.11	1.53
40-44	0.0	1.95	0.0	0.51	1.04	1.02	0	3.06
45-49	3.95	1.95	0.0	2.04	1.04	0.0	1.04	1.53
50-54	0.0	0.0	3.11	0.0	0.0	0.0	1.04	2.55
55-59	0.0	0.0	0.0	0.0	0.0	0.0	3.11	0.0
60 above	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Overall	7.91	10.71	6.22	5.10	3.11	4.08	9.33	10.20

Source: PPPI database

6.4.3 Mortality rates among support staff

The HRMD data set includes deaths among support staff in the MoEST for the period 1993 to 1998. However, it was not possible to calculate mortality rates because data on the total number of staff employed by main category was not available. Total deaths increased from 34 in 1993 to 59 in 1996 but then declined thereafter reaching 38 in 1998.

6.4.4 Comparative Prevalence and Mortality Rates

It is widely believed that teacher mortality rates are considerably higher than the adult population as a whole. A World Bank projection made in the late 1990s that 40% of teaching staff would die over a five-year period is frequently cited (World Bank, 1998). However, the mortality data presented in this report indicate that this is a serious overestimate of the likely impact of the epidemic on teaching staff.

Teachers are considered to be at higher risk from contracting HIV because they are relatively young, mobile and better off. However, it should also be pointed out that over 90% of teachers work at schools in rural areas where HIV prevalence rates are around one-third lower than in urban areas.

There is virtually no data available that would allow a robust assessment to be made of the absolute and relative risk profile of the teaching profession with respect to the AIDS epidemic. It appears, however, that the mortality rate among primary school teaching staff is roughly the same level as for the adult population as a whole. According to the 1998 National Population Census, the crude death rate for the general population is 2.2%. Unfortunately, mortality rates for specific groups of the population as well as other occupations are not available.

HIV prevalence rates among well-defined categories of the population, including teachers, are not known. National prevalence rate rates are based on sentinel surveillance surveys of pregnant women who attend ante-natal clinics at selected sites. The 1999 survey also collected information on educational attainment, which can be used as a proxy for socio-economic status. Table 6.21 shows that the overall HIV prevalence rate for women with post-secondary education is not significantly higher than the average rate for the adult population

as a whole. Furthermore, there is a strong negative correlation between education attainment and syphilis rates.

Table 6.21: HIV and syphilis prevalence rates by level of educational attainment, 1999.

Education level	% sample	HIV+	Syphilis
None	21.9	22.6	5.4
Primary	59.3	23.3	3.2
Secondary	14.8	29.5	2.0
Post-secondary	1.2	25.0	2.4
Unknown	2.7	24.4	2.6
Total	100	24.1	3.5

Source: Sentinel Surveillance Report 1999, National AIDS Control Programme 1999.

6.4.5 Other Attrition

According to EMIS data, total attrition of teaching staff has been around 10-15% per annum in recent years (see Table 6.22). Thus, in 2000, total teacher deaths (from all causes) were less than 20% of total attrition.

Table 6.22: Primary schoolteachers, in-post 1997-1999

Year	Female	Male	Total	% change	PTR
1997	18696	28647	47430		61.3
1998	15675	23975	41769	-11.9	69.3
1999	18320	27464	45784	9.6	63.3

Notes: Total attrition was 12.0% during 1998 and most of these teachers were replaced with new recruits in early 1999. PTR=pupil:teacher ratio
Source: EMIS 1997, 1998, 1999.

However, data from the DEO survey shows teacher mortality accounting for a very much higher share of total attrition (see Table 6.23).

Table 6.23: Attrition among primary schoolteachers in 16 District Education Offices, 1999

Reason for leaving	FEMALE			MALES			TOTAL		
	No	%N	Attrition	No	%N	Attrition	No	%N	Attrition
Death	138	63.4	1.32	173	42.5	1.32	313	50.2	1.33
Retirement	49	22.6	0.45	143	35.1	1.09	192	30.8	0.82
Resigned	19	8.8	0.18	49	12.0	0.37	68	10.9	
Medical grounds	9	4.1	0.09	23	5.7	0.18	34	5.4	
Cross transfer/posting	2	0.9	0.02	9	2.2	0.07	12	1.9	
Interdicted	0	0.0	0.0	6	1.5	0.05	6	1.0	
Dismissed	0	0.0	0.0	4	0.1	0.03	4	0.6	
Total	217	100.0	2.08	407	100.0	3.11	624	100.0	2.65

Source: DEOs

6.6 AIDS IN THE WORKPLACE

6.6.1 Government policy and practice

The National HIV/AIDS Strategic Framework launched in 1999 acknowledges the importance of well designed workplace programmes for HIV/AIDS and the mainstreaming of HIV/AIDS in human resource planning in all the sectors (MoHP 1999). However, sector ministries have not yet introduced any of the key interventions proposed in the Strategic Framework. This is despite the fact that senior managers in the civil service are well aware of the heavy toll of the epidemic on skilled and other staff. Many posts are vacant due to AIDS-related deaths. Urban areas are reported to be worst affected as are professions that involve mobility[19]. For example, the health education section of the Ministry of Health and Population lost nearly half of its staff of 17 between 1996 and 2000 through HIV/AIDS related illness.

No changes have been made to the Malawi Public Service Regulations as a consequence of the AIDS epidemic.

6.6.2 MOEST

There is no comprehensive AIWP programme within MoEST. This is partly due to the absence of any clear policy initiative for the government as a whole. However, it is also true to say that HIV/AIDS has been largely marginalised in the Ministry with the result that the response to date has been very limited. As elsewhere, the main focus has been on efforts to prevent HIV infection among school students. Very little effort has been made either to prevent or mitigate the impact of the epidemic on education sector personnel.

The Human Resources Development and Management Department has overall responsibility for human resource planning and management, but it lacks the necessary capacity to formulate and implement an effective AIWP programme. However, with the recent establishment of the Task Force on HIV/AIDS in MoEST (with members from all major departments), it is hoped that this will change.

Similarly, at the school level, very little has been done to support teaching and support staff. Most teachers at the survey schools do not believe that the Ministry is effectively tackling the impact of HIV/AIDS on teachers. Most teachers also feel that their schools have not offered adequate support to colleagues who have been directly affected by the epidemic (see Table 6.24).

Opinions on this issue among education managers are more divided. While some felt that the Ministry has an adequate policy on HIV/AIDS, there were many others who were seriously concerned by the inadequacy of the response to date: As one senior officer pointed out:

'It seems NGOs and donor community are very concerned with the HIV/AIDS situation in Malawi and the education sector but not the Ministry of Education. The ministry has been passive for long and it is now time for it to become active and do something'.

[19] Interview with senior managers in the HRDP.

In most of the survey schools, limited support is offered through each school's Social Welfare Committee. The committee collects monthly contributions from teachers for its welfare fund, which assists teachers when they are sick and bereaved. Teachers are also supportive of each other. For example, they normally visit sick colleagues.

Table 6.24: Teacher responses to statements concerning staff affected by HIV/AIDS (percentages)

STATEMENTS	PRIMARY						SECONDARY					
	Female			Male			Female			Male		
	D	NS	A	D	NS	A	D	NS	A	D	NS	A
The MOE is effectively tackling the impact of HIV/AIDS on teachers	52	20	28	51	15	33	72	22	6	44	41	16
Teachers can discuss their personal problems with school management	38	8	54	48	8	45	53	16	32	38	6	56
Teachers affected by HIV/AIDS are properly supported by the school	71	14	14	70	13	18	37	47	16	43	54	3

Notes: D=disagree, NS=not sure, A=agree

6.6.3 The Teacher's Union of Malawi

The Teacher's Union of Malawi has not actively lobbied or negotiated with the Ministry or government on any issue concerning the impact of HIV/AIDS on its members. However, a member of the TUM secretariat who was interviewed indicated that the union is keen to sensitise and educate teachers on a range of HIV/AIDS issues.

There is widespread dissatisfaction among teachers about TUM. Most feel largely unsupported by their union. Many teacher interviewees said that '*TUM is useless and ineffective' and 'TUM is doing nothing'*.

6.6.4 Sickness and Retirement

Malawi Public Service Regulations state that teachers, along with other civil servants, may be granted six months' sick leave with full pay and up to a further six months' sick leave with half pay in any one year period. After one year, all sickness benefits cease. An officer who is unable to return to work after taking long-term paid sick leave may be granted unpaid sick leave or can opt for premature retirement on medical grounds.

In practice, very few teachers take long-term sick leave[20]. This is mainly because of financial reasons. Quite a number of senior officers in MoEST are also very unclear about sick leave regulations and related procedures. Some stated, for example, that long- term sick leave was only three months on full pay and three months thereafter on half pay.

Sick leave regulations have not been amended as a result of the AIDS epidemic. In particular, there is still a clause that sick leave may only be granted 'as long as there are reasonable prospects of eventual recovery and fitness for duty' (GoM, 1999:540). This clearly needs to be changed or suspended. Some teachers also suggested that the official age of retirement should be lowered in the light of much reduced life expectancy.

[20] Only two teachers at the survey schools had ever taken long-term sick leave

Teachers themselves are also ignorant or unclear about their sick leave and other benefit entitlements. A number of teacher interviewees commented, for example, that government should process the gratuities and pensions of those staff who have clinical AIDS prior to their death.

6.6.5 Medical Support

There is no medical aid scheme for public servants (including teachers) in Malawi. Where teachers seek special or private treatment they have to pay from their wages. Teachers are entitled to emergency advances for medical expenses, but the revolving fund from which these are made is far too small to meet total demand and advances have to be repaid within six months.

The government recognises the benefits of making anti-retroviral drug therapies available to children and adults infected with HIV. However, despite very large reductions price reductions over the past year, the cost of these drugs is still way beyond the means of most Malawians, including teachers. Thus, there seems little hope of reducing mortality rates among teachers through the use of ARTs, at least in the immediate future.

6.6.6 Death and Funeral Benefits

MOEST is supposed to provide three vehicles and a coffin for funerals of deceased staff and their immediate family. However, most ministries do not have the funds to meet these expenses and considerable debts are being incurred. Within ministries, a wall of silence surrounds the whole issue of funerals as death is a taboo subject. Divisional and district education officers complained about the huge funeral expenses (i.e. costs of transport and coffins) they are incurring as a result of increased teacher death. Most of their monthly funding now goes to meeting the funeral costs of teachers and their immediate families. This means that other essential activities and needs (including school supervision, acquisition of stationery and other teaching and learning materials for schools, and even payment of salaries and allowances) are being seriously affected. Some DEOs stated that their total expenditure on funerals now exceeds the funding they receive from the MoEST.

However, the MoEST has not made any special financial provision to deal with the additional expenditures that are directly and indirectly related to the AIDS epidemic. Resources available at the divisional and district offices are grossly inadequate to deal with the situation. In particular, DEOs bemoan the lack of vehicles or inappropriate vehicles. Most are too small to carry the coffin and the deceased's personal belongings to their respective homes. Most of the DEOs also said that they are unable to immediately transfer the deceased family from the duty station to their respective homes because of lack of transport and in some cases the deceased family remains on the school premises for long periods of time. This makes it difficult to replace the deceased teacher because of lack of housing.

With teachers being deployed all over the country, this has also resulted in a marked escalation in funeral-related transportation costs because, traditionally, the dead are always buried in their home village. Urban DEOs are the worst affected because the death rates are higher and they attract teachers from all over the country.

6.6.7 Teaching Cover

Over 90% of primary school teachers at the survey schools indicated that teaching cover is provided for their classes when they are absent. 70% of male and 56% of female teachers at the survey secondary schools also indicated that some kind of teaching cover is provided. It is clear that actual cover varies significantly from school to school depending on staff availability and other resources at the disposal of the school. Numerous strategies are employed by school managers to deal with teacher absenteeism.

- The teacher arranges to make up or provide extra classes in the evening (usually possible in a boarding school).
- The teacher concerned leaves some work (prepared in advance) for the person who will cover his/her class
- The subject is changed.
- Teachers swap periods with each other so that absence is not disruptive.
- Sometimes other teachers `sit in' for study period with pupils to cover for absent teachers.
- In double shift schools it is possible for a teacher to attend a funeral and return in the afternoon (assuming it is close by.)
- Some classes are put together.

In primary schools:

- The head and the deputy provide cover for absent teachers because both of them have no teaching loads (only one school mentioned this).
- Teachers are reassigned from classes with more than one teacher to the class without a teacher.
- Some classes are put together or combined into one class.
- Teaching time is re-organised so that there is not much disruption.
- Absent teachers leave lessons to be covered prior to their absence.

Although there is a fairly high level of teacher absenteeism, this is not generally seen as having a serious impact on teaching and learning because teacher cover is available or absent teachers make up for lost time. However, it is doubtful whether teaching cover is adequate especially given very high pupil-teacher and pupil-class ratios in most schools. (see Table 6.25). None of the survey schools had floating teachers who can provide instant cover whenever the need arises. Nor are any of the above-mentioned coping strategies adequate to ensure proper teaching cover. For example, combining streams or classes in primary schools where there is more than one teacher per class results in extremely large classes (particularly in the lower standards and at urban schools). One of the urban survey schools is seriously under-staffed and also lacks physical space, which means that many classes are already combined. Classes of 120 or more are not uncommon in the lower standards. In such situation, teacher absenteeism results in combined classes of upwards of 240 children! Meaningful learning is obviously quite impossible in such large classes.

Table 6.25: Pupils per teacher, class and classroom at the survey schools

Std	Pupils:teacher			Pupil:class			Pupil:classroom		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
1	82	91	88	82	138	110	128	192	162
2	56	83	72	56	124	94	99	174	141
3	67	67	67	57	106	95	160	148	152
4	51	61	57	51	112	93	103	149	130
5	74	67	69	35	103	94	75	134	112
6	47	61	57	26	94	86	66	122	103
7	57	51	52	28	85	75	68	113	97
8	32	45	41	25	89	73	45	115	86
Total	60	66	64	47	108	92	47	145	125

In a few of the schools it was argued that though teaching cover is provided it places a burden on the remaining teachers because they end up teaching very large classes. Other teachers remarked that teacher absenteeism increases the teaching load of teachers and in some cases pupils still lose out as the teaching cover may not be provided for the whole time they are in school. A recent study on teacher mobility in selected primary schools found that movement of teachers between classes within a school was the norm with nearly half the teachers having being reassigned classes during one school year. Teacher movements were caused by teacher transfers, death, sickness or temporary leave, resulting in serious disruptions of the system (IEQ, undated). The study suggests that absenteeism of the teachers whatever the cause can create serious disruption within the school system as several classes are affected as the teachers are reallocated from other classes to provide cover for the class without a teacher.

6.6.8 Deployment and Transfers

Current MoEST policy is to deploy teachers anywhere in the country. In particular, the Ministry wants to re-deploy the large excess teachers at urban schools to schools in rural areas, many of which are understaffed. There are also obvious benefits of teachers working in their home districts. The housing problem would be eased and it will be considerably easier to implement the language policy, which requires mother tongue as the medium of instruction for the first four standards. Furthermore, as the AIDS epidemic deepens, staffing disruptions will be lessened if teachers are near family and friends if they become ill and/or they need to care for the sick. However, most teachers do not want to be posted to schools in their home areas and have mounted strong opposition to such a policy over the years. In 1989, a presidential directive ordered all teachers to teach in their home region, but this proved to be so unpopular that it was reversed when the new government took over power in 1994. More recently though, there has been an increase in the number of teachers seeking transfers to schools near their home areas or hospitals.

There are some concerns that the proposed redeployment of teachers to rural areas will result in spouse separation, which could increase the vulnerability of the separated teachers to HIV infection. 'Following spouse' is the most common transfer reason, (particularly amongst female teachers). According to DEO interviewees, over half of all inter-district transfers are for this reason.

While teachers are a highly mobile group, the DEO survey shows that currently less than 5% of transfers are AIDS-related.

6.6.9 Teacher discrimination

It is generally argued that teachers and other staff with HIV/AIDS suffer from social exclusion both within the school and also in the wider community (see, for example, Kelly, 2000, Shaeffer 1994, and Tayari 2000). However, the school survey found no evidence of overt discrimination and stigmatisation by either staff or students. Most teachers strongly disagreed with the statements that teachers who are affected by HIV/AIDS are discriminated against by the MoEST, school management, or other colleagues. Teachers feel that the key issue is not so much one of discrimination but rather a general lack of support for affected teachers by their employer, the MoEST as well as their own union. While staff who are ill or bereaved are given moral and material support by their colleagues, this support is fairly limited given the precarious financial position of most teachers.

However, where instances of discrimination have occurred, most teachers felt that school management had not dealt with it decisively enough. While MoEST officials also agreed that there is very little AIDS-related discrimination in schools, the ministry does not have an effective anti-discrimination policy.

Table 6.26: Teacher responses to statements concerning discrimination

STATEMENTS	PRIMARY						SECONDARY					
	Female			Male			Female			Male		
	D	NS	A	D	NS	A	D	NS	A	D	NS	A
Teachers affected by HIV/AIDS are discriminated against by the Ministry	82	17	1	76	21	3	84	16	0	50	44	6
Teachers by HIV/AIDS are discriminated against by school management	83	17	1	79	21	0	90	11	0	60	37	3
Teachers affected by HIV/AIDS are discriminated against by other teachers	84	14	2	84	11	5	79	21	0	57	37	6
School management has taken firm action to counter discrimination against teachers and students who have AIDS	66	21	13	46	25	28	61	28	11	49	34	17

Although teachers are generally quite supportive of each other when they are sick or bereaved, there is still enormous secrecy and anxiety about HIV/AIDS in schools. Most teachers who were interviewed said they do not feel free to discuss HIV/AIDS issues among themselves. This lack of openness makes it very difficult for school managers and other teachers to effectively support affected teachers.

6.6.10 HIV/AIDS Education

Virtually all HIV/AIDS education in the MoEST has targeted students only. HIV prevention for teachers and other Ministry personnel has been almost totally absent. While there have been some very limited in-service training on HIV/AIDS, this has also focused on student prevention. While some teachers do recognise the need for AIDS education for teaching and support staff, the level of denial and secrecy concerning AIDS is such that management at all levels has been incapable of intervening decisively in this area. Most teachers believe that ‘our managers do not want to talk about HIV/AIDS’ and that they themselves are not free to

discuss AIDS-related issues. As was repeatedly pointed out, 'the only time we talk about HIV/AIDS is when there is a funeral and the person is suspected to have died of AIDS'. Many head teachers, on the other hand, argue that, it is not them, but their own staff who are in denial. For example, one head teacher commented that when a health worker distributed condoms among teachers at his school, some of the teachers took it as a joke as if 'they were not sexually active'.

6.6.11 Testing for HIV

There is no special voluntary testing and counselling programme for teachers. New recruits to the teaching profession are now required to pass a medical examination, but this does not include an HIV test.

There are still very few centres in Malawi which offer pre- and post-test counselling. Most are located in urban areas, which further limits the access of teachers to these services. Some private doctors and clinics also offer testing services but most do not provide proper professional counselling.

The absence of a comprehensive AIDS in the Workplace Strategy in the MoEST has meant that so far little encouragement has been given to teachers to test for HIV. However, teachers at the survey schools argued that that MoEST should introduce HIV testing but that this must be done in conjunction with other measures that effectively support teachers who are living with AIDS.

PART II

WHAT SHOULD BE DONE?

The first part of this report has identified the main impacts of HIV/AIDS on students and staff in primary and secondary schools. Part II addresses mitigation issues in the three main areas: student prevention, students affected by HIV/AIDS and teachers and support staff.

Some commentators have argued that the schools in high HIV prevalence countries in Africa should be 'transformed' in order to deal effectively with the multiple impacts of the epidemic on children. However, in the Malawi context this is not a realistic proposition given the immense pressures that already exist on schools (overcrowding, lack of resources and poor teacher motivation). Although schools are in a strategic position in communities and have great potential to mobilise around HIV/AIDS issues, up to now little has been done. The MoEST should, therefore, play a far more pro-active role in the forging of new partnerships with other government and non-governmental organisations. The multi-sectoral approach needs to be more fully developed in order to wage a more effective struggle against AIDS. This will require support from both international donors and the private sector.

Another fundamental pre-requisite for change is greater commitment and openness on the part of senior politicians and civil servants in order to combat the epidemic. The process of raising the awareness of AIDS issues and developing more appropriate strategies needs to be more participatory and involve a wide range of stakeholders in communities, schools and government ministries.

CHAPTER 7

HIV/AIDS PREVENTION AMONG STUDENTS

To date, AIDS education campaigns and other interventions have had relatively little impact on the sexual behaviour of school children in Malawi. Although students are continuously exposed to information about AIDS from numerous sources (including the mass media, teachers, local health workers and religious leaders), mixed messages are causing confusion and serious knowledge gaps with respect to reproductive and sexual health. Many continue to put themselves at risk by having unprotected sex with multiple sex partners

The school survey identified numerous problems with the current integration and infusion approach. What should be done, therefore, to ensure that school-based AIDS education is more effective? Given the seriousness of the AIDS epidemic in Malawi, it is essential that students at both primary and secondary schools have the knowledge and skills that will enable them to make informed decisions and avoid HIV infection. Accordingly, a comprehensive and holistic HIV/AIDS prevention strategy needs to be adopted by the MoEST, which focuses on all the key contributory factors, which result in adolescents putting themselves at risk of infection. This strategy would take account of both gender and cultural issues and participatory techniques should be utilised wherever possible.

7.1 INFORMATION AND RESEARCH

The collection of reliable information on students' knowledge, attitudes and behaviour in relation to sexuality and HIV/AIDS is essential if the MoEST is to develop an effective and comprehensive HIV/AIDS education programme for primary and secondary schools. It is recommended, therefore, that a comprehensive study into sexual behaviour is undertaken that takes into consideration cultural and gender issues, in order to inform appropriate interventions and strategies to reduce high risk sexual behaviour. Hospitals and clinics also need to supply schools and Ministry of Education with statistics on STD infections among school students.

7.2 LIFE SKILLS AND HIV/AIDS EDUCATION

"AIDS education should be a subject on its own for every student"

Life skills as a separate subject: Students must have the basic life skills that will enable them avoid HIV infection. The key areas that must be squarely addressed include dealing with peer pressure, problem solving, assertiveness, sexuality, and alcohol and drug abuse. Given the current situation in schools in Malawi, the only effective way of ensuring that children acquire these life skills is for them to be taught *as a separate subject in the core curriculum*. It is recommended, therefore, that at least two periods a week are devoted to life skills education. As discussed earlier, the MoEST working with UNICEF have developed a Life Skills programme, which is based on this principle of separate provision. However, it is imperative that this programme is introduced into both primary and secondary school without further delay. It should be introduced into Standard 1 of primary school and run through the whole school system.

In Uganda, during the late 1980s, the School Health Education programmes focused on the provision of basic factual information about HIV/AIDS. However, once the scale of the AIDS epidemic became apparent, it was decided to place far more emphasis on life skills training. The Ugandan experience has shown that 'effective advocacy has created a supportive environment for life skills education'. It is clear from the experience of other countries that life skills packages, aimed at behaviour change will not be successful without a more open approach generally to HIV/AIDS issues on the part of the schools and the community at large (Gachuhi, 1999).

Integration and infusion: Although not adequate on its own, HIV/AIDS education should still continue to be infused in all relevant 'carrier' subjects. It is hoped that improvements in teacher training regarding HIV/AIDS and the development of more interactive teaching methods will make these inputs more effective than they have been in the past. It is MoEST policy to maintain infusion and also extend it to other areas such as teacher education, planning and management, human resources management and other areas.

Start early: HIV/AIDS prevention efforts should also start as early as possible before children have become sexually active and before too many have dropped out of school. It is recommended, therefore, that life skills education should start in Standard 1. The main focus should be on promoting sexual abstinence.

Teacher training: The teacher education programme should mainstream HIV/AIDS, family life education, and life skills into the certificate, diploma and degree curricula. A comprehensive review of the teacher education curriculum is required to include HIV/AIDS and Life Skills components, in order to ensure that all newly trained teachers are able to integrate and infuse HIV/AIDS topics into their teaching subjects.

7.3 GUIDANCE AND COUNSELING SERVICES

MoEST is committed to strengthening the provision of guidance and counselling services. In view of the increasingly serious impact of the AIDS epidemic on the material and emotional welfare of many children, improving these services should be given top priority. In particular, professional staff should be appointed with responsibility for the co-ordination of G&C services at national and divisional levels.

It is also essential that all schools have full-time G&C teachers with specialist pre- and in-service training in life skills education including HIV/AIDS. These teachers would have both teaching and pastoral responsibilities. They would teach the time tabled Life Skills classes in each school and, more generally, ensure that schools do all they can to support the rapidly growing number of children affected by AIDS, in particular orphans. The counsellors will need, therefore, to work very closely with District AIDS Co-ordinators and District Social Welfare Officers as well as other key partners in the community. For the large urban schools, as many as four counsellors will be required.

7.4 TEACHER TRAINING

"All teachers must be trained in counselling skills"
"All teachers should be exposed to HIV/AIDS education and be oriented on how to teach it"

All teachers must have the skills to support the emotional needs of students during the AIDS crisis and beyond and also be able to deliver effectively AIDS topics that are infused in their particular subject. Intensive pre- and in-service training must be provided as a top priority to all teacher trainees and serving teachers respectively. A dedicated cadre of teacher trainers is required who should work closely with NGOs which have proven training capacity in this area.

Due to the sensitivity of the subject matter, teaching methods must be child-centred and participatory. As noted earlier, previous attempts to deliver HIV/AIDS subjects have been top down and not interactive enough. This has partly been because of the discomfort felt by many teachers in delivering these subjects, which is not helped by the lack of open discussion of these sensitive issues.

7.5 REFERRAL SERVICES

Schools need to be much better informed about what services are available for both students and staff affected by AIDS and effectively refer individuals to these service providers when the need arises. Close liaison with other government departments and NGOs is crucial if this is to be done effectively. School should have the necessary documentation, which describes all relevant service providers.

7.6 PEER EDUCATION

In many countries around the world, peer-led risk reduction interventions have been effectively utilised among adolescents to change unhealthy or risky behaviour. A far more concerted effort is needed to introduce school-based peer education in Malawi. Peer education and counselling must be included in the orientation of students on the executive of primary and secondary schools, prefects and student leaders of various organisations, as well as clubs and societies in the schools. Emphasis should be placed on training students in life skills, HIV/AIDS, peer education and counselling, in collaboration with youth NGOs and relevant government departments. Promoting peer education would be the responsibility of the school-based guidance counsellor.

AIDS TOTO Clubs (with some adult facilitators) should be revitalised and employ peer education techniques in order to develop mutual self-respect and improve the self-esteem amongst girls and boys. It is often low self-image and fear of being assertive, combined with the need for cash that leads girls into early pregnancy and risky sex. By using drama and interactive methods, the clubs can help to widen their membership and also involve other groups such as parents through PTAs and school committees in anti-AIDS activities. The AIDS TOTO Clubs using peer education should expand their activities into the community in order to involve out of school youth.

7.7 SEXUAL MISCONDUCT

Decisive action should be taken against all forms of sexual harassment perpetrated by teaching staff or other students. The existing MoEST regulations, which allow for the suspension of teachers involved in sexual liaisons with students, should be strictly enforced. The maintenance of high ethical standards and provision of positive rather than negative role models can only benefit the teaching profession and the school as a whole.

In Malawi, the age of consent is 13 years old, although the Law Commission is in the process of revising the penal code to bring it in line with constitutional provisions, which define the minimum age for marriage as 16 years. Despite these provisions, the constitution allows children between the ages of 14 and 16 to marry with parental consent. In the light of both the HIV/AIDS epidemic and human rights considerations, it is clear that 14 is too young an age for children to marry.

The recommendation of the National Gender Policy (MoGYCS, 1999) that the legal minimum age of consent should be raised to 18 years is likely to be unworkable. Draft legislation to this effect in Uganda has been strongly opposed in parliament and has not been made law. We recommend, therefore, that for Malawi the age of consent be raised to 16 years. This would help to reduce the dropout of girls and boys in both primary and secondary schools and it would also protect young females (who are particularly susceptible to contracting HIV/AIDS) from under-age sex and abuse.

A national campaign should be mounted by NGOs and other groups in civil society to publicise the dangers of under-age schoolgirls having relationships with 'sugar daddies.' The existence of sexual relations between adults and children at school clearly reflects what is going on in the wider community. This practice must be challenged by all possible means using the media, the churches, women's organisations, trades unions etc.

7.8 CONDOMS

Malawi has experienced erratic supplies of condoms with very few being available in more remote rural areas as well as huge variations in quality. As discussed earlier, school children receive mixed messages with regard to the use of condoms. Whereas messages from the Ministry of Health and many anti-AIDS NGOs emphasise 'safe sex' and the use of condoms, religious lobbies and even the WHY WAIT programme, promotes abstinence as the 'only way'. The school survey highlights the extent to which children are confused about condom use.

There is an urgent need for the MoEST in collaboration with the National AIDS Control Programme, to engage the various stakeholders on how best schools can provide balanced information on both abstinence and condoms. What is clear is that teachers and students do not think it is appropriate to distribute condoms in schools, despite the high level of sexual activity among secondary students. It is the opinion of many teachers and parents that making condoms freely available encourages sexual activity amongst young people. It is essential, therefore, that condoms are only distributed in conjunction with good quality information and counselling services. Where these services can be assured, condoms should be accessible to students in a neutral place, for example, in clinics, dispensaries, hospitals and through youth NGOs. School-based counsellors could advise students how to obtain condoms if necessary.

CHAPTER 8

STUDENT MITIGATION

This chapter examines what should be done to support students directly affected by the epidemic, in particular orphans, student carers, and students who are HIV positive. The first section presents projections of the school-aged population, school enrolments, and the three groups of children directly affected by HIV/AIDS. The second section then makes a number of recommendations concerning what support should be provided by schools, the wider community and the state to affected children in order that they are properly educated.

8.1 PROJECTIONS

8.1.1 School-aged Population

The AIDS epidemic in Malawi will seriously reduce population growth. Far fewer children will, therefore, need to be educated than would have been the case in the absence of the epidemic. The overall rate of population growth declined from 3.2% in 1987 to 2.2% in 1998, which has been partly attributed to the impact of HIV/AIDS. .

Table 8.1: Projected school-age population with and without-AIDS, 1998-2014 (millions)

Year	6-13			14-17			18-24		
	F	M	Total	F	M	Total	F	M	Total
1998- Base year									
Without AIDS			2.14			0.90			1.38
With AIDS	1.06	1.08	2.14	0.46	0.44	0.90	0.73	0.65	1.38
1999									
Without AIDS			2.19			0.92			1.41
With AIDS	1.10	1.09	2.19	0.47	0.45	0.92	0.74	0.66	1.40
2004									
Without AIDS			2.42			1.04			1.54
With AIDS	1.16	1.14	2.30	0.52	0.52	1.03	0.77	0.74	1.51
2009									
Without AIDS			2.95			1.15			1.73
With AIDS	1.35	1.31	2.66	0.57	0.55	1.12	0.87	0.85	1.72
2014									
Without AIDS			3.59			1.34			1.93
With AIDS	1.60	1.56	3.16	0.61	0.59	1.20	0.93	0.92	1.85

Notes: Calculated using population parameters estimated from the 1998 Population and Housing Census.

How large then will the school-age population be during the coming decades? Most children in Malawi attend primary and secondary school between the ages of 6 to 24 years. Without AIDS, this group would have increased from 4.42 million in 1998 to about 6.86 million by 2014 but, 'with AIDS', the projected population is 6.2 million, around 10% lower[21]. With

[21] The population projections and the HIV prevalence projections were calculated for this study using the Spectrum model by Dr. Martin Palamuleni, Demographic Unit, Chancellor College. A full description of the assumptions used to projection population and HIV/AIDS demographic impacts are provided in Appendix 2.

AIDS, the primary school-aged population of 6-13 year olds is projected to reach 3.16 million by 2014 - 12% less than the projected population of 3.59 million without AIDS. Similarly, the secondary school-aged population of 14-17 year olds is projected to grow from 0.90 million in 1998 to 1.20 million by 2014, which is 10% lower than the projected population without AIDS.

8.1.2 Projected School Enrolments

Apart from the overall demographic impacts, the epidemic may undermine the ability of affected households to send and keep children in school. This will mean that the Education for All targets may not be attainable unless appropriate actions are taken to mitigate the negative impacts of the epidemic on schooling.

In order to explore the likely impacts of the epidemic on school enrolments, two future enrolment scenarios are contrasted with current enrolment trends (based on pupil flow rates in the base year 1999). The first enrolment scenario assumes that the PIF enrolment targets are attained with no change in current dropout and repetition rates. Under the second scenario, it is assumed that HIV/AIDS results in a 50% increase in repetition and dropout rates.

The PIF targets for primary education are as follows:

- A net enrolment ratio of 95% by 2007, up from 75% in 1997/98 [22]
- Dropout rates will fall to 5% in all standards and repetition rates will also be 5% in standards 1-7 and 10% in standards 8 (from an average of 15% in 1997).
- Increased female participation from 48% in 1997 to 50% by 2002.

At the secondary level, the PIF has the following objectives:

- A gross enrolment rate of 30% by 2012 (up from 18% in 1997).
- Gender parity by 2012. Females comprised 37% of enrolments in 1997.

The enrolment projections based on the PIF targets are compared with the enrolment projections assuming that enrolment targets remain constant from the base year. It has been assumed that by 2014 all children will begin primary school at the official starting age. Consequently, the admission rate to primary school for both girls and boys has been steadily reduced from 204.1% in the base year to 100% by 2014. The admission rate for secondary education is reduced from 49% to 30% in order to achieve the PIF enrolment targets.

Table 8.2 shows the PIF enrolment targets for primary and secondary levels over the 15-year projection period. With constant repetition and dropout rates, enrolments are projected to increase by 60% from 2.9 million to 4.64 million. Overall enrolments would have to grow by about 4% per annum, which is unrealistic as the high admission rates would be impossible to sustain over this period. Secondary enrolments would grow at even faster rate increasing by as much as 86% by 2014.

[22] According to the Integrated Household Survey (NSO, 2000). [22]

Assuming that the PIF targets of lower repetition and dropout are achieved, primary enrolments are expected to grow by 25% from 2.9 million in the base year to 3.64 million by 2014. Secondary enrolments would increase by 75%.

Table 8.2:Projected primary and secondary school enrolments,1999- 2014 (millions)

Year	PRIMARY			SECONDARY		
	No change	PIF targets	AIDS impacts	No change	PIF targets	AIDS impacts
1999	2.90	2.90	2.90	0.24	0.24	0.24
2000	2.98	2.96	2.94	0.26	0.25	0.25
2001	3.05	3.01	2.95	0.28	0.27	0.26
2002	3.11	3.04	2.91	0.30	0.28	0.27
2003	3.14	3.05	2.84	0.33	0.30	0.27
2004	3.20	3.08	2.78	0.36	0.32	0.29
2005	3.28	3.12	2.73	0.40	0.35	0.31
2006	3.40	3.17	2.72	0.42	0.37	0.32
2007	3.55	3.24	2.73	0.44	0.39	0.32
2008	3.74	3.32	2.77	0.44	0.40	0.31
2009	3.92	3.41	2.80	0.45	0.42	0.29
2010	4.08	3.47	2.81	0.45	0.42	0.27
2011	4.23	3.53	2.81	0.46	0.42	0.25
2012	4.38	3.58	2.81	0.46	0.42	0.23
2013	4.51	3.62	2.80	0.48	0.42	0.21
2014	4.64	3.64	2.78	0.49	0.42	0.19

Impact of HIV/AIDS on school enrolments: The likely adverse impacts of the epidemic on rapidly growing numbers of children will make the PIF enrolment targets more difficult to achieve. The general consensus among parents/guardians, teachers, students, and orphans is that children most directly affected by HIV/AIDS do face more problems with their schooling and are, therefore, more likely to dropout of school because of lack of basic support.

The cost of secondary schooling is already prohibitively high for most households in Malawi, the large majority of whom live below the poverty line. The PIF proposes major cost sharing strategies that will further increase the cost burden on households. Since HIV/AIDS usually impoverishes affected households, more families will be unable to support their children's secondary schooling. This could mean that the PIF target of 30% enrolment rate for secondary education is not achievable. The number of children needing assistance to attend secondary schooling will almost certainly increase dramatically thereby undermining the PIF policy objective of lower government subsidy for secondary schooling.

To model the impact of HIV/AIDS on school enrolment, it has been assumed that overall repetition and dropout rates for primary education increase by 50% over the 15 year period, while, at the secondary level, dropout rates are projected to increase from zero to 5%.

Table 8.2 shows that projected primary and secondary school enrolments in 2014 when the impact of HIV/AIDS is taken into account. Projected primary school enrolments are 4% lower in 2014 than in 1999 while secondary school enrolments are 20% lower. The gross enrolment rate for primary education decreases from 132.1% in 1999 to 88.1% in 2014. The gender gap also widens as the epidemic is expected to affect girls schooling more than boys. The relative gender gap decreases from 92.2% in 1999 to 80.7% in 2014.

8.2 CHILDREN DIRECTLY AFFECTED BY HIV/AIDS

Mitigating the impacts of HIV/AIDS on education will depend crucially on the level and type of support given to affected children, both in and out of school. The chronically high levels of poverty in Malawi seriously compound the problems faced by these children. According to the 1997-98 Household Income Survey, 66.5% of rural and 54.9% of urban populations live below the poverty line and 28% of the population live in abject poverty (NSO, 2000). This has major implications for the efficacy of community and home based care for orphan, which is the main focus of the national orphan care programme in Malawi. Given that the ability of most households to cope with the economic impacts of the epidemic is severely limited, the success of the community-based approach for orphan and patient support will depend to a large extent on how quickly the livelihoods of the poor can be improved.

It is not even known how many children currently affected by HIV/AIDS are facing additional problems with their schooling and just how many of them, therefore, need various kinds of targeted support so that they successfully complete their education. Estimating just how many affected children will need to be supported over the next 10-15 years is even more difficult. However, whatever the numbers may be, it is vital that the MoEST in conjunction with other key partners (both in government and in civil society) develops a comprehensive strategic response that specifically addresses the needs of these children.

8.2.1 Orphans

The number of maternal and double orphans doubled between 1990 and 2000. Currently, it is estimated that this group of children comprise 12% of the under 15 population. 27% of children have lost one or both parents. At the survey schools, about 30% of the students randomly selected for interview were orphans.

Table 8.3: Projected number of orphans under 15 years of age, 1990-2010 ('nearest 000)

Year	1990	1995	2000	2005	2010
Population < 15	4284	4375	4488	4504	4376
Maternal/double orphans	259	392	554	715	861
Maternal/double orphans as % children < 15	6.05	8.97	12.34	15.87	19.68
Total orphans	741	981	1231	1430	1566
Total orphans as % of children < 15	17.29	22.41	27.43	31.75	35.78

Source: UNICEF (1999) 'Children on the Brink'.

Nearly 36% of the under 15 population will be orphans by 2010. The projected number of maternal and double orphans is projected to increase by around 200,000- from 550,000 in 2000 to 860,000 by 2010. The total orphan population (i.e. both single and double orphans) will increase from 1.23 million in 2000 to 1.57 million in 2010.

These projections suggest that orphans will account for very sizeable proportion of children for the foreseeable future. Detailed information on the actual number of orphans and their characteristics is currently not available as there is no effective system of registration of orphans. However, given that the number of maternal/double orphans is projected to increase to about 20% of all children, it is imperative that a comprehensive national survey of the

orphan situation is carried out as soon as possible in order to identify effective support systems for them.

8.2.2 Children Looking after Sick Family Members

The AIDS epidemic in Malawi will peak during the next decade. Consequently, the burden of care for the sick will continue to increase. Children are a major source of labour within most households. Thus, without additional support, it is likely that children living in households with a sick adult member will bear much of the burden of care and demands for their labour will also increase considerably as they take on the roles of the sick family members.

It is difficult to accurately project the number of child carers. However, the number of people with AIDS does give us an indication of the likely number of children that might be affected. The number of new AIDS cases is projected to rise from 57,000 in 1998 to nearly 100,000 per annum by 2010.

8.2.3 Children Living with AIDS

Given the age structure of school enrolments in Malawi it is possible that some students might be infected and sick within the school system. In addition, so far there have not been any prevention programmes to reduce the incidence of mother-to-child transmission implying that some children in the infant sections of primary schools could be infected. The secrecy and silence surrounding the epidemic mean that schools do not keep any records on children who are seriously sick. The prevalence rate amongst children aged 0-15 years was estimated to be 2.2% in 1999 (NACP, 1999). Furthermore, the age profile of primary and secondary school enrolments suggest that some students in upper primary and secondary schools might be infected and suffering from HIV/AIDS.

8.3 SUPPORT STRATEGIES

8.3.1 Stakeholder Suggestions

Students, teachers and school management teams suggested the following types of school-based support for orphans.

- Identifying sponsors (charitable organisations like Lions Club International and Rotary Club) to pay school fees for needy students including orphans;
- Permitting orphans to pay school fees in instalments;
- Teachers offering orphans and needy students seasonal jobs like *'ganyu'* in order to raise money to pay for their schooling and for other basic needs;
- Providing transport money to boarding orphans to allow them to go home during holidays;
- Providing them with pens and notebooks;
- Setting up a general purpose fund to help orphans with transport in particular.
- Use GABLE funds not used by female students who have dropped out of secondary school to assist the orphans.

It was also suggested that schools should provide counselling to orphans in order to help them deal with the psychological impacts of their loss and trauma and also encourage them to stay in school**.** It is clear that teachers would like to see the school (and MOEST) taking a

more pro-active role in supporting orphans either by identifying assistance for them or even raising funds for orphan care. Teachers at all the survey schools generally agreed that there is need to improve support given to orphans by the schools. Some of the things that the teachers suggested should be done include:

- Provision of counselling services to address the emotional and psychological needs of orphans
- Identifying organisations that can offer support to orphans.
- Solicit donations of clothes and other basic needs such as food for distribution to orphans in the school to address their basic needs.
- Creation of social welfare funds through staff and student contributions to be used in assisting orphans and other children affected by HIV/AIDS.
- Co-ordinate NGO and other orphan care organisations activities within the school.
- Provide orphans with all required learning materials.
- Provide bursaries to orphans in need.
- Encourage PTAs to take a more pro-active role in the care of orphans and support for their education.
- Introduce income-generating activities within the school to raise money, which can be used to support orphans.
- Create a school-based committee on orphans.
- Provide extra tuition or remedial lessons to orphans and other children affected by HIV/AIDS in view of their frequent absences from school.

8.3.2 General Considerations

As was discussed earlier, MoGYCS has developed a comprehensive policy for orphans based mainly on community (as opposed to institutional) care. The programme calls for a multi-sectoral approach with the Ministry taking a lead role in co-ordinating orphan care activities. In addition, Ministry of Health and Population provides for community and home based care programmes for AIDS patients. Yet, despite their obvious potential advantages over other forms of care, both programmes have had limited coverage and are seriously under-funded.

Mitigating the impacts of the epidemic on school enrolments will largely depend on the effectiveness of support given to children most affected by HIV/AIDS. However, targeting orphans and other affected children is a contentious issue given the extent of poverty in Malawi. The schooling problems faced by orphans are not unique to them. There are other equally vulnerable groups among non-orphans, most of whom live in very poor households who are also at risk of not enrolling and completing their schooling. To ensure equity, targeting should therefore be inclusive so that all vulnerable children, including those orphans at most risk, are provided with assistance. Effective targeting can only be done if there is a sound information base, which currently does not exist.

Since most orphans and other children affected by HIV/AIDS are cared for within their communities, often by close relatives, improving the economic well being of households should be the main priority. For example, the majority of orphan carers who participated in focus group discussions mentioned that what they needed most was assistance (such as credit) to enable them generate income and produce enough food for their family. However, orphans have other special needs as well apart from basic needs of food, shelter and clothing, in particular psychological and emotional support.

8.3.3 Social Welfare Provision

Given the magnitude of the orphan crisis, government in collaboration with donor partners urgently needs to review the provision of welfare and other benefits to the needy. The proposed National Safety Nets programme offers a window of opportunity to develop and offer comprehensive support systems for orphans and their carers. More resources (both financial and human) should be put at the disposal of the MoGYCS in order that basic social welfare services can be provided to the most needy groups. However, the Ministry currently lacks the capacity to implement and monitor orphan programmes. In particular, the present establishment of social welfare officers is far too small.

It is recommended that a special cadre of social welfare assistants (SWA) is created which would work closely both with schools and communities in providing and monitoring orphan care services. The recruitment of SWAs would also enable the ministry to expand its fostering and adoption services, which are limited because of lack of staff on the ground. Apart from assessing and monitoring children under different care programmes, SWAs could also be trained to provide counselling to both carers and orphans.

Government should also increase its budgetary support for social welfare services so that MoGYCS can more effectively respond to the orphan crisis and also provide the much-needed leadership in orphan care by co-ordinating the activities of various stakeholders.

8.3.4 Co-ordination between agencies

The current organisational and institutional arrangements for addressing orphan needs are not adequate given the magnitude of the orphan crisis. Senior officials interviewed in the MoESC and MoGYCS bemoaned the lack of effective co-operation on orphan issues between the two ministries. There is an urgent need to strengthen the multi-sectoral approach to orphan care, which should also be extended to include other children in difficult circumstances (including those who are HIV positive and those caring for sick relations). Collaboration between MoGYCS and MoEST must be intensified at both central and district levels. District Social Welfare Offices should work hand in hand with District Education Offices and schools in monitoring the orphan situation. SWA should work with schools and communities to ensure that orphan needs are met and also provide support to children attending to sick family members and those who are sick.

8.3.5 Needs Assessment

An orphan needs assessment should be undertaken in order to identify the kinds of support that orphans and their carers need. This exercise should involve all the major stakeholders.
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There is need to collect information on orphans, which can be used for planning. The exact number of orphans and their characteristics, needs and situations is not known. Without this information it will be difficult to adequately plan for support and effectively target those orphans who are at risk and in need of support. Systems for monitoring the orphan situation should be put in place as well. Community-based orphan care groups should be legally required to register all orphans who they are assisting. There is need to strengthen the capacity of these groups to identify orphans and other children in need.

8.4 THE ROLE OF MOEST

8.4.1 Information Systems

Schools and District Education Offices must systematically collect data and keep records on all orphans. The information collected should include the social and economic characteristics (including their living conditions) of the children and their carers in order to identify those children who are most vulnerable. This data should be fed into the education management database. The database on orphans should include age, sex, parenthood status and living arrangements. Schools should be encouraged to work closely with community based orphan care groups within their locality order to monitor the orphan situation and target orphans out of school. During the survey teachers and students indicated that there is need to identify orphans who are at most risk such as those who have lost both parents and target them for government support.

A community-based study is also required in order to identify orphans and other affected children who are out of school in order to determine their needs and assess the obstacles that are keeping them out of school. As stated earlier, this study did not fully 'capture' these children.

8.4.2 School-Community Links

Schools should be encouraged to link up orphan-care groups working in their catchment areas in order to co-ordinate the support provided to orphans. Most community-based orphan care groups keep up to date records of orphans and some details of their home situation, which the schools could find useful for their records. Regular meetings should be held between schools, members of the community and NGOs in order to discuss the issues affecting orphans and CAAs. Through this process, it may also be possible to encourage the fostering of orphans by non-relatives, possibly other parents at the school.

The renewed AIDS TOTO clubs should not only be involved in prevention activities in the community but also help to raise awareness of the problems faced by orphans and other children affected by AIDS through the use of peer education and drama.

Schools should also work closely with other relevant NGOs. In particular, the recently established NGO for Social Mobilisation (CRECCOM) has carried out a mobilisation campaign against AIDS which seeks to:

- Create an atmosphere of dialogue regarding HIV/AIDS proliferation within and among communities.
- To empower communities to accept responsibility for influencing, implementing and achieving initiatives that combat HIV/AIDS proliferation. This involves assisting communities and schools in employing local resources.
- To create an atmosphere of communication in the school by engaging teachers in dialogue with other teachers, pupils and community members and empowering teachers to involve community members to assist schools in their struggle against HIV/AIDS.

The Social Mobilisation Campaign of the GABLE project has been adapted in order to achieve these objectives. The SMC approach has already proved to be effective in changing cultural beliefs and practices concerning issues such as initiation that were thought to be

immutable. Now the pilot phase is complete, USAID supporting an extension of this programme. These participatory approaches involving the creative mobilisation of the resources of community and school have great potential in the struggle against the AIDS epidemic.

Teachers in some survey schools mentioned the importance of reviving PTAs as one way of developing links between school and community and thereby ensuring adequate support for children affected by HIV/AIDS. The newly established Malawi Parents Schools Association, a national body of parents with school age children intends to work with school PTAs to identify and assist orphans.

8.4.3 Creating support systems

Every school should not only closely monitor the attendance and progress of all orphans and other affected children, but also develop support systems for these children. Each head teacher, working closely with the head of guidance and counselling, should develop a school action plan.

Teachers at the survey schools made a number of suggestions about what should be done by schools to help affected children. The most frequently mentioned were:

- Training in basic counselling skills so that they can provide emotional/psychological support for affected children.
- A special fund with contributions from the school community or through income generating activities should be established to cater for the needs of orphans.
- A committee at each school for orphans and other disadvantaged children.

These kinds of interventions would enable schools to be more responsive to the needs of orphans and other affected children. Explicitly acknowledging the orphan crisis will go a long way in ensuring that orphans are not unintentionally excluded from key activities, as is the case in many schools at the moment.

8.4.4 School meals

Schools should provide disadvantaged orphans and other needy children with at least one nutritious meal every day.[23] Orphans at a number of pre-schools in the Blantyre area are already fed twice a day. It is well know that if children are hungry during the school day it affects their concentration and general health. Such a scheme would ensure not only that children receive vital nutrition but the meals themselves would also act as an important incentive for disadvantaged orphans to attend school.

8.4.5 Schooling costs

The government should maintain its free primary education policy as this has enabled many orphans to attend school. However, because MoEST funding does not cover all operational

[23] The World Food Programme (WFP) have already conducted a pilot school feeding programme in Malawi originally aimed at girls although it proved impossible to exclude other needy children.

and maintenance costs in most primary schools, parents are still required to make financial contributions. This places a considerable burden on poor parents and results in many children dropping out of school. Although it would require some kind of means-testing, schooling must be completely free for all children from very poor households.

Disadvantaged orphans, both female and male, should also be given priority in the scholarship schemes currently being developed for secondary education. A comprehensive bursary scheme for orphans should not only cover direct fees but other costs such as transport, uniforms, and school supplies. A holiday allowance could also be included. These measures are particularly important for female students who have less access to safe income earning opportunities than boys.

8.4.6 Non-formal Education and Vocational Training

The education and training needs of orphans and other needy children who have dropped out of school and are unlikely ever to return should also be carefully assessed and appropriate forms of provision developed. In particular, most orphans interviewed as part of this study stated that they wanted skills training, which would equip them with life and vocational skills to meet basic livelihood needs. One community orphan care group in rural Zomba has been offering skills training to all orphans under its care including those who are still at school. Training is being offered in tailoring, carpentry, metal work, livestock production and horticulture. The group through its income generating activities and support from individuals in the community has been able to provide regular support to orphans under its care. Orphans are also provided with rations of food and soap every fortnight. Other NGOs offer similar types of skills training in Blantyre City, mainly to out of school orphans.

CHAPTER 9

TEACHING AND SUPPORT STAFF: PREVENTION AND MITIGATION

This chapter examines what should be done to mitigate the impact of HIV/AIDS on teachers and other MoEST staff. As has been noted in Chapter 6, HIV/AIDS epidemic is undermining the human resource capacity within education system through loss of personnel and reduced productivity as a result of frequent absenteeism. Teacher mortality rates are rising, particularly at primary level and there are indications that this is affecting the delivery of quality education within schools. Despite this situation, little effort is being made to address the impacts of the epidemic on education personnel. The main response of the MoEST to the epidemic has, until recently, been in the area of student prevention. To date, no prevention and mitigation programmes targeting teachers and other MoEST staff have been designed. The MoEST is in the process of developing a strategic plan to address HIV/AIDS issues affecting the education sector which will include strategies to mitigate the impact of the epidemic on teachers as well as prevention programmes for teachers and support staff. The MoEST strategic plan draws from the overall National Strategic Plan for Malawi launched in 1999.

The MoEST will also need to work out new projections on teacher requirements and establish recruitment targets for the next decade that take into account the increased mortality rates amongst teachers, the increased levels of morbidity and associated absenteeism and the lower enrolment projections.

9.1 AIDS IN THE WORKPLACE STRATEGY

Approximately one-half of public sector workers in Malawi are teachers. The importance of developing an effective AIDS in the Workplace (AIW) programme for the prevention and mitigation of the epidemic among teaching and support staff cannot be over emphasised. Many of the teachers interviewed for this study stressed that MoEST should do much more to support teachers affected by the epidemic. It is essential therefore that all head teachers, teachers and support staff should receive intensive training in AIWP issues. The Teacher Union of Malawi (TUM) should also be centrally involved in the design and implementation of the AIWP policies in the schools and other MoEST institutions.

The following discussion focuses on the key elements of an AIWP programme for the education sector.

9.1.1 HIV/AIDS Education

"AIDS education should be given to both teachers and students…" (Teachers).

A comprehensive HIV/AIDS education programme should be introduced as soon as possible, which specifically targets the teachers and other MoEST staff at all levels. The objectives of such a programme would be to provide information and skills that will help them to guard against infection, and learn to live positively if already infected. In schools, guidance and counselling teachers should be responsible for the AIDS education programme. Regular staff meetings should be held to discuss issues pertaining to HIV/AIDS prevention and mitigation for both staff and students.

The main objectives of the programme are as follows:

- ❒ Provide teachers with relevant information on HIV/AIDS and life skills training.
- ❒ Break the silence and denial that often surrounds AIDS in schools and encourage all staff in the education sector to freely discuss HIV/AIDS issues and acknowledge its existence.
- ❒ Promote voluntary testing
- ❒ Counter discrimination and encourage staff to support those infected and sick.

MoEST should ensure that learning materials for the teacher education programmes are made available to all schools. These include written material such as posters, leaflets and booklets as well audio-visual tapes (where there is electricity). Some of these materials such as audio-visual tapes could be allocated at zonal level libraries in the teacher development centres (TDC) from which the guidance and counselling teachers can borrow for use in their schools. A teacher's handbook detailing the aspects of the programme outlined above and also providing guidelines on risk management within schools should be developed and distributed to every teacher.

9.1.2 Prevalence and risk assessment

Currently no information on prevalence rates among teachers and other MoEST staff exist. The paucity of a comprehensive database on teachers also means that there is scanty information on the risk factors, which predispose teachers to HIV infection. Without this information it will be difficult to design effective prevention programmes for education personnel and also develop realistic human resource plans. The findings of this study have highlighted the fact that mortality rates differ very markedly among teachers according to type of school, gender and location. This is hardly surprising in a profession which is as large, heterogeneous and geographically dispersed. It is not acceptable, therefore, to assume that patterns of HIV prevalence are the same among teachers as they are for the adult population as a whole. Without a more precise understanding of prevalence rates among teachers by gender, type of school and location, it is simply not possible to make sufficiently accurate teacher requirement projections.

It is vital therefore that a comprehensive assessment of HIV prevalence and risk among teachers and support staff is undertaken as soon as possible. With regard to HIV prevalence, a sufficiently large random stratified sample of teaching staff should be requested to provide on a completely voluntary and anonymous basis a specimen of their saliva. Testing of this kind is a well-accepted 'best practice' in all AIW programmes and has been successfully

undertaken in many countries. Saliva testing for HIV is more than 95% accurate. Each teacher would simply be asked to spit into a container. The only information on each container would be the sex, age, and type of teacher (primary, secondary) and education district. There is no way, therefore, that individual teachers can be identified. The testing would be done by an independent organisation with recognised expertise in conducting tests of this kind.

To assess risk factors, a Knowledge, Attitudes and Practice (KAP) survey should also be conducted. This would allow a proper assessment to be made of the risk profile of teaching staff and provide the proper baseline for monitoring behavioural change over time. Again, this survey should be contracted out to individuals with recognised expertise in undertaking KAP surveys of this kind.

9.1.3 Counselling and support groups

The MoEST should introduce professional counselling services for teachers and support staff. When asked what they thought should be done to counter the negative impacts of HIV/AIDS epidemic, 14% of the teachers interviewed thought some counselling services could be provided by the trained guidance and counselling teacher. However, given the sensitivity of the issues involved, a group of professional AIDS counsellors should be employed by MoEST who would provide individual and group counselling to teachers and other support staff and also monitor the implementation of AIWP. Each counsellor would be responsible for a number of schools i.e. a zone at primary level and cluster at secondary level. They would make regular visits to schools in order to provide counselling to staff on an individual and group basis and also assist school managers to design and implement school AIDS action plans.

Teacher support groups should also be encouraged at the school level. TUM should take the lead in establishing a national 'Teachers against AIDS' organisation to raise awareness. As we have seen, social welfare committees already exist in most schools, but support groups are also needed for teachers, both those living with AIDS and those who are not. The mandate of social welfare committees could be expanded to include anti-AIDS activities using peer educators or invited guest speakers. NGOs currently supporting student prevention programmes in schools such as the AIDS TOTO club could also extend their services to teachers.

9.1.4 Testing and disclosure

*"MOEST should introduce HIV testing and provide support for those infected" (*Teacher FGD).

The MoEST needs to have a clear policy to encourage voluntary HIV testing among its teachers and support staff. Such testing should always be accompanied by professional pre- and post-test counselling. Experience elsewhere (in particular in Uganda) has clearly demonstrated that getting individuals to establish their HIV status is probably the single most effective way of reducing high risk sexual behaviour and is, therefore, an essential component of any prevention strategy.

Given that there are relatively few testing centres, most of which are located in urban areas, MoEST should establish its own testing programme in collaboration with existing

organisations offering full testing and counselling services. Arrangements for mobile testing clinics could be made with these organisations to serve rural areas where many teachers are working. All the accepted best practices for HIV testing should be observed, in particular total confidentiality of test results.

Effective medical support (including the provision of anti-retroviral drugs) provides a strong incentive for teachers to establish their HIV status. This would be expensive and require good medical facilities so there might be a problem of providing such treatment to those in rural areas.

9.1.5 Morbidity and absenteeism

Given the rising levels of AIDS related illnesses, (particularly long term illnesses), the MoEST needs to review its present policies on sick leave and also deal with the problem of escalating absenteeism rates. As was noted earlier, very few teachers are taking long-term sick leave but choose to continue working even when they are too sick to teach properly. Furthermore, teacher absenteeism has increased primarily as a result of attending funerals of either teacher relatives or in the neighbourhood and though this kind of absence is only for a short period it is nonetheless very disruptive.

New sick regulations must carefully balance both individual and institutional needs. While sick teaching staff must not be discriminated against in any way, the MoEST has the duty to take all necessary steps in order to prevent any serious deterioration in teaching and learning that may occur as a result of much high levels of morbidity. A number of interventions need, therefore, to be seriously considered:

- It is essential that all managers and staff are aware of the sick leave regulations. During the survey it was evident that some education managers were not fully conversant with the MPSR provisions for sick leave. A clear explanation of the regulations could be included in the proposed HIV/AIDS Handbook for Teachers and be an important part of the overall education programme for staff.
- Teachers in the FGDs suggested that the retirement age should be reduced in order to reflect the reduced life expectancy and also to process pension and gratuities of those who are ill before they die. We recommend that the retirement age could remain unchanged, but teachers who are too sick to work should be allowed to retire early with full benefits.
- The results of the school survey indicate that absenteeism whether it is short or long term seriously disrupts teaching and learning in most schools. MoEST should, therefore, establish a new cadre of qualified 'supply teachers' who can be quickly deployed to all schools, which require additional teaching support. These temporary teachers might have a lower qualifications and be drawn from the local area. Head teachers should closely monitor teachers who have long-term illnesses and request for teaching cover as soon as a teacher is too ill to teach on a full- or part-time basis.
- Schools, school committees and PTAs should do all they can to ensure continuity of teaching and learning in the face of increasing teacher absenteeism. More generally, there may be a need for greater flexibility in the way schools are staffed. Schools could, for example, be allowed to employ temporary teachers, teaching assistants, and voluntary teachers when necessary. Retired teachers are also a potentially key resource.
- Disruptions caused by funerals should be minimised as much as possible. While teachers should be allowed without any hindrance to attend funerals of family members, there should be some restrictions placed for non-family members. This will be difficult to

enforce, but it could be an issue that may be taken up in the education programmes for teachers and at staff meetings on HIV/AIDS issues that have been proposed in this study. Schools should be encouraged to consult with the community leaders and school committees to work out modalities for school's attendance at funerals in the community.

- Providing teacher cover at secondary level is more difficult because of subject specialisation. Secondary teacher graduates from Chancellor College have only one major and one minor teaching subject. One way around this is to ensure that secondary school teachers are trained to teach a wider range of subjects than they do at present. At the very least, teachers should have two major and one minor teaching subject.

9.1.6 Medical aid and anti-retroviral drug therapies

Many teachers at the survey schools felt that 'the Ministry of Education should create a medical scheme for its staff so that they are assured of assistance upon falling ill'. When asked what personnel policies should be introduced to counter the impact of HIV/AIDS, one-third of teachers interviewed proposed the creation of a medical scheme for teachers. However, such a scheme needs to be carefully formulated in order to benefit the majority of teachers in urban as well as rural areas if it is not to prove costly and wasteful. The need for a special fund that could be used to meet both medical expenses and funeral costs was also frequently mentioned.

In addition to providing reliable and effective medical support to teachers, the Government should make more effort to find alternative ways of making cheap and affordable anti-retroviral drugs available throughout the country, as has been done in other Sub-Saharan African countries such as Uganda. The present arrangements for procuring cheaper drugs have not managed to make these drugs widely available, because the cost is still beyond the means of most Malawians. If it were possible, the provision of anti-retroviral therapies could be the most effective strategy to reverse the increasing death rate amongst primary school teachers. The provision of ARTs should be part of a comprehensive medical aid scheme.

9.1.7 Death and funeral benefits

The Government should review death and funeral benefits in view of the escalating costs. Coffins and transport should only be provided for government employees. A special revolving fund should also be established to assist employees to meet funeral costs of their spouses, children and other relations. Alternatively, MoEST in collaboration with TUM could explore the possibility of encouraging teachers to take up an insurance policy cover for funeral costs.

MoEST should also carry out an assessment of the financial implications of increased mortality among staff. Either a special fund should be developed to cover funeral expenses of MoEST employees to be administered through the DEOs or these costs could be covered through an insurance system.

9.1.8 Deployment and transfer

HIV/AIDS may exacerbate the existing rural-urban disparities in teacher allocation. It is possible that, as the epidemic worsens, more teachers will want to be transferred to schools that are near hospitals or in their home areas so that they can care for sick family members. Though, indications from the survey data suggest that AIDS- related transfers are minimal at present, a proper information system needs to be developed which can monitor accurately all

staff deployments and transfers and assess whether deployment polices are contributing to the spread of the epidemic.

Deployment and transfer policies and practices should be urgently reviewed in order to minimise the risk of HIV infection among education personnel. In particular an assessment should be made to find out the extent of spouse separation. Teachers in higher-risk groups should be targeted for intensive education and support.

Current deployment practices are mainly responsible for escalating funeral expenditures. Those teachers who are sick and are requesting to be transferred to their home areas should be granted the opportunity to do so. In so doing it will reduce direct or indirect costs of funeral arrangements. A window of opportunity exists in the current decentralisation programme in government, which will enable the DEOs to recruit their own teachers most of whom will hopefully be from within the district catchment area which could be the district itself or an administrative region.

9.1.9 Conditions of service and teacher morale

Conditions of service for teaching staff need to be urgently reviewed. If teachers are to play a major role in the prevention and mitigation of HIV/AIDS amongst students within their schools then there is an urgent need to address the low morale among teachers. As pointed out by Kelly (2000), schools have a great potential of becoming the focal point for HIV/AIDS education and preventive activities within communities because of the centrality of schools in most rural communities. In addition, the inclusion of HIV/AIDS and sexual reproduction topics in the curriculum has placed a great portion of the responsibility for changing students' behaviour on teachers. If morale and motivation of teachers remains poor then it is highly likely that HIV/AIDS preventive and mitigation programmes within school will remain ineffective.

Teachers both during the group discussions and interviews repeatedly mentioned that government should improve the conditions of service for teachers and increase salaries of teaching staff in order to properly motivate them.

9.1.10 Sexual misconduct

Some students felt strongly that measures should be taken to discipline teachers who have sexual relationships with female students. They felt that teachers should set a good example to students with regard to sexual behaviour. *'Teachers should be in the forefront of advising students against behaviours, which are likely to spread the disease'*. Students need better role models.

Urgent steps need to be taken, therefore, to ensure that existing sanctions and regulations concerning sexual relationships between teachers and students are consistently enforced. Every report of sexual harassment should be thoroughly investigated. AIDS counsellors, guidance and counselling teachers, school committees or PTA and representatives of the teaching staff should carry out these investigations and recommend appropriate action to the DEO. An intensive campaign should also be mounted in order to sensitise students, parents, school committees and the community in general on sexual harassment issues and equip them with information that will assist them to take decisive action to curb the practice in their schools. Teacher prevention education programmes should also address the issue of sexual harassment.

9.1.11 Staff development

MoEST has two major in-service training programmes (MIITEP and SSTEP), which seek to upgrade the very large numbers of untrained teachers in both primary and secondary schools teachers, through a combination of residential and school-based training. The teachers enrolled on these programmes are supposed to have a lighter teaching load, but this is not possible in all schools. The GAPS study found that temporary teachers have heavier working loads than trained teachers (Kadzamira & Chibwana 2000). At secondary schools, upgrading is constrained by subject specialisation, which makes it more difficult to find a replacement or relief teacher for the in-service trainees. HIV/AIDS may therefore make it that much more difficult to attaining the Ministry's upgrading targets. This once again highlights the importance of MoEST establishing realistic staffing norms that will enable those teachers who are upgrading to study effectively. Increased workloads and low morale could also adversely affect the extent to which teachers are able to study on the job.

9.2 TEACHER REQUIREMENT AND RECRUITMENT TARGETS

As a direct consequence of the AIDS epidemic, projected school enrolments in Malawi will be considerably lower than previously expected. Similarly, teacher mortality and morbidity will also be higher (although, as discussed earlier secondary school mortality rates appear to have peaked already). It is essential, therefore, that robust teacher requirements estimates are derived, which take full account of the multiple impacts of the epidemic.

We had intended to produce teacher requirement and recruitment projections as part of this study, but have not done so for two reasons. Firstly, it is necessary to know what HIV prevalence rates are for the different groups of teachers. As noted earlier, it is simply not acceptable to assume that all teachers have the same prevalence and mortality rates as the adult population in the corresponding age cohorts. The margin of error of projections that are based on this assumption are likely to be so large that they serve little practical value for MoEST policymakers and planners. Teachers should be first tested and then it will be possible to produce well-founded projections. And secondly, even if it is assumed that

prevalence profiles for teachers are the same as for adults as a whole, the necessary staffing and demographic data is still not available to make projections for the next 10-15 years.

The following discussion presents preliminary estimates of teacher requirements and recruitment targets on the basis of the projected student enrolments and crude estimates of likely AIDS- and non-AIDS related attrition.

9.2.1 Projected teacher attrition

The PIF assumes that total teacher attrition will remain at its current level of around 11% per annum for the next 15 years (MoEST 2000). On the basis of this projected level of attrition, the MoEST estimates that a total of around 5000 new teachers will need to be recruited each year in order to replace those that are lost from the system.

There are around 11,000 untrained primary school teachers. The current capacity of primary teacher training colleges in Malawi is 3000. However, the number of trained teachers will expand rapidly as the two main upgrading programmes become fully operational. The adequacy of current teacher training outputs has been assessed by MSSSP using two crude prevalence scenarios. Under the lower prevalence scenario, which assumes a prevalence rate of 13%, existing teacher-training capacity will be sufficient to meet projected demands for new teachers between 2001-2006. However, under the higher prevalence scenario of 40%, sizeable shortages of teachers will emerge.[24]

Given current mortality rates and trends among primary teachers and current and projected levels of HIV prevalence in the adult population as a whole, it is likely that AID-related mortality rates for primary school teachers will increase from 2% in 2000 to 3-4% in 2010. This is 27-36% of projected total attrition. While, the loss of so many teachers is clearly an enormous tragedy, the schooling system should be able to replace these teachers without a massive expansion in current training capacity. Assuming that the PIF enrolment targets can be met with no increase in current repetition and dropout rates and the overall student: teacher ratio is 60:1, then a total of 58,000 primary school teachers will be required in 2010 (see below), 12,000 more than are currently employed. Between 1700-2300 teachers will need to be hired in order to replace teachers who die and another 4500 for other types of attrition. The recruitment target combines the net growth in the overall numbers of teachers required with replacement as a result of AIDS and non-AIDS related attrition. In 2010, a total of 7400-8000 will need, therefore, to be recruited. Under the second enrolment scenario, where it is assumed that dropouts will double as a result of the AIDS epidemic, enrolments will be considerably smaller and thus fewer teachers will be required. Under this enrolment, the recruitment target for 2010 falls to 5100-5500 (see Table 9.1).

[24] This modelling exercise does not however take account of projected lower enrolments.

9.3 INFORMATION REQUIREMENTS

A comprehensive, up to date management information system is essential in order to monitor and evaluate the impact of HIV/AIDS on the schooling system. As has been pointed out earlier, the existing information systems and databases are seriously inadequate. Essential data is not being systematically collected at the school and district levels, which would enable an assessment of trends in key areas. This includes student and teacher absenteeism, orphans and other children directly affected by AIDS, and dropout.

Table 9.1: Primary teacher requirement projections and recruitment targets, 2005 and 2010

	PIF TARGET		HIGHER DROPUT	
	2005	**2010**	**2005**	**2010**
Total enrolments ('000)	3120	3470	2730	2810
Total teachers required	52000	57800	45500	46800
AIDS-related attrition				
3% per annum	1600	1700	1400	1400
4% per annum	2100	2300	1800	1900
Non-AIDS related attrition (8%)	4200	4600	3600	3700
RECRUITMENT TARGETS				
Recruitment for teacher growth	1400	1100	100	100
Recruitment for teacher replacement				
AIDS-related 3%	5800	6300	5000	5100
AIDS-related 4%	6300	6900	5400	5600
TOTAL RECRUITMENT				
AIDS-related 3%	7200	7400	5100	5200
AIDS-related 4%	7700	8000	5500	5700

Though major strides in information management have been made in recent years (in particular the establishment of EMIS), it is apparent that schools have not been touched by these recent advances. However, the success of an EMIS lies in the quality of data that comes from schools. There is urgent need for schools to develop their own information management systems and head teachers should receive training in information management.

There are three key data sets available at MoEST that could provide the information necessary for analysing HIV/AIDS impact on the sector. These are the computerised payroll, personnel, pension integrated (PPPI) database, education management information systems (EMIS) and human resource section database. However, there are some existing deficiencies in each of these data sets. For example, the EMIS database only includes the primary sub-sector. Efforts to develop an EMIS for secondary education have so far not been successful. Such data includes the number of teachers by age, sex and qualification, which are all key indicators that are required to assess the impact of HIV/AIDS on the teaching staff. The primary education EMIS does not collect some key variables on teachers such as age, though there are plans now to include mortality data. Some of the key variables for an AIDS impact analysis are not readily available from the PPPI such as sex, level of education, marital status etc.

The following information is essential in order to plan and manage effectively the impact of the AIDS epidemic on the education sector in Malawi.

- ❒ Overall number of teachers in primary and secondary schools by age, sex, martial status, level teaching, years of service, professional grade. For secondary teachers it is essential to obtain information on the type of school i.e. CDSS or conventional.

- ❒ Overall attrition from different sources such as death, retirement, resignation, transfers, temporary absences (e.g. maternity leave), absconding and dismissals. All these should be collected by sex, age, marital status, qualifications, level teaching, years of service, professional grade.

- ❒ Projections of AIDS deaths in the 20-64 population over a 10 year period.

- ❒ Projected AIDS cases in the adult population (20-64).

- ❒ Number of sick teachers.

- ❒ Annual projections of sick teachers and average number of days they are off sick.

- ❒ Projected number of teachers who will have AIDS.

CHAPTER 10

CONCLUSIONS

This report has assessed the actual and potential impacts of HIV/AIDS on primary and secondary education in Malawi. It is clear that the AIDS epidemic threatens the Education for All (EFA) and equity goals of the MoEST. In the context of an education system already struggling to deliver a minimal standard of education, teacher death, high teacher absenteeism, and rising expenditures on AIDS related deaths and funerals, are serious causes for concern. Projected school enrolment will also be significantly lower than expected (mainly for primary school). Detailed predictions are urgently needed in order to assess accurately the longer-term impacts of HIV/AIDS on the education system. Only when this is done can firm conclusions be reached with regard to student demand and teacher provision.

Although the national adult HIV prevalence rate in Malawi is already approaching 20%, it will continue to rise during the next decade. Decisive interventions need to be made as part of an overall strategic plan in order to prevent any further erosion of the education system and to promote more effectively HIV prevention in schools. The findings also highlight the importance of promoting better coordination between different agencies involved with countering HIV/AIDS. GoM, needs, therefore to promote more actively its declared policy of a multi-sectoral response to the epidemic.

10.1 Further Research

This study is the first of its kind in Malawi. Due to limitations of time and resources, it was only possible to undertake a small school survey and other areas of education were not included. More detailed research needs to be done in a number of key areas, notably:

- Community based AIDS strategies that involve links between community and school.
- Sexual behaviour of youth.
- Sexual harassment.
- Peer education and drama techniques to promote prevention messages and more open discussion of HIV/AIDS issues.
- The educational needs of out-of-school youth.
- The impact of teacher deployment on vulnerability to HIV.
- Better demographic projections can be made once the MoEST has improved its data collection methods at the school, district and national level.
- A risk assessment of teaching staff in primary and secondary schools.
- The feasibility of introducing a medical aid scheme for all civil servants including teachers.
- The HIV/AIDS component in MIITEP.

10.2 Organisation and Management

As we have seen in Chapter 2, structures have already been put in place by the MoEST in order to develop a strategic plan for HIV/AIDS in education. Given the fact that the epidemic has yet to reach its peak, HIV/AIDS should be a priority for the MoEST for the next decade. Indeed, a countrywide mobilisation is required to confront the epidemic.

The following general lessons concerning organisation and management of HIV/AIDS strategies have been learned from the other country studies:

- The focus for AIDS activities should be the Ministry as a whole and not one department.
- Any AIDS management team should have a dedicated staff who are committed full time to the fight against AIDS (both mitigation and prevention). Too often individuals appointed as AIDS focal points are over-burdened with other commitments.
- Too much responsibility should not rest with one individual.
- Outside expertise needs to be involved (from the private sector and NGOs) in the development and implementation of a strategic AIDS plan for education, since ministries lack human resources in this area.
- High level commitment of senior MoEST personnel is needed.

10.3 Information requirements

It is crucial to generate a broad data-base in order to plan and design HIV/AIDS policies. The current EMIS includes questions on the number of orphans by gender and standard. However, an assessment of the impact of HIV/AIDS on education requires more detailed data. MoEST should collect the following information for both primary and secondary schools:

Students
Type of orphan in schools – paternal, maternal or double and living arrangements of those students. If possible this information on living situations should be collected for ALL students in order to identify children at risk and in need of support/counselling. Attendance data (by parental status) should also be routinely collected.

Teachers (both primary and secondary)

- Marital status of teachers.
- Date of posting to the school.
- For risk assessments, consistent data is needed on deployment and transfers.
- Attendance (reasons for absence).
- Teacher deaths and attrition should be recorded at school level.
- PPPI should provide data on overall attrition (deaths and other reasons). This data should be made more amenable to manipulation by a wider range of software
- PPPI should develop a data base that can be used for both renumeration and also Human Resource Management.
- PPPI data base should include variables such as type of school, gender, date of birth.

District level
Further discussions with interested parties (teachers, school management, students, PEAS and DEOs) are required in order to develop a district level strategy.

District Education Offices should:

- Monitor causes of teacher turnover and mobility.
- Collect data on orphans and other children affected by AIDS from the schools, (numbers, absenteeism, drop outs).
- Enforce the regulations concerning sexual harassment of students by male teachers.
- Integrate HIV/AIDS into the workings of district level management.

- Encourage greater multi-sectoral coordination (i.e. between education and health) regarding AIDS prevention and mitigation.
- Cooperate with NGOs and CBOs in their district. (The last two could be linked up as part of a district AIDS plan (re:education).

New initiatives should be channelled through existing leadership structures i.e. District AIDS Coordinating Committees and they should be developed after full consultation with groups in the community.

LIST OF PEOPLE INTERVIEWED

Ministry of Education, Science and Technology

Mr. Charles Gunsaru	Director, Secondary & Higher Education
Mrs. Maria Nkaonja	Director, Guidance, Counselling & Youth Development Centre for Africa
Mr. Prince Moyo	Primary Teacher Education Section
Mr. Benson Matola	Director, Education Methods and Advisory
Mr. Briar Khonje	Director, Basic Education
Mrs. I. Salamba	Assistant Director, Basic Education
DEO, Zomba Urban	District Education Office, Zomba Urban
Mr. W. Mazulu	Assistant DEO - Zomba Rural
Mrs. L.V. Magaleta	Division Manager, South East Division – Zomba

Other Ministries and Government Departments

Mrs. Efinita Banda	Ministry of Gender Youth & Community Services
Mr. Mhango	Ministry of Gender Youth & Community Services
Mr. Manjolo	Ministry of Gender Youth & Community Services
Mr. Kamiyoke	Ministry of Labour
Mr. Nyasaia	Department of Human Resource Management and Development
Mr. B. Banda	Department of Human Resource Management and Development
Dr. Ngombe	Principal Secretary, National Economic Council
Mr. J. B. Nkhoma	Ministry of Health
Dr. Wilfred Nkhoma	AIDS Secretariat
Dr. Owen Kaluwa	National AIDS Control Programme (NACP)

Other organisations

Mr. John Bisika	World Bank Secondary School Project Coordinator MIE
Mr. John Maganga	Senior Curriculum Specialist and Coordinator Life Skills Project, MIE
Mr. Masautso C. Yonamu	Teachers Union of Malawi

Donor agencies

Dr. Sarah. Wright	USAID
Ms. Olivia M. Liwewe	Gender Advisor, CIDA
Ms. Barbara Gill	Sector Co-ordinator, CIDA
Mr. Charles Nuttall	BRITISH COUNCIL
Mr. Keith Gristock	DFID Education Sector Adviser
Mr. Mike Keirnan	DANIDA
Ms. Saeri Muto	JICA- Education Adviser
Ms. Zara M. Nuru	Resident Representative, UNDP
Mr. Kabuka M. Banda	Head Water & Environmental Sanitation, UNICEF
Ms. Pamela Twea	UNICEF
Ms. Angela Trenton-Mbonde	UNAIDS
Mr. J. Smith	WORLD BANK

Non-Governmental Organisations (NGOs)

Mrs. Margaret Ali	Executive Director Save the Children of Malawi
Mr. Simeon Mawindo	Executive Director, CRECCOM
Mr. Matiki	Youth Arms Organisation
Mr. Chris Mwase	Project Manager Samaritans

Mr. Anderson Kamwendo	Executive Director, CCAP Blantyre Synod Projects Office
Mrs. Doreen Maloya	CCAP Blantyre Synod, Projects Office
Ms. T. Harawa	Yamikani House
Rev. Dr. Khulumuke	Executive Director, Unity Association for the Aged and Orphans
Mr. Kalima	Assistant Programme Manager, Hope Humana, People to People Projects
Mrs. Seodi White	Board Member, German Education Assistance in Malawi for Orphaned Children (GEOMAC)
Mrs. Mbiri	Executive Director, Peace in God Organisation (PIGO)
Mr. John Phiri	Executive Director, Fight AIDS Malawi (FAMA)
Mr. Hewton Samuel	Executive Director, Adventist Development Relief Agency (ADRA)
Mr. Kamanga	ADRA
Mr. James D. Chapita	Chairperson, Malawi Parents Schools Association
MACRO (Lilongwe)	Counsellors
Mr. Henry Banda	SOS Village, Lilongwe
Mr. Steve Bowler	SOS Village, Lilongwe
Sister Lilia	Blantyre – orphan pre-school playgroups
Ms. Sara Davis	Volunteer counsellor, Samaritans

Community Based Organisations (CBOs)

Committee members	Chiyanjano Orphan Care Group, Zomba
Committee members	Songani Community Based Orphan Care Group, Zomba

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APPENDIX I

PROCEEDINGS OF DISSEMINATION WORKSHOPS

Lilongwe Dissemination Workshop

The first part of the workshop involved a presentation by Esme Kadzamira and Nicola Swainson of the main research findings of the report on 'The Impact of HIV/AIDS on primary and secondary education in Malawi.' After the presentation, the rest of the morning was spent discussing issues arising from the research findings and recommendations of the report.

There was some concern expressed about the scope of the study as it only covered eleven schools, all in the Southern region. Our view is that what the study lacked in coverage it made up for by its depth of analysis. For this reason we do not believe that radically different findings would emerge from a larger study conducted in different parts of the country.

Life Skills
A participant from MIE explained the background to the Life Skills programme, soon to be introduced in all primary and secondary schools in Malawi. (At present it is only taught in Standard 4 of primary school). However, despite being designed in 1997 by the MOE and UNICEF, due to printing problems and the time it has taken to develop materials for all grades, it will not be introduced into the schools until 2002. The intention is also to get the Life Skills approach integrated into teacher training programmes. At the moment only teachers in Standard 4 receive inservice training using the new Life Skills materials.

School feeding programmes

UNFPA have conducted a pilot school feeding programme in which they tried to target girls. The experience gained from this pilot suggests that feeding programmes need to be carefully designed. In some cases it can be disruptive to the education process. However if the meals were provided at the end of the school day (between 12.45 and 1 pm) this is less likely to apply. A discussion ensued about the means of identifying ' needy children' in the community. A participant from Save the Children mentioned that in one of their projects they asked the community to compile orphan registers and concluded that the community are able to identify accurately the children most in need.

Sexual behaviour and the AIDS curriculum
A question was asked as to whether any SRH or AIDS education programmes delivered through the curriculum had been 'successful' in terms of promoting behaviour change in Sub-Saharan Africa. Nobody was able to point to any positive examples apart from a few small-scale projects. However, an important point was made that the best form of protection against HIV/AIDS was to ensure that children remain in the education system. 'Good ' HIV/AIDS materials are likely to be ineffective without thorough teacher training inputs. In this respect, it was stressed that the training of teachers in SRH and AIDS should involve detailed and clear lesson plans, which would then be repeated regularly. AIDS subjects need to be examinable or the teachers and students will not take them seriously.

Discussion concerning the multiple dimensions of impact of HIV/AIDS on education and schools - and how (in the case of teachers particularly) the perceptions can differ from the questionnaire responses.

General Issues:

Teachers

- The TUM representative suggested that the recommendations in our report needed to be prioritised. Also, instead of recommending the use of supply teachers to cover for those absent, he was of the opinion that the overall supply of teachers should be improved.
- High level political commitment is needed since the government is totally reliant on teachers to implement any new AIDS strategies.
- All key recommendations should address the issue of teacher motivation.
- The PPI data system needs to be reformed before any progress can be made in relation to teacher's salaries.

Prevention: There was a strong feeling that 'Teachers against AIDS' Clubs should be established and voluntary testing and counselling should be provided.
Absenteeism: The recommendation that teachers should only attend the funerals of relatives in order to cut down absenteeism provoked a lively discussion. A key issue is the meaning and adaptation of culture to changing circumstances. Many of the participants admitted that indeed cultural practices had to change in the context of AIDS. One example was that teachers should be buried where they die rather than returned to their home villages, a change which would help to conserve DEO resources. Other suggestions made were that teachers should be given access to cash advances which could be used for death-related expenses. In terms of death-related issues, transport is always a problem, particularly in rural areas. The general view was that cultural practices would change over time in response to the AIDS crisis.

Regulations: One participant suggested that the public sector adopt what is already practised: a set number of leave days. Any leave taken beyond the limit must be unpaid. This is now standard practice in the private sector and international organisations.

There was some agreement with the report's recommendation that teachers should be encouraged to take long-term sick leave – because, amongst other reasons, if they remained in the classroom while sick, they would spread illness to others.

Advocacy:
Participants asked what would be done with the report… 'We need answers now'. The general opinion was that the impact of HIV/AIDS on the education sector was such a serious problem that these research findings and recommendations should be taken to the highest levels. It was also suggested that better use is made of groups in civil society to put pressure on the government to take action.

Blantyre Dissemination Workshop

The second dissemination workshop was held at Blantyre Polytechnic. Research Findings were presented and discussed in the morning. In the afternoon, separate working groups discussed the four main areas covered by the report: student prevention, students affected by HIV/AIDS, teachers, and organisation and management issues

STUDENT PREVENTION

1. Curriculum

- Integrate HIV/AIDS education in all subjects including maths (e.g. calculate HIV statistics) and history (e.g. examine the work of WHO and UNAIDS).
- Orientation of all primary and secondary teachers in HIV/AIDS education through a carefully planned INSET programme. Education Methods Advisors should train head teachers who would then in turn train teachers.
- NGOs should develop a common strategy for HIV/AIDS education in order to have uniformity in the messages that are currently been imparted to pupils. It was observed that, at present, NGOs involved in prevention programmes are using different and sometimes conflicting strategies thereby confusing the youth. Some NGO messages are in conflict with what is being taught in the curriculum. It was, therefore, suggested that NGOs should come together in order to harmonise their strategies and ensure that the same messages are being imparted to the youth. It was further noted that there is no contradiction between church messages (abstinence) and NGO messages (regarding 'safe sex') but rather the confusion comes because of the conflicting messages given by NGOs themselves.
- MOEST should monitor the teaching of HIV/AIDS education. In particular, MOEST should have a right to vet materials and messages that are being imparted to students in schools by NGOs and other organisations. It was observed that lack of coordination amongst various stakeholders providing HIV prevention programmes has allowed a situation whereby the education and information is provided indiscreetly.
- MOEST should involve the AIDS secretariat in developing and monitoring of the impact of HIV/AIDS education in schools.
- Revitalise the AIDS TOTO clubs involving youth, both in and out of school and motivate AIDS TOTO teacher patrons/matrons to actively participate in the activities of AIDS TOTO clubs. The Ministry should offer incentives to encourage the participation of teachers (this went against our recommendation which was to enhance the role of peer educators!)
- Enhance peer education.

2. Guidance and Counselling

- All teachers should be trained in guidance and counselling.
- Provide incentives for teachers involved in guidance and counselling.
- Involve trained school committee members in counselling.
- Use the existing trained guidance and counselling personnel in HIV/AIDS to counsel the youth.

- Involve the specially trained health personnel in HIV/AIDS (e.g. MACRO personnel) to provide counselling for students in schools.

3. Condom Distribution

- Teachers should not distribute condoms to students in school, but only offer advice as to where to get condoms. While school-based programmes on prevention should focus on abstinence, they should still provide students with information about where they can get condoms.

STUDENT MITIGATION

- Need for careful targeting of orphans and needy children.
- Communities should be trained to cope with the impact of HIV/AIDS including the orphan crisis.
- Skills training should be provided for out-of-school youth
- The school curriculum should be less academic, have a greater technical orientation and help to develop skills for self-reliance.
- District Aids Coordinating Committees should coordinate and link up with existing leadership structures.
- Pupils should be sensitised so as to become aware of the special needs of orphans and other affected children.
- Schools should provide at least one nutritious meal to all children in rural areas since it is impossible in the context of general poverty to target only orphans.

TEACHER PREVENTION AND MITIGATION

1. Absenteeism

- Current provisions for compassionate leave for civil servants should be adhered to and enforced. Penalties should be imposed on teachers who absent themselves from schools without authority and outside of the regulations.
- Head teachers should be encouraged to keep records of all teacher absentees and the reason for each absence. In particular, records on funeral attendance should specify the relationship of the deceased to the teacher in order to keep attendance of funerals of those who are not related, to the minimum. (Although it was recognised that the social implications of this would be great).
- Need to revitalise the Malawi Public Service Regulations in light of the HIV/AIDS epidemic.

2. Sexual Misconduct

- Teachers who have sexual relationships with pupils should be instantly dismissed so long as there is enough evidence and thorough investigations have been carried out.
- Prompt action should be taken against teacher's sexual misconduct soon after investigations have been completed.
- In this regard DEOs should be mandated to take disciplinary measures against teachers including dismissals. Lack of action has been partly attributed to the long bureaucratic procedures for dealing with such cases, especially since all disciplinary cases dealing with teachers are processed at ministry headquarters.
- Establish a Teacher's Council that is empowered to register and deregister teachers, (as is the case with other professions such as nursing). The council would develop a *code of conduct* for teachers to deal with cases of sexual misconduct. The newly formed council should advocate delinking of teachers from the civil service and this should be initiated either by the teachers themselves or through TUM.

3. Teaching Cover

- Schools should be encouraged to make use of community volunteers particularly in non-teaching activities
- MOEST should employ/ create a cadre of temporary teachers on contract basis who can be called upon to provide cover when needed but these teachers need some training before they can be deployed in the schools. Some reluctance to recommend use of untrained volunteers as teachers - rather try and attract retired teachers for that task.
- Where possible encourage the use of multi-grade teaching to help cover for absent teachers and ensure that current and future INSET and PRESET should involve training in multi-grade techniques.

4. Conditions of Service and Benefits

- Stricter regulations are needed regarding the use of MoEST vehicles which are used by teachers and other civil servants to transport the bodies of distant relatives.
- A system of loans for teachers should be introduced which would cover death related expenses.
- Improve the conditions of service for teachers.
- Government should procure cheaper AIDS drugs for teachers in order to help those infected.

5. HIV/AIDS Education and Training

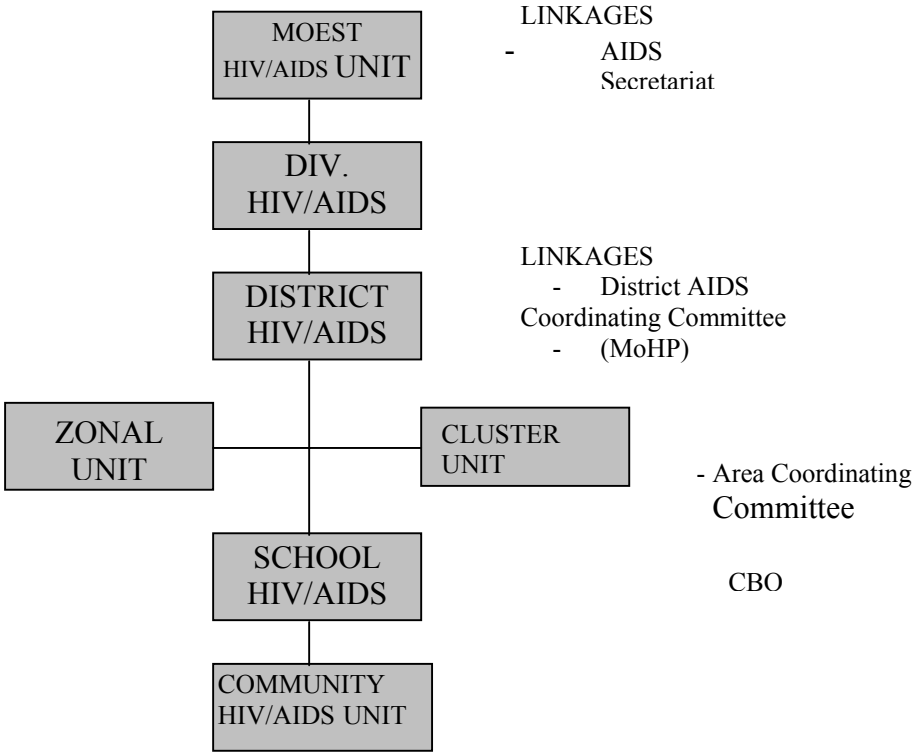
- All the recommendation on HIV/AIDS education suggested in the report should be adopted and implemented.
- Provide training for PEAs and head teachers in counselling skills

ORGANISATIONAL STRUCTURES AND LINKAGES

- In terms of organisation and management, there is need to create a HIV/AIDS unit with a full time HIV/AIDS coordinator within the Ministry. There is also need for structures at division and district level to coordinate HIV/AIDS activities.

- Primary and secondary schools should have a person specifically dealing with HIV/AIDS issues i.e. Guidance and counselling and prevention programmes.
- Linkages between MoEST and other institutions: at the national level, MOEST should link up with the NACP. At the district level DEOs should link up with the District AIDS Coordinating Committees which are also multisectoral. At the area level or school/zonal level there is need to link up with the area AIDS committees and the CBOs.
- HIV/AIDS activities should have a separate budget line.

Suggested Structures and Linkages



LIST OF PARTICIPANTS TO THE HIV/AIDS DISSEMINATION WORKSHOPD HELD IN LILONGWE AND BLANTYRE ON 2 MAY AND 4 MAY 2001.

BLANTYRE PARTICIPANTS

1.	Mr A S Mhlanga	Malawi Institute of Education
2.	Mrs S Ndaferankhande	Chichiri Full Primary School
3.	Mrs D Malemia	Chichiri Full Primary School
4.	Mrs J S B Juma	DEO Blantyre Urban
5.	Mr J D Chapita	Malawi Parents Schools Association
6.	Mr M Nkhokwe	MOEST- South West Education Division
7.	Mr. W Mazulu	DEO Zomba Rural
8.	Mrs L V Magreta	MOEST- South East Education Division
9.	Mrs G L Mabedi	Makata Full Primary School
10.	Mr N A C Mhango	Domasi College of Education
11.	Mr M Thyangathyanga	Makata Full Primary School
12.	Mr A C H M wandama	Makata Full Primary School
13.	Mr A W B Chikadza	Makata Full Primary School
14.	MR R Mandere	World Vision International
15.	Mrs M Fabiano	Forum for African Women Educationalists Malawi
16.	Mr C Dzimadzi	Centre for Educational Research and Training
17.	Mr G N Chimangire	Blantyre Secondary School
18.	Mr R W Menyere	Blantyre Secondary School
19.	Mr L C C Nyirenda	Peace in God Organisation (PIGO)
20.	Mr F S Kerekesa	DEO Chiradzulu
21.	Mr G Salapa	MOEST -Shire Highlands Education Division
22.	Mr L F Chakhota	Blantyre Secondary School
23.	Mr F J Phiri	DEO Blantyre Urban
24.	Mr K Msowoya	MACRO- Blantyre
25.	Mr Z H W Kaunda	Creative Centre for Community Mobilisation
26.	Mr J B Kamulete	Njamba Secondary School
27.	Mr. D Kunje	Centre for Educational Research and Training
28.	Dr J Chimombo	Centre for Educational Research and Training

LILONGWE

1.	Mrs Annie Ntambo	GTZ- Basic Education
2.	Mrs. Patricia Saukila	World Food Programme
3.	Mr. A.S. Mhlanga	Malawi Institute of Education
4.	Mr. G.Y. Chamdimba	DEO Lilongwe (urban)
5.	Mr Patrick Nayupe	SCF (UK) Salima
6.	Dr. Bernard Gatawa	UNICEF
7.	Mrs. M.I. Nkaonja	Guidance, Counselling & Youth Development Centre for Africa
8.	Mr. Demis Kunje	Centre for Educational Research and Training
9.	Mrs Mary Ngwale	Kawale Full Primary School
10.	Mrs Jovita Chisati	Bwaila Secondary School
11.	Mr Ramsey Sosola	MOEST, Planning Unit
12.	Mr. David Gondwe	Bwaila Secondary School

13.	Mr Jackson Sambila	Bwaila Secondary School
14.	Mr M.T. Katswiri	DEO Lilongwe Rural East
15.	Mr Prince Moyo	MOEST- Basic Education Department
16.	Ms Lindsay Howard	E.S.S.P/ DFID
17.	Mr Keith Gristock	DFID
18.	Ms. Georgina Rawle	MOEST- Planning Unit
19.	Ms. Tracy Dolan	SCF (US)
20.	Mr M.C. Yonamu	TUM
21.	Mr Joe Q Kamvautope	NACP
22.	Mr Ken Longden	MOEST Department of Teacher Education and Development
23.	Mr Thomas Kanyemba	Kawale LEA Primary School
24.	Mr Stenala Gazani	Kawale LEA Primary School
25.	Mr Obed Ngwira	C/o H. Konyani
26.	Mr. Titus Chalusa	MOEST- Planning unit
27.	Mr. Solomon Tesfamariam	Royal Danish Embassy
28.	Dr. Joseph Chimombo	Centre for Educational Research and Training