

Final Report

Impact of HIV/AIDS on Education and Teachers in Uganda

Submitted to:

Uganda National Teachers' Union (UNATU)

By

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Acronyms

ACP	AIDS Control Program
AIDS	Acquired Immune Deficiency Syndrome
AIC	AIDS Information Centre
ARVs	Anti-retro-viral Drugs
CEFORD	Community Empowerment For Rural Development
CAO	Chief Administrative Officer
CBO	Community Based Organizations
CHAI	Community HIV/AIDS Initiatives
DEO	District Education Officer
DOL	Department of Labour-USAID
EDC	Education Development Centre
EFA	Education For All
EFAIDS	Education For All AIDS Program
EI	Education International
ESWAPI	Education Sector Workplace AIDS Policy Implementation
FGDs	Focus Group Discussions
FM	Frequency Modular
GDP	Growth Domestic Product
HCT	HIV Counseling and Testing
HIV	Human Immune Virus
IGA	Income Generating Activity
IMR	Infant Mortality Rate
JCRC	Joint Clinical Research Centre
KII	Key Informant Interviews
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoWL E	Ministry of Water Lands & Environment
MMR	Maternal Mortality Rate
NGO	Non Government Organization
PLWHA	People Living With HIV/AIDS
PTC	Primary Teachers' College
PIASCY	Presidential Initiative on AIDS in School Children and Youths
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
SPSS	Statistical Package for Social Scientists
STD	Sexually Transmitted Diseases
TAAG	Teachers' Anti-AIDS Group
TASO	The AIDS Support Organization
TFR	Total Fertility Rate
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic Health Survey
UHPC	Uganda Housing and Population Census
UNATU	Uganda National Teachers' Union
UNAIDS	United Nations Against AIDS
UNESCO	United Nations Education Scientific Cultural Organization
USAID	United States Agency for International Development
UPHOLD	Uganda Program for Human and Holistic Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

This report presents results of a baseline survey commissioned by Uganda National Teachers Union (UNATU) to gather baseline information that will guide the planning and implementation of the EFAIDS project. The study investigated the impact of HIV/AIDS on the education sector with particular focus on teachers. Both qualitative and quantitative data collection methods were employed. The survey covered a total sample of 240 teachers drawn from pre-primary, primary, secondary and core primary teachers' colleges in 8 districts sampled out of the four main regions of the country.

The survey found that awareness about HIV/AIDS among teachers was nearly universal. While 99.6% knew that sexual intercourse is the main channel of transmission, 88% reported abstinence from sex as one of the preventive measures against HIV/AIDS. Indeed in the focus group discussions and key informant interviews, HIV/AIDS was cited as one of the leading health problems afflicting teachers. The radio was the main source of information on HIV/AIDS reported by 83% of the teachers.

The majority (90%) of the teachers interviewed considered themselves to be at risk of contracting HIV. The reasons cited included: easy access to adolescent girls (32%); HIV/AIDS is a disease that anyone can acquire (26%); involvement in unprotected sex; (9%) and unfaithfulness to partners (9%).

Nearly all teachers interviewed (99%) had heard of drugs that can prolong the life of a person living with HIV/AIDS. Of those, (69%) knew about ARVS, 17% were aware of septrin prophylaxis and 8% reported traditional medicine.

Thirty eight percent of the teachers interviewed reported that their school had lost a teacher to HIV/AIDS within the last 5 years. Teachers in urban areas were said to be more vulnerable to the pandemic compared to those in the rural. Qualitative findings revealed that many teachers have suffered and died of ailments that were associated with HIV/AIDS. However no evidence could be adduced as most teachers do not disclose their sero-status to the school administrators.

92% of the teachers said that HIV/AIDS has affected them either directly or indirectly. The impact was said to be manifest in increased absenteeism (24%), time lost caring for the sick (23%), inefficiency in teaching (16%) and stigma and discrimination (14%). The same issues were pointed out in the FGDs and key informant interviews.

Teachers' coping mechanisms included involvement in HIV/AIDS sensitization (81%), seeking HIV/AIDS counseling and testing services (42%), joining psychosocial support groups (9%) and uptake of ARVs (6%). The coping mechanisms mentioned during focus group discussions and Key informant interviews include: disclosure of Sero-status, sharing workload; joining care and support organizations and groups; accessing IGAs and HIV/AIDS sensitization among others.

The challenges schools face in addressing HIV/AIDS included: limited information (42%), limited access to HIV/AIDS services (36%), poor pay (32%) and stigma and discrimination (31%).

The existing HIV/AIDS programs in schools mainly target learners. Teachers sought HIV/AIDS services from government, NGO and care and support organizations such as TASO. Provision of HIV/AIDS information was the most widely mentioned service offered by the schools reported by (54%) of the teachers.

65% of the teachers reported to have tested for HIV. Of those who had tested for HIV, 47% went to government health facilities and (15%) HIV/AIDS support organizations. A similar proportion (18%) reported to have taken the test in private clinics and NGO hospitals. 47% of the teachers who had not tested felt they are safe from HIV and saw no reason for taking the test.

99% of the teachers who tested for HIV received their results and 91% shared the results with other people. Of those who shared their results 83% shared with partners/spouses, 8% with friends and 6.5% with relatives.

Only 11% of the teachers had heard about the MoES HIV/AIDS workplace policy. 98% of the teachers agreed that an HIV positive teacher should be left to teach.

In regard to HIV/AIDS needs for teachers, 55% of the teachers reported the need for provision of HIV/AIDS information, 50% provision of HCT, 49% support and care services and 39% ARVs. Qualitative findings indicate income generating activities, job security, care and support services, improved remuneration and other conditions of service, emphasis on teachers' code of ethics, reduction of work load, implementation of the HIV/AIDS workplace policy, campaign against stigma and discrimination, sick leave, terminal benefits and gratuity.

In conclusion the survey results revealed that the negative impact of HIV/AIDS on the education sector and teachers in particular is enormous both at the individual and institutional levels. The survey therefore recommends a multi-pronged approach in addressing the negative impact of HIV/AIDS on the education sector. It points out the urgent need to operationalize the HIV/AIDS work place policy for teachers as a matter of priority.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

The health challenges posed by HIV/AIDS on the global development landscape remains the prime cause of the increasing prevention and control efforts at all levels to curb the negative consequences of the pandemic on the world population especially living in developing countries. Despite these efforts, by 2004, in Sub Saharan Africa alone, approximately 25 million people were infected with HIV/AIDS (UNAIDS, 2004). Although the most obvious effect of HIV/AIDS has been illness and death, in other ways it has significantly affected households, education, work places and economies along with other sections of society. The HIV/AIDS pandemic, it was noted does not simply claim human lives; it destroys families and erodes the social and economic fabric of communities (UNESCO, 2003). Without exception Uganda where the first cases of HIV/AIDS were reported in early 1980's in one rural fishing community in south western Uganda- Kasensero, it has afflicted all sectors of the economy and all population categories. This report covers the findings from a survey undertaken to assess the extent to which HIV/AIDS impacts on the on the education sector with specific focus on teachers in Uganda. It draws on primary data collected using qualitative and quantitative data collection approaches and secondary data derived from documents review (*see detail in methodology section*).

1.2 Background on the HIV/AIDS Epidemic in Uganda

In Uganda, concerted efforts between government and other development partners (both local and international) have had a positive effect towards reducing HIV prevalence rates. However, HIV/AIDS prevalence still remains unacceptably high and is claiming tens of thousands of lives each year. Currently, almost one million people are infected with HIV, (6.4%) of adults aged 15-49 years (MoH and ORC Macro, 2006). The HIV epidemic in Uganda is profoundly heterogeneous by gender, geographical area, socio-demographic and economic characteristics. Women and urban residents are more disproportionately affected, with national HIV prevalence estimates among women being 7.5% relative to 5.0% among men and 10.2% among urban residents relative to 5.7% among their rural counterparts. The urban-rural disparity is stronger for women than for men with HIV prevalence of 13% among urban women compared with 7% among rural women, while HIV prevalence among urban men is 7 per cent compared with 5% for rural men.

As the epidemic has matured, the population groups most severely affected have shifted from young unmarried individuals to older and married or previously married individuals. Currently, HIV prevalence peaks among women aged 30-34 years and men aged 40-44 years, a shift of 5-10 years from the early 1990s. The population groups with disproportionately high HIV prevalence rates identified in Uganda include; commercial sex workers, mobile populations such as long distance truck drivers, the military and fishermen (STD/ACP, MoH, 2003).

While it is still contestable if teachers are equally at higher risk of becoming infected with HIV/AIDS than the general population, the fact is that HIV/AIDS is still having a devastating effect on the already inadequate teachers in Africa (AVERT, *unpublished*).

1.3 Patterns and Trends of HIV in Uganda

Over the past 25 years, the HIV epidemic in Uganda appears to have progressed through three distinct phases. The first phase was characterized by rapidly rising HIV prevalence throughout the country during the 1980s peaking around 1992 with antenatal HIV prevalence ranging between 25-30% in major urban areas. This was followed by a downward trend of HIV prevalence and incidence particularly in the urban areas during 1992-2000 (Kirungi *et al*, 2006). (Asiimwe Okiror *et al*, 1997) observed that during the 1990s, Uganda experienced nationwide declines in HIV prevalence among antenatal clinic attendees as well as clients for VCT (Baryarama *et al*, 2005). In addition, there was a decline in HIV incidence and prevalence in population based cohorts in rural areas of Masaka and Rakai districts (Mbulaiteye *et al*, 1998) and (Stoneburner *et al*, 1998).

The decline in HIV incidence and prevalence has been attributed to increased age of sex debut (Kirungi *et al*, 2006) and (Asiimwe- Okiror *et al*, 1978), reduction in sexual partnerships outside marriage (Stoneburner *et al*, 1998) and increased use of condoms among others.

The third phase has been characterized by stabilization of HIV prevalence ranging between 6-7% (STD/ACP, MoH; 2006). However, there are anecdotal indications from the national surveillance system corroborated by data from longitudinal cohort studies of apparent increase in HIV prevalence and incidence during the last few years although this evidence is not yet compelling (Shafer LA *et al*, 2006).

The recent trends in HIV incidence and prevalence coincide with increased risky behaviour and the decline in preventive sexual behaviour in the country's population (Opio *et al*, 2006). These early indications point to a gap in the current HIV prevention interventions in the country and calls for re-invigorated and focused HIV prevention programs targeting different groups. The current EFAIDS Project in Uganda is one such initiative.

1.4 HIV/AIDS and the Education Sector in Uganda

Although there is a continuing emphasis on HIV prevention, there is comparatively little focus given to care and support, workplace issues and disease impact management in the education sector. Despite the evident effects of the epidemic on the education sector, there has been no systematic research to look at its impact on education governance in Uganda, in terms of the performance of the descriptive and prescriptive roles of the different actors in the sector. There is still a paucity of data that quantitatively and qualitatively describe and analyze the impact of HIV/AIDS on the education sector.

1.5 UNATU and Education For All (EFA) Programme

UNATU stands to promote and protect the social, intellectual, economic, political and professional interests of the teachers. UNATU has the obligation of assisting the Ministry of Education and Sports to create conducive environments for providing quality in educational opportunities for all children including the disadvantaged.

The EFA Programme was born in 1999, with six key principles including:

1. Ensuring that all children have access to free quality public education;
2. Eliminating gender disparity in primary and secondary education and achieve gender quality in education;
3. Providing equitable access to appropriate learning and life skills;
4. Improving levels of adult literacy;
5. Expanding and improving early childhood care and education; and
6. Improving all aspects of the quality of education and ensuring excellence for all.

1.5.1 HIV/AIDS (EFAIDS) Project in Uganda

The EFAIDS project in Uganda is an offshoot of the EFAIDS programme which was launched in June 2006 by Education International (IE); the Voice of Teachers World Wide and its partners: the World Health Organization (WHO) and Education Development Centre (EDC). It is a pro-active response to address the twin objectives of education for all (EFA) and HIV/AIDS control and prevention. The EFAIDS project is a UNATU response to the impact of HIV/AIDS in education and the teachers particularly. The programme gives the teachers a lead role and empowers them through capacity building to address HIV/AIDS and related issues in schools. The implementation of the project is already under way and the main goals are to: 1) prevent new HIV infections among teachers and learners 2) mitigate the negative effects of AIDS on achieving EFA goals and 3) increase the number of learners completing basic education. The strategies laid down for achieving the goals are: research, training, advocacy, communication, publication and information sharing, and policy development.

1.6 Survey Objectives

The main objective of the survey was to gather baseline information that will guide UNATU's interventions in the area of HIV/AIDS and education and more particularly the EFAIDS project.

1.6.1 Specific Objectives

Specifically the survey set out to:

1. Document the effects of HIV/AIDS on the education sector and teachers particularly.
2. Establish teachers' hands on experience, knowledge, attitudes and perceptions of HIV/AIDS prevalence, prevention and their coping mechanisms.
3. Identify existing strategies and programmes aimed at mitigating the negative impact of HIV/AIDS on the education sector and teachers in particular.
4. Identify indicators the project will use to monitor and evaluate the effectiveness of the EFAIDS project.

1.7 Justification of the Survey

The survey in question fits well within the strategic objectives of the EFAIDS project where research is singled out as one of the strategies for realizing the project goals. In order to undertake any meaningful interventions to address the negative effects of HIV/AIDS on the education sector and teachers in particular it was deemed necessary to generate empirical-based evidence. The few available studies on HIV/AIDS and education remain general at best and some were carried out outside Uganda. The results from such studies cannot therefore be relied upon for designing appropriate interventions in the education sector. It is worth noting that only two studies in Uganda have been identified focusing on the subject and have provided useful insights into the problem of HIV/AIDS on the education sector (Amone & Bukuluki, 2004; Action Aid, 2005). The major shortfall of both studies is that they do not provide bench mark data for monitoring and evaluation of EFAIDS' project activities and outputs. This survey was conducted therefore to gain a deeper understanding of the interface between HIV/AIDS and the education sector with emphasis on teachers and thereby determine action plans for reversing the trend. In addition, the data will be used to measure the project successes.

1.8 Uganda Basic Demographic and Health Indicators

This section describes the geography, demographic and socio-economic characteristics of Uganda, including indicators such as: age composition, population distribution, education, health, sanitation and hygiene.

Table 1.1: Major Population Indicators in Uganda

Indicator	Rate / Percentage
Population	26.8M (12% urban)
% of population below poverty line	37.7%
IMR	132/1000 (UDHS)
Under 5 mortality	152/1000 (UDHS) 138/1000 (WHO)
Latrine coverage	58% (MoWEE); 79% (DHS) 83%; (UHPC, 2002)
Access to clean water	61% Rural; 51% Urban
Life expectancy	49 (51 female; 48 male)
Literacy	64% (54% females; 75% males)
Total Fertility Rate	6.7
HIV prevalence	6.4 (MoH, 2005)

Uganda is one of the poorest countries in Sub-Saharan Africa with an Annual Gross Domestic Product per capita of \$1,800, a debt of 29% of GDP (CIA) and a growth rate of 5% per annum with considerable variations in wealth between its regions, the northern being the poorest with 64% of the people there living below poverty line. Uganda has a high population growth rate of 3.3% and Total Fertility Rate of 6.7 (the highest in East Africa) which is not proportionate to the economic growth (UDHS, 2000). The Housing and Population Census, 2002 indicates that Uganda has a fairly young population with a big proportion of the population under 15 years (49%), under 5 years (19%), while those over 60 years of age constitute 7%.

The country has been badly affected by the HIV/AIDS pandemic with current prevalence of 6.5% (reported to have gone higher to 8%) and about 2 million people living with HIV/AIDS. Officially some 900,000 have died of HIV/AIDS (UAC, 2005). The ethnic makeup is as follows: Baganda 17%, Ankole 8%, Basoga 8%, Iteso 8%, Bakiga 7%, Langi 6%, Banyarwanda 6%, Bagisu 5%, Acholi 4%, Lugbara 4%, Batoro 3%, Banyoro 3%, Alur 2%, Bagwere 2%, Bakonjo 2%, Jopadhola 2%, Karamojong 2%, Rundi 2%, non-African (European, Asian, Arab) 1%.

CHAPTER TWO

METHODOLOGY

2.1 Introduction

In this chapter, the survey implementation process as well as the analysis procedure is highlighted. It presents the survey design and area, the various categories of the survey population, methods of data collection, sampling strategies and data analysis procedures.

2.2 Survey Design

It was a cross-sectional descriptive study involving the use of quantitative and qualitative research approaches to collect information on the impact of HIV/AIDS on the education sector and teachers in particular. Under the qualitative component, key informant interviews and focus group discussions were conducted while a quantitative approach involved structured survey interviews. In addition, review of relevant documents was done.

2.3 Study Area

The survey was carried out in 8 purposively selected districts viz, Kampala, Mukono, Kamuli, Iganga, Nebbi, Masindi, Mbarara and Kasese. The selection of the survey areas was based on two considerations: regional representation and districts where ESWAPI and DOL project activities have not been carried out.

2.4 Study Population

The study population consisted of head teachers, teachers, district education officers, UNATU leaders (EFAIDS project), the Association of Teachers Living with HIV/AIDS as well as personnel working with HIV/AIDS programmes.

2.5 Data Collection Methods

2.5.1 Structured Individual Interviews

A total of 240 structured interviews were conducted using a semi structured questionnaire with a randomly selected sample of teachers. The questionnaire was used to collect data on background characteristics of respondents, knowledge, attitudes and practices regarding: HIV/AIDS prevalence, prevention and coping mechanisms; MoES HIV/AIDS workplace policy; existing HIV/AIDS programmes targeting teachers and EFA project. The field interviewers located the teachers from their place of work and administered the questionnaires. The selection of the teachers interviewed took into account gender balance.

2.5.2 Key Informant Interviews (KIIs)

A total of 25 key informant interviews were held with head-teachers, local government officials, HIV/AIDS program staff, AIDS Control Program official, Uganda AIDS Commission staff and UNATU EFAIDS project staff. The issues explored during these interviews were: impact of HIV/AIDS on teachers; MoES HIV/AIDS workplace policy; existing programs on HIV/AIDS; local government's response to teachers needs in relation to HIV/AIDS; and EFA project implementation as indicated in Table 2.1.

Table 2.1: Category of Key Informants Interviewed

Category of key informants	Number
Head teachers	8
District officials	8
MoES officials	2
UNATU staff	2
NGO staff	3
MoH-ACP	1
UAC	1
Total	25

2.5.3 Focus Group Discussions (FGDs)

A total of 8 Focus Group Discussions were conducted with teachers, two per region. Separate group discussions were conducted with primary and secondary teachers. Each group comprised of 8-12 participants. The FGDs explored teachers' knowledge, attitudes and perceptions on: HIV/AIDS prevalence, prevention, care and support; impact of HIV/AIDS on education and teachers; MoES HIV/AIDS workplace policy; existing HIV/AIDS programs and mitigation strategies.

2.5.4 Documents Review

A number of relevant documents were reviewed including: EFAIDS proposal, HIV/AIDS surveillance reports, MoES HIV/AIDS work place policy and research reports on HIV/AIDS.

2.6 Sampling Strategy and Sample Size Selection

2.6.1 Sampling Design

A multi stage sampling procedure was used to select study respondents at each of the two levels of district and school. Sixteen schools were selected from each of the regions. Eight schools were selected from each of the two districts.

In each of the districts, 3 primary schools, 3 secondary schools, 1 core primary teachers college (PTC) and 1 pre-primary school were selected. Four teachers were interviewed from each of the sampled schools except pre-primary where two were selected.

2.6.2 Sample Size Determination

The sample size was calculated using the Kish and Leslie (1965) formula for sample size calculation. An estimated fifty percent (50%) prevalence of outcome was used in calculating the sample size as it maximizes the sample. At 95% confidence level, and with a 6% error term, the total survey sample size was 240 respondents.

Sample size formula

Where;

$$n = \frac{Z^2 pq}{e^2}$$

Z is the value from statistical Tables, which contain the area under the normal curve, at 95% confidence level as 1.96.

p is the estimated prevalence of outcome

q is (1-p)

e is the desired level of precision (or acceptable error), taken at 6%

Making a total sample size of 240 respondents

2.7 Data Processing and Analysis

Data processing and analysis aimed at reducing raw data into manageable proportions and summarizing it in a form that brings out salient features.

2.7.1 Qualitative Data

Following field data collection, hand-written notes mainly from the FGDs and key informant interviews were assembled and typed into a word processing program - Microsoft Word. The notes were read thoroughly and coded manually to classify them into meaningful categories so as to bring out their essential patterns and main themes of the survey.

2.7.2 Quantitative Data

Quantitative data from structured survey interviews was first cleaned and open ended responses coded. Data was then entered into the computer using the Special Program for Social Scientists (SPSS) program. Logical checks and frequency runs were made on all variables to further ensure the accuracy and consistency of the data. Some statistical tests such as chi square were performed on all variables of interest to examine the associations based on *p-values*. Statistical significance was considered when the *p-value* was below or equal to 0.05. Frequency tables, descriptive statistics, graphs and charts have been used in the presentation of the findings.

CHAPTER THREE

RESULTS

3.1 Introduction

This chapter presents the results of the study, their interpretations and further where applicable uses evidence from previous relevant studies in Uganda and elsewhere to ratify empirical data from the current survey. Specifically, the chapter highlights the background characteristics of the respondents, the main source of information about HIV/AIDS, knowledge and perceptions on HIV/AIDS. The chapter further explores perceived effects of HIV/AIDS on the education sector and teachers in particular, factors that account for the prevalence of HIV/AIDS among teachers and teachers' coping mechanisms. The chapter concludes with an overview of the existing HIV/AIDS mitigating programs, understanding and expected benefits of the MoES HIV/AIDS workplace policy and challenges faced in addressing the impact of HIV/AIDS on teachers.

3.2 Background Characteristics of Respondents

The survey covered more male teachers (57%) than females (43%). The majority of the teachers (67%) were between 25 and 39 years of age. In terms of location, majority (57%) of the teachers were teaching in rural-based schools/institutions compared to those in the urban (43%). By design, the survey covered both private and public institutions. Majority (64%) of the teachers were teaching in public/government aided schools compared to 37% in the private schools.

There were more primary teachers (43.2%) in the sample followed by those teaching in secondary (36%). A few (12%) and (8%) were in PTCs and nursery schools/ kindergartens respectively. All the dominant religious sects in Uganda were represented in the sample. The majority (46%) of the teachers were Anglican followed by Roman Catholics (35%), Pentecostals (12%) and Muslims (4%). Majority (74%) of the teachers were married or co-habiting. Those who were single/never married were 25% and only 1% were widowed.

In terms of educational qualifications, the majority (56%) were Grade III teachers followed by graduate teachers (27%). Grade II teachers were 6% and those with nursery teaching certificates constituted 4% while those with no teaching professional qualifications were 3%. Only 2% reported holding Masters Degree in Education. Table 3.1 summarizes the background characteristics of the sample of teachers interviewed.

Table 3.1: Socio-Demographic Characteristics of Respondents

Characteristic	Frequency	Percentage
Location		
Rural	138	57.3
Urban	103	42.7
Type of school		
Public / government	153	63.5
Private	88	36.5
School category		
Nursery / Kindergarten	20	8.3
Primary	104	43.2
Secondary	87	36.1
Core PTC	30	12.4
Age		
15-24	19	7.9
25-29	59	24.5
30-34	53	22.0
35-39	49	20.3
40-44	37	15.4
45+	24	10.0
Sex		
Male	138	57.3
Female	103	42.7
Religion		
Anglican	110	45.6
Catholic	84	34.9
Muslim	10	4.1
Seventh Day Adventist	6	2.5
Orthodox	1	0.4
Pentecostal	30	12.4
Marital Status		
Married/Cohabiting	179	74.3
Single / Never Married	59	24.5
Widowed	3	1.2
Education level		
Licensed	8	3.3
Grade II	14	5.8
Grade III	134	55.6
Grade 5	4	1.7
Graduate teacher	66	27.4
Masters Degree	5	2.1
Nursery teaching certificate	10	4.1

There were slightly more teachers (45%) teaching arts subjects compared to sciences (41%) and languages (26%). Seven percent of the respondents were teaching pre-primary subjects. In relation to length of service, majority of the teachers (78%) had taught for more than five years. More teachers in the rural areas and in government schools had taught for more than 5 years than those in the urban and private schools respectively. The study did not find regional variations regarding length of time in teaching service. Majority of the teachers (84%) interviewed were staying with their families irrespective of location and school category.

The study found that about half (53%) of teachers had families of 5-10 members followed by those with 1- 4 members (40%) and only 7% of the teachers had families with more than 11 members. More teachers in public / government schools had bigger families than their counterparts in private.

3.3 Teachers' Other Responsibilities at School

In addition to teaching, teachers had other responsibilities at schools with more teachers doubling as heads of departments and class teachers as illustrated in Table 3.2.

Table 3.2: Teachers' other responsibilities at school

Responsibility	Frequency	Percentage
Head of department	67	27.8
Class teacher	51	21.2
Sports / games master	28	11.6
Deputy head teacher	16	6.6
Director of studies	14	5.8
Senior woman teacher	13	5.4
Senior male teacher	4	1.7

3.4 Teachers' Other Sources of Income

The survey found that the majority (68%) of the teachers had extra sources of income to supplement what they earn from teaching. The most frequently mentioned activities were: trade (49%) and farming (48%) as illustrated in Table 3.3.

Table 3.3: Teachers' Other Sources of Income

Source (s)	Frequency	Percentage
Trade / business	81	49.4
Farming	79	48.2
Community development work	4	2.4

3.5 Membership to Associations

The majority (66%) of the teachers reported to be members of one or more organizations. More teachers in south western and central regions belonged to associations than in the east and the North. Government schools had more teachers in associations than those in the private. The categories of associations reported included: social (37%), economic (34%), professional (33%) and religious (26%) as illustrated in Table 3.4.

Table 3.4: Categories of organizations teachers belong to:

Type	Frequency	Percentage
Social	57	36.5
Economic	53	34.0
Professional	51	32.7
Religious	41	26.3
Charitable	18	11.5
Political	5	3.2
Health	2	0.8
Other	1	0.4

Totals may exceed 100% due to multiple responses

3.6 Teachers' Knowledge, Perceptions and Practices on HIV/AIDS.

3.6.1 Knowledge of HIV/AIDS

It is evident in the literature that knowledge on HIV/AIDS in Uganda is almost universal particularly with regard to modes of transmission and prevention (UDHS, 2002, UAC, 2006). The survey found that all the teachers interviewed (100%) knew that sexual intercourse with an infected person is the main way through which HIV/AIDS can be spread. Other transmission routes mentioned included sharing sharp piercing instruments (74%), transfusion of infected blood (63%) and mother to child transmission (42%) as illustrated in Table 3.5.

Table 3.5: Knowledge on HIV/AIDS Transmission

Transmission route	Frequency	Percentage
Sex with infected person	237	99.6
Sharing sharp piecing instruments	178	74.8
Transfusion with infected blood	150	63.0
Mother to child transmission	101	42.4
Use of un-sterilized needles	61	25.6
Accident	45	18.9
Breast-feeding	24	10.1
Other	7	2.9

Totals may exceed 100% due to multiple responses

3.6.2 Knowledge on HIV/AIDS Prevention

Teachers exhibited high knowledge levels regarding HIV/AIDS prevention with majority (89%) reporting abstinence from sex, followed by faithfulness (75%) and use of condoms (73%) as indicated in Table 3.6.

Table 3.6: Knowledge on HIV/AIDS Prevention

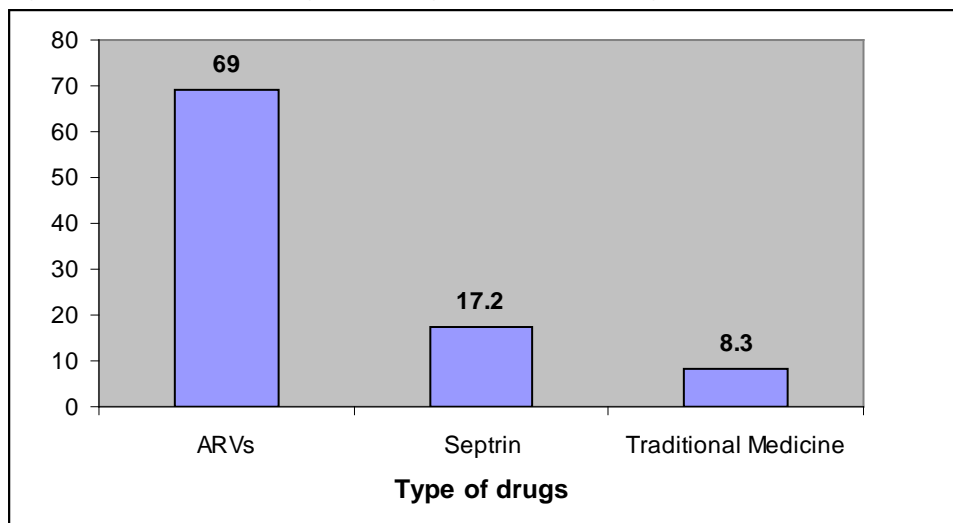
Methods	Frequency	Percentage
Abstain from sex	210	88.6
Zero grazing/be faithful	178	75.1
Use of condoms	174	73.4
Avoid sharing sharp piercing instruments	72	30.4
Avoid getting injections from none qualified medical staff	44	18.6
HIV Counselling and Testing (HCT)	33	13.9
Avoid blood transfusions	29	12.2

Totals may exceed 100% due to multiple responses

3.6.3 Knowledge on HIV/AIDS Care and Support Services

Almost all teachers interviewed (99%) had heard of drugs that can prolong the life of a person living with HIV/AIDS. Of those majority (69%) knew about ARVs, 17% were aware of septrin prophylaxis and 8% reported traditional medicine. However 6% of those who said they had heard of these drugs did not know the name of the drugs.

Figure 1: Knowledge on Drugs Used to Prolong Life of PLWHAs



Despite the fact that most teachers knew about ARVs, less than half (47%) rightly reported that ARVs is a life-time treatment. Teachers' knowledge regarding the length of time one should take ARVs was lowest in the east followed by south western. The study did not find any relationship between teachers' knowledge on ARVs and location as well as type of school.

Table 3.7: Knowledge on Duration of Treatment Using ARVs

Length of	Frequency	Percentage
Don't know	122	50.6
Life time	113	46.9
Only when feeling sick	3	1.2
Other	1	0.4

3.6.4 Misconceptions about HIV/AIDS Transmission and Treatment

Although there was widespread awareness among teachers about HIV/AIDS transmission, prevention and care, the survey found some lingering misconceptions held by teachers. For instance, 7% reported that HIV/AIDS can be spread through mosquito bites and 4% reported sharing a bed. In addition, 3% equally mentioned sharing a toilet and food. Ten percent of the teachers interviewed believed that HIV/AIDS is a curse from God while some 2% said HIV/AIDS can be cured. Comparing the regions, this belief was not found in the south western region.

3.6.5 HIV/AIDS Risk Perceptions among Teachers

Majority (90%) of the teachers interviewed considered themselves to be at risk of contracting HIV/AIDS. A range of reasons were given for the perceived high risk and included: easy access to adolescent girls (32%), HIV/AIDS is a disease that anyone can acquire (26%), involvement in unprotected sex and unfaithfulness to partners with equal proportions (9%). Other reasons cited were: being away from partners due to transfers (6%), little pay especially for the female teachers (4%), influence of alcohol and being single (unmarried) with equal proportions (4%). Table 3.8 presents reasons for perceived risk to HIV/AIDS.

Table 3.8: Reasons for Perceived Risks to HIV infection

Reasons	Frequency	Percentage
Teachers have access to girls	68	31.9
HIV is for every body	56	26.3
Unprotected sex	20	9.4
Unfaithfulness to partners	19	8.9
Transfer/away from family	12	5.6
Financial gains/small salary	9	4.2
Influence of alcohol	8	3.8
Many teachers not married/not committed/still young	8	3.8
Accidents	6	2.8
Women are attracted to teacher because they have money	3	1.4
Teachers think students are HIV free	2	0.9
No morals/ ethics for teachers	2	0.9

However, further analysis reveals that access to girls as a pre-disposing factor was most commonly reported in the north western region compared to other regions. In addition, the number of teachers who reported access to girls was highest in secondary schools followed by PTCs, primary schools and least in nursery schools. Access to girls was also more commonly reported by teachers in urban areas and in private schools. More teachers in the central region as well as those teaching in the urban pointed out unfaithfulness as a risk factor in acquiring HIV/AIDS. The western region and secondary schools had the highest number of teachers reporting unprotected sex as a risk factor in HIV/AIDS infection as so were those teaching in the urban schools. The north-western region and teachers in public\ government schools including PTCs had more teachers citing transfers of teachers to distant schools as a risk factor for HIV/AIDS infection.

Similar reasons were cited in the key informant interviews as well as FGDs. It was reported that poor pay is one of the main predisposing factors to HIV/AIDS especially among females. It was noted that in both government and private schools teachers are paid too little salary to enable them meet their basic needs hence putting them in tempting situations.

Due to inadequate remuneration teachers tend to look elsewhere for supplementary income. The female teachers for example are easily lured to give in to men who can afford to offer them money or other material gifts (FGD, Masindi).

Female teachers are taken up by businessmen particularly the young female teachers. This is due to low income and salary delays that make them prone to sexual exploitation by rich businessmen (FGD, Iganga).

These teachers are a working class but their salary does not meet their needs. They have a lot of responsibility like large and extended families which they have to support so a teacher who is sick finds it difficult to manage (District Official, Masindi).

Although teachers are poorly paid, in the rural communities teachers are seen as relatively of higher social and economic status. This is based on the fact that they earn a salary at the end of every month and are able to maintain a better standard of living compared to the rest of the community who are mainly peasant farmers. For this reason the male teachers especially the headmasters are a center of attraction to women in those communities which predisposes them to risky behavior as suggested in the quotes below:

Teachers are seen to be better off and are targeted by money hungry girls. They are taken to be learned people and women like to be associated with them (FGD, Nebbi).

Teachers are exposed to different communities, at school and in the villages. They also interact with a lot of other people in workshops and seminars. This exposes them to HIV/AIDS. There is also that student-teacher relationship (FGD, Nebbi).

The life style of teachers is most significant when considering the factors responsible for HIV prevalence. In the past teachers were not exposed to facilities such as loans but now they access loans and after getting the money they turn away from their priorities. They instead get second wives (DEO, Nebbi).

Closely related to poor pay, qualitative findings further indicate that the delay by the Ministry of Education to process and include teachers on the pay roll was blamed for increased vulnerability to HIV/AIDS especially among female teachers. It was observed that newly posted teachers take long to get on to pay rolls making it difficult for them to survive. Men including head teachers reportedly take advantage of that to sexually exploit them.

A teacher can be posted to a school and takes years without getting on to the payroll. In such cases, female teachers are promised by their bosses that if they give in to their sexual demands, they will be facilitated to get on the payroll, what is known as “secondary interview”. In case of an infected person, the teacher ends up with the infection (FGD, Iganga).

Failure to access pay rolls in time predisposes the newly appointed teachers especially young female teachers to HIV/AIDS infection. Some officials disguise themselves to be helping them get on the pay roll yet they have intentions of using them (DEO, Iganga).

The problem of alcoholism also emerged as a major contributing factor to the prevalence of HIV/AIDS among teachers. It was noted that some teachers drink a lot, lose self control and get involved in risky sexual behaviour including indulgence in unprotected sex. Participants lamented that teachers these days do not follow their professional code of conduct.

If teachers observed their code of conduct their exposure to HIV/AIDS infection would be greatly reduced, remarked one key informant in Iganga district.

Alcohol is a drug that affects the brain and it is a stimulant. When one takes it and becomes drunk he is stimulated sexually and anyone whom he meets on the way he starts a sexual affair (FGD, Mbarara).

When you drink even if you are very faithful to your partner, you are no longer faithful because alcohol takes over control. Alcohol takes away the faithfulness and you end up getting involved with other women (FGD, Mbarara).

Also noted was the fact that teachers have easy access to the adolescent young girls they teach. Some teachers get tempted to move into sexual relations with these girls who may be infected. This was said to be more common in senior secondary schools and teacher training colleges where some of the girls are mature enough to go with men.

This is due to the fact that teachers are very busy people and the only people they interact with on a daily basis are other teachers and students (DEO, Masindi).

The teachers easily get attracted to students and fellow teachers because they are always with them and they spend most of their time in the company of students and fellow teachers (FGD, Mukono).

The findings of this survey further pointed out that teachers are humans like any body else. They are therefore also prone to all the risky situations that the other sections of the population are exposed to. According to most of the participants, anybody can get HIV/AIDS and therefore teachers are not exceptional.

As ordinary persons teachers have sexual desires and need to enjoy life. In pursuit of these they also face the risk of infection (FGD, Nebbi).

Another important issue that emerged out of the FGDs and key informant interviews was the transfer of teachers from one school to another. Often teachers are transferred to schools that are far away from their homes or former school. It would follow that the teacher will stay away from the family for sometime as he prepares for his family to join him or her. In other cases, it may not be possible to move with family if the wife or husband is working in or near the former school. These according to the participants tend to tempt teachers to find casual sexual partners to fulfill their sexual desires.

A teacher may have a wife who is also a teacher and they are posted or transferred to different schools. For example one may be posted to a school in Pakwach and another in Nebbi. (DEO, Nebbi).

It was also reported that some headmasters and district officials use their positions to sexually exploit female teachers a factor that was said to fuel the spread of HIV/AIDS among teachers. This usually happens when the teacher has a problem and needs the assistance of the head teacher or district official.

Such problems were said to include inclusion in the pay roll, transfer to a better school or cancellation of a transfer the teacher doesn't like to go for, provision of accommodation and promotion.

Lack of accommodation facilities in some schools was said to expose teachers to risks of getting involved in risky behaviors. In schools that do not provide accommodation or housing allowance, the teacher is expected to find his or her own accommodation somewhere out of the school. Due to financial constraints teachers find themselves residing in places that expose them to risky behaviours.

Teachers in higher institutions such as secondary schools and teachers' training colleges were said to be at risk because students tend to develop relationships with them with expectations that the teacher will favor them by passing them in exams and other assignments. This was reported to be more common among young and single teachers.

3.6.6 Reasons for Low Risk Perception among Teachers

The survey established that only a few teachers (10%) did not consider themselves to be at risk of contracting HIV/AIDS. More teachers in the central and North Western regions did not consider themselves at risk of contracting HIV/AIDS compared to the other regions. The study did not find any significant relationship between risk perception of HIV/AIDS and place of residence in terms of rural or urban. A number of reasons were cited for the low risk perception as illustrated in table 3.9 below.

Table 3.9: Reasons for Perceived Low Risk to HIV/AIDS

Reasons	Frequency	Percentage
Awareness of HIV/AIDS	8	42.1
Adherence to teachers' code of conduct	6	31.6
Have busy a schedule	3	15.8
Faithfulness to partners	2	10.5

3.6.6 Teachers' Sexual Behaviour

The survey also investigated the sexual behaviors among teachers. Teachers were asked whether they had had sexual intercourse with non regular sexual partner in the last 12 months preceding the survey. Based on the results, 10% of the teachers reported having had sex with non regular partners. Of these, 4% reported more than one sexual partner. Sexual encounter with non regular partners was highest in the northwest than the other regions. In addition, more teachers in the private reported having sexual intercourse with non regular patterns than those in public/government school. There was no disparity between rural and urban. Eighty seven percent of the teachers who had had sex with a non regular partner used condoms. The main sources of condoms were ordinary shops (45%), private clinics/drug shops (25%), government facility (15%), and bars/lodges (10%). Table 3.10 presents the main sources of condoms.

Table 3.10 Main Sources of Condoms

Source	Frequency	Percentage
Ordinary shops	9	45
Private clinic / drug shop / pharmacy	5	25
Government facility	3	15
Bars / lodges	2	10

3.7 Sources of information on HIV/AIDS

All the teachers interviewed in the survey were asked their main sources of information about HIV/AIDS. As illustrated in Table 3.11, the most prominent sources of HIV/AIDS information among teachers are the radio (83%), newspapers (61%), seminars and workshops (45%) and health facilities (37%). The others were television (34%), books (31%) friends (28%), posters and leaflets (19%) and drama (12%).

Table 3.11: Sources of Information on HIV/AIDS

Source	Frequency	Percentage
Radio	199	82.6
Newspaper	146	60.6
Seminars/workshops	108	44.8
Health facility	90	37.3
TV	82	34.0
Books	75	31.1
Friends/other teachers	68	28.2
HIV/AIDS school program	50	20.7
Posters/leaflets/brochures/banners	45	18.7
Drama	28	11.6
Religious leaders	24	10.0
NGO	21	8.7
Internet	9	3.7

Totals may exceed 100% due to multiple responses

Teachers were also asked about their most preferred source of information about HIV/AIDS and as presented in Table 3.12, the radio emerged as their most preferred source of information about HIV/AIDS accounting for 26%, followed by workshops and seminars and health facilities/health workers (17%), books (10%) and newspapers (8%).

Table 3.12: Teachers' Most Referred Source of Information on HIV/AIDS

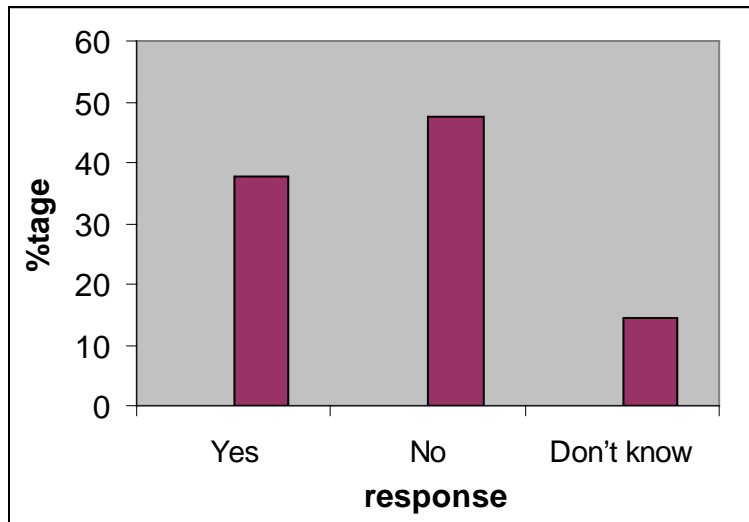
Source	Frequency	Percentage
Radio	63	26.1
Health facilities/health worker	40	16.6
Seminars/workshops	40	16.6
Books	24	10.0
Newspaper	18	7.5
Friends	11	4.6
TV	10	4.1
HIV/AIDS school program	9	3.7
Posters/leaflets/brochures/banner	9	3.7
Drama	7	2.9
Internet	2	0.8

3.8 Perceptions on HIV/AIDS Prevalence among Teachers

In Uganda the national HIV prevalence rate is 6.4 (MoH and ORC Macro, 2006). However, prevalence is not disaggregated according to occupation hence lack of information on prevalence of HIV/AIDS among teachers. For purposes of this survey, a crude quantitative indicator was used to assess prevalence of HIV/AIDS among teachers. All teachers interviewed in the survey were asked if their school had lost a teacher due to HIV/AIDS in the past 5 years. The study found that 38% of the teachers interviewed reported that their school had lost a teacher to HIV/AIDS, as illustrated in Figure 2. Reported teachers deaths due to suspected HIV/AIDS was highest in the central region, with more cases reported in government schools.

‘Among some fifty teachers you can get a maximum of five teachers who are HIV/AIDS infected. I have been in the town council for twenty years but within that time almost every school has lost a teacher to HIV/AIDS (Head Teacher, Nebbi)

Figure 2: Reported Teacher Deaths Due to HIV/AIDS



Of the teachers who reported that their schools had lost a teacher to HIV/AIDS, 27% reported male teachers while 17% said they had lost female teachers. This is not to suggest however, that there are more male than female teachers infected but it could be because there are more male than female teachers in the teaching profession. One would therefore expect a correspondingly higher number of males infected than females.

Qualitative findings however, seem to suggest that there are more female than male teachers infected with HIV/AIDS. It was noted that many females qualify from teachers training colleges when they are not married, remain single or take time to marry while having multiple sexual partners. In the process of identifying partners for marriage they usually venture in a number of relationships that increase chances of coming into contact with a person infected with HIV/AIDS.

Others were of the opinion that female teachers were more vulnerable because when it comes to making decisions on sexual issues such as condom use, men have an upper hand. Women therefore can not do much to protect themselves.

It was reported that female teachers are more vulnerable because men use money and other material things to entice them into sex. It was said that men from other professions including business men find it prestigious to go with female teachers because of their educational status and respect the community accords them.

Female teachers are also more prone when single because they begin to look for people who have money to take good care of them. They tend to go for business-men who are even more exposed to HIV/AIDS (FGD, Nebbi).

Women are always there and they will always accept men because of poverty, they want money (FGD, Mukono).

By gender, female teachers are more affected. For example, we have three female teachers in this school who are living with HIV/AIDS. They have been with me for about ten years. One is a very close person but was not open about her condition. She knew about her status and kept quite until the time she had broken down (Head Teacher, Masindi).

It was found that teachers in the urban areas were said to be more vulnerable to the pandemic. This is attributable to the fact that HIV/AIDS first concentrated in urban areas. On the contrary some participants were of the view that teachers in the rural areas are more vulnerable to HIV/AIDS due to lack of sensitization as one participant remarked

Teachers in urban settings are more sensitized while those in the rural areas may be more prone because they think HIV/AIDS is not common in the rural areas”.

Comparison between primary and secondary school teachers showed that most of participants perceived secondary school teachers to be more vulnerable. The explanation given is that teachers in secondary schools tend to develop relationships with their students who are more mature compared to those at primary level.

It was observed that due to the fact that primary teachers are more in number the situation seems to be worse in primary schools. Some respondents felt that HIV is more prevalent among older teachers because they still believe and indulge in risky traditional practices such as widow inheritance.

Secondary school teachers may be more vulnerable because of the kind of students they are teaching. These are adults over 18 years of age (FGD, Nebbi).

Yes, secondary school male teachers mainly because they are exposed to mature girls that they teach and so they can easily get attracted to them (FGD, Mukono).

Teachers who belong to the older generation still indulge in traditional practices such as widow inheritance, in addition, when they try to cope up with the new lifestyle as a result of increase in salaries they end up falling victims of HIV/AIDS (FGD, Nebbi).

The survey participants further observed that the seemingly high prevalence could be due to the fact that teachers are very many in number compared to other professions. As a result, more cases of HIV/AIDS among teachers was reported to be high compared to the other sectors.

Still others expressed the opinion that teachers are public figures and if something happens to them it is usually highly publicized. It was said that if a teacher falls sick or dies for example, the impact is greatly felt by the society and raises a lot of concern. In addition, it was noted that HIV/AIDS infection among teachers comes as a surprise to the community because it is thought they are enlightened and therefore least expected to contract the disease.

I would not say that HIV/AIDS prevalence among teachers is high. Teachers being public figures when any thing happens to one it is highly publicized. When a teacher dies, all the surrounding communities including pupils and teachers from nearby schools come to attend (FGD, Nebbi).

In all the FGDs there was agreement that many teachers have suffered and died of ailments that were associated with HIV/AIDS but in most of the cases it could not be confirmed. It is difficult to establish the exact cause of death because most of the teachers don't disclose even if they know their status. However, it was said that due to increased sensitization now more and more teachers have opened up and talk about their status.

Some of the participants felt that HIV prevalence among teachers is not high as it is perceived because teachers are very busy people and therefore have little time for leisure which is the main entry point for getting involved in risky activities.

Prevalence is not possible to establish because it needs a scientific study, like testing the teachers and coming up with results. There is information about teachers who die but the causes are not established. They are just suspected to be dying of HIV/AIDS (District Official, Nebbi).

Prevalence rates cannot be ascertained but the truth of the matter is that nearly every school has lost a teacher to HIV/AIDS (District Official, Kamuli).

3.9 Impact of HIV/AIDS on the Education Sector and Teachers in Particular

HIV/AIDS emerged as one of the common health problems affecting teachers. During the survey many of the schools/institutions visited had either lost a teacher to the pandemic or had a teacher living with HIV/AIDS. Results revealed that 92% of the teachers said that HIV/AIDS has affected them either directly or indirectly. Table 3.13 shows ways in which HIV/AIDS has affected teachers. These include: increased absenteeism (74%), time lost caring for the sick (71%), inefficiency in teaching (51%) and reduction in salary (35%). Other effects reported include; indiscipline (24%), stigma/ discrimination (20%) and dismissal from school (13%).

Table 3.13: Impact of HIV/AIDS on the Education Sector and Teachers.

Ways	Frequency	Percentage
Increased rate of absenteeism	134	73.6
Time lost caring for sick people	130	71.4
Inefficiency in teaching	92	50.5
Loss/ reduction of salary	64	35.0
Indiscipline	44	24.2
Stigma & discrimination	76	19.8
Dismissal from school	23	12.6

Totals may exceed 100% due to multiple responses

The quantitative findings above were supported by the views and experiences shared by teachers in the various FGDs and key informant interviews as presented below.

Psychological Impact

In the first instance, it came out from the discussion that upon realizing that one is infected though not yet physically sick the teacher becomes psychologically traumatized and loses concentration in work. It was observed that teaching is a profession that requires a lot of peace of the mind and any psychological disturbance can greatly impact on quality of teaching both at the lesson preparation stage and during the actual teaching in the class room.

I witnessed a case when I was still teaching in one of the schools. A teacher lost her husband and every time she would come to teach, her mind was not with us, you could clearly see that she was really disturbed (District Official, Mbarara).

Decline in Performance

HIV/AIDS was said to affect the performance of infected teachers due to loss of strength when the teacher falls sick. An HIV/AIDS positive person is vulnerable to frequent attacks by different kinds of opportunistic infections. Whenever the teacher is not feeling well it means that he/she will not be able to perform as would be expected under normal circumstances.

When a teacher is infected, his performance drops because he does not concentrate. All the time his mind is pre-occupied with the sickness (District Official, Masindi).

Teachers' performance becomes poor in terms of output and quality of the education when one is infected with HIV (FGD, Kasese).

If a teacher is infected, he feels out of place. He becomes so weak and fails to teach. This results into increased absenteeism. Even if he went to teach his mind would be very far, does not concentrate at all. This in the end affects the quality of his performance (FGD, Mukono).

HIV/AIDS brings about all sorts of inefficiency that greatly affects academic performance of learners. For example, one of the best English teachers in the district got infected in 2005 and was part-timing in three different schools. Unfortunately, he broke down very fast and died. It was thought that he could have deteriorated so fast as a result of the heavy work load he was involved in. He died at such a critical moment when senior four students were preparing for their final examinations. Since English teachers are very few and highly competed for, the candidates in his class missed the final touches. In that year the students performed poorly particularly in English language compared to the previous years (FGD, Kamuli).

Failure to Prepare Lesson Plans

It was reported that when a teacher is not feeling well it becomes difficult to prepare schemes of work. Without a lesson plan the teacher is not expected to teach properly. In addition, since the procedure requires that the teacher must show evidence of the lesson plan this has often led to tension between the teachers and their head teachers who are supposed to be their immediate supervisors.

Most of these sick teachers do not prepare their lessons adequately and when an inspector comes to the school to check and it is found out the teacher may be castigated (District Official, Masindi).

Increased absenteeism

It commonly emerged from the FGDs and individuals interviews that one of the major effects of HIV/AIDS on teachers is increased absenteeism from school. According to the survey respondents, while the problem of teacher absenteeism has always been there, the new dimension HIV/AIDS has added to the problem is the frequency and length of time the teacher may be away from school. It was noted that teachers living with HIV/AIDS are often absent and may take weeks before the teacher feels better to return to class.

Also pointed out was the fact that the teacher may actually come to school and report to the class room but may not have the morale and adequate strength to effectively conduct the lessons. Sometimes the teacher may not be able to stay at school for the whole day and that means some of the lessons will not be completed.

Even if you force that teacher to come to school he or she will not perform because of the sickness. You may see them present when they are not teaching. Teaching is practical, it involves jumping around with pupils, so if someone can not perform he/she should give way for someone energetic (FGD, Mbarara).

Clearly, there is a problem of absenteeism in schools. Absenteeism is high and most often the excuse is sickness and some of the sickness could be due to HIV/AIDS (District Official, Mbarara).

Dismissal from service

The survey also established that some teachers living with HIV/AIDS have lost their jobs on account of the sickness. This was said to be more common in private schools. Unlike in government schools where a sick teacher may be kept on the pay role for sometime even when he/she is not teaching, the case of private schools was said to be different.

Private schools aim at minimizing costs as much as possible and will terminate the services of a teacher who is not delivering. In some private schools teachers are paid only for the hours or days worked.

In a private institution like this one, a teacher is in full control of a class. If anything happens to that teacher it affects the class and the performance of the children. Parents pay money and want good results from the head teacher. The head teacher may sympathize with a teacher who is sick but the sympathy may not last long because the whole issue goes back to performance (Head teacher, Masindi).

If your performance has gone low the administration may think of deleting you from the payroll to create a gap for another teacher (FGD, Mbarara).

Stigma and discrimination

The problem of stigma and discrimination was pointed out in FGDs and key informant interviews as one of the major effects of HIV/AIDS on teachers. Stigma was reported to be at different levels including self stigma and that from the environment where the teacher works and lives.

Students and pupils were reported to be a source of stigma and discrimination to HIV/AIDS infected teachers. For instance, when they get to know that a teacher is suffering from HIV/AIDS then they can talk about it or behave in a manner that can offend the teacher.

When a teacher is sick, students who are aware of this begin talking about it and that can cause stigmatization (FGD, Nebbi).

An HIV/AIDS infected teacher who knows that others are aware of his/her status by himself may feel stigmatized and tend to isolate himself from the others. Even when it may not be the case, such a teacher is always suspicious that other teachers or pupils may be pointing a finger at him/her.

“For instance a teacher died last year in December at the UCE examinations marking center. This was a manifestation that the teacher had deliberately kept the problem to himself. Had he shared it with someone, preferably a counselor, probably he would have been advised to remain at home and avoid stress” (FGD, Kamuli).

It was further observed that when HIV/AIDS signs and symptoms become obvious and the pupils come to know of the teacher’s condition, then they begin to keep a distance from him. This kind of attitude can make the teacher feel stigmatized. This has a negative impact on teachers and the learning process in general since teaching involves teacher and pupils interactions (District Official, Mbarara).

Pupils and parents tend to have bad attitude towards a teacher who is sick. The pupils will fear and start dodging classes (FGD, Mbarara).

Both pupils and teachers discriminate against the sick. It is only of recent that sick people are accepted. A sick person tends to be isolated. Some people think that by interacting with them they can get HIV/AIDS (FGD, Mbarara).

There were some cases of reported stigma and discrimination from parents and communities as well surrounding the schools. In one of the districts, a primary school head teacher was rejected by parents of a school where she had been newly transferred. The parents insisted that it was not safe for an infected teacher to freely mix with pupils at school.

There is a case of a head teacher who was said to be HIV/AIDS positive and was always harassed by parents of the school. Many times she was insulted to the extent that she had to leave the school (FGD, Kasese).

The survey further revealed that HIV/AIDS positive teachers were also stigmatized and discriminated by the communities around the schools. The communities were reported to be against teachers suspected to be living with HIV/AIDS to teach their children. It was reported that some parents even go the extent of removing their children from the schools. In order not to lose students head teachers tend to avoid hiring teachers that are known or suspected to be HIV/AIDS positive. This was reported to be more common in private schools.

Being private, the community in which the school is located has a lot of influence and you may find yourself doing what the community wants because you want business and must make profits (FGD, Mukono).

In case of rashes on the skin, the teacher loses confidence and feels stigmatized and a misfit in the school. Students can start talking about him, pointing fingers at him that that teacher is like this and that (FGD, Mukono).

Loss of opportunities

It was also established that an HIV/AIDS infected teacher may not be considered for certain opportunities. For instance, teachers known or suspected to be living with HIV/AIDS have less chances of being considered for further studies or taking on other responsibilities at school. It is assumed that the teacher may not live for long and therefore it is considered a waste of resources.

High costs of living

There were concerns that living with HIV/AIDS is very expensive yet teachers' income is very meager. In situations where a teacher can not access free ARVs and septrin it means that the teacher has to meet these costs. Even for those who get free drugs there are other related costs such as transport to the treatment centers that are in some cases far away. The cost of treatment of opportunistic infections and proper nutrition were also cited.

Teachers get low pay and the medication for HIV/AIDS is expensive. Most teachers can not afford to access ARVs and they end up dying prematurely (District Official, Mbarara).

The disease is also expensive to manage and yet the salary is not adequate enough to take care of the treatment costs. First of all, the teacher is not even able to meet the needs of the household (DEO Masindi).

At first ARVs were very expensive and teachers could not afford even though today they may be cheap but the service points are still far for a sick teacher in the rural setting. For example, someone at the extreme end of Kibanda must travel that long distance to Kiryandongo to get that service and then be linked to TASO for support (DEO, Masindi).

A common complaint across all the discussion groups was that the money teachers earn is not sufficient to meet their daily needs yet the nature of their job does not easily allow them time to get involved in other income generating activities. The situation becomes even worse when a teacher gets infected with HIV/AIDS.

Support to dependants

It was reported that most teachers working in the rural areas serve in their home areas where a teacher by virtue of his status as a salary earner is seen as the person who can provide assistance such as paying school fees for dependants and caring for the sick. This was reported to be taking a lot of time and money.

Teachers are affected by their relatives who have died, the moment you have lost your relative at home it affects your income because you have to look after the children who are left behind, that means your teaching also has to be poor because of extra responsibilities which are disturbing. (FGD, Kasese).

Some of us have lost our dear ones and their children and wives look on to us for assistance. With our merge resources we have to provide for the extended family (FGD, Nebbi).

Increased work load

HIV/AIDS was reported to increase teachers' workload when a teacher is sick and is not able to teach his/her lessons. In such situations, other teachers take on the load of the sick teacher in addition to their daily load.

The workload is shifted to another teacher because when a teacher breaks down from time to time his performance falls below average and others come have to come in to fill the gap (FGD, Nebbi).

Sympathetic teachers take up the load of their sick colleagues knowing that when pupils perform poorly in their subjects, their wages will be deducted or they will be dismissed in case of private schools (District Official Iganga).

When fellow staffs are sick, you do not want him/her to be scrapped off the payroll. So you devise means of helping the infected colleague by taking over the work load. (Principal, Core PTC).

In relation to increased workload, participants in the discussions were critical about the staff ceiling policy of the Ministry of Education and Sports. The arrangement makes it difficult to replace a teacher who is critically ill and can no longer teach.

As a result, the lessons formerly taught by the affected teacher have to be spread to other teachers making the work load too big to be effectively handled.

The decline in academic performance as a result of HIV/AIDS was blamed on the staff ceiling policy. It is difficult to recruit a substitute teacher even when the sick teacher is not able to teach (DEO, Nebbi).

On the quality of education for example in government schools, it goes low because it is very hard to dismiss a teacher even if he or she is not performing. The pupils miss out lessons because the teacher is down and this is very common in UPE schools. Government fails to replace teachers who have become weak until when they die (FGD, Mukono).

A sick teacher may be down for even three weeks without reporting at school. The headmaster is in a dilemma on what to do since he cannot recruit another teacher due to government policy of staff ceiling. The class has to remain unattended because the headmaster cannot bring in another teach (District Official, Iganga).

Low savings

There was concern that due to the teachers' poor remuneration they are not able to save and acquire assets. When teachers fall sick or die they barely have anything to support them in times of difficulty or leave for their surviving family members.

When teachers die of HIV/AIDS, their families remain with nothing because of the low salaries teachers receive that enables almost no savings (FGD, Iganga).

HIV/AIDS has greatly impacted on the teaching community where children suffer after the death of their parents. Some resort to child labor or being inconsistent in class due to lack of concentration. The impact of this is that we have very many orphans in the school left by the deceased teachers (FGD, Iganga).

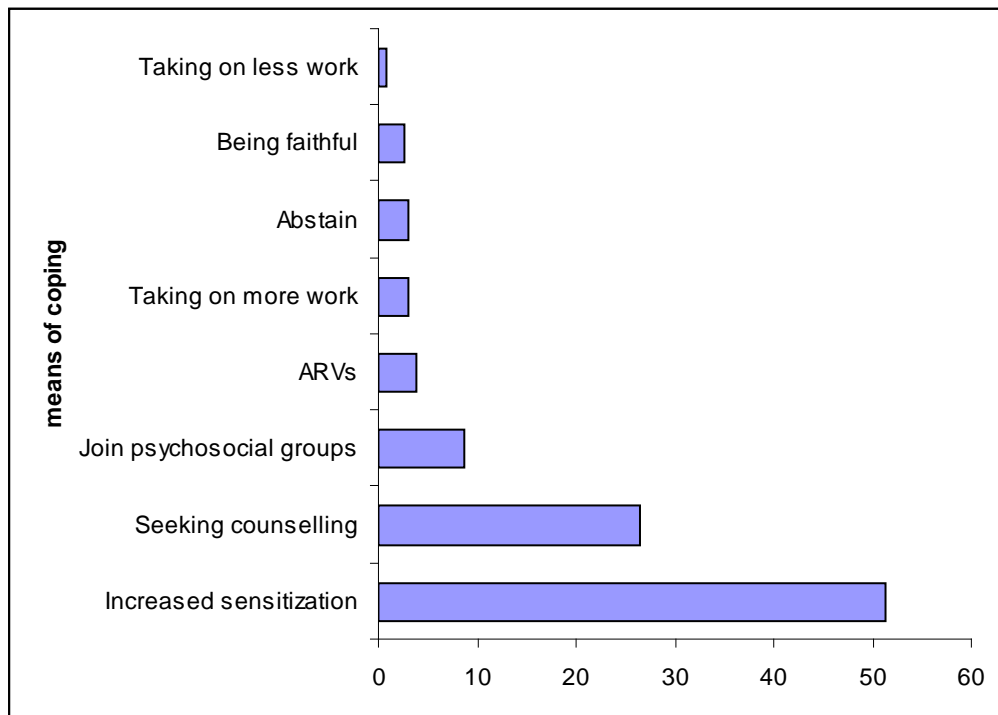
Unfair transfers

Another impact of HIV/AIDS on teachers reported was the unfair transfer of teachers living with HIV/AIDS. It was reported that school administrators and parents fear that an HIV/AIDS infected teacher may not deliver effectively. While in private schools such teachers are simply discontinued, in the government schools, transfers are initiated by head teachers and parents who connive with the District Education Officers.

3.10 Teachers' Coping Mechanisms

The survey investigated ways through which Teachers are coping with the effects of HIV/AIDS. As illustrated in Figure 3, 51% of the teachers reported increased involvement in HIV/AIDS sensitization, 26% reported that teachers seek HIV counseling and testing services, 9% psychosocial support groups and only 4% reported an uptake of ARVs.

Figure 3: Teachers' Coping Mechanisms



Focus group discussions with teachers as well as key informant interviews revealed that teachers' have responded to the effects of HIV/AIDS in several ways including: disclosure of sero-status, sharing workload; joining care and support organizations and groups; accessing IGAs and HIV/AIDS sensitization among others. Using the voices of the teachers during the various focus group discussions, we examine each of these coping mechanisms one in turn.

Disclosure of Sero status

Disclosure of HIV/AIDS Sero-status was cited as one of the ways in which teachers are responding to the negative impact of the HIV/AIDS pandemic. It was noted that as a result of the increased sensitization on the importance of taking HIV/AIDS tests, a number of teachers have come out to declare their sero-status and are accessing the available HIV/AIDS care and support services.

Some teachers have declared that they are living with HIV/AIDS and they are not discriminated against. Sick teachers can now also access ARVs (District Official, Mbarara).

Those who disclosed and accessed ARVs have regained strength and are now back to the classrooms to teach (District Official, Iganga).

Sharing Work-load

It was repeatedly mentioned that whenever a teacher falls sick, the practice is for fellow teachers to come in to help during the days when he/she is not able to teach the assigned lessons.

In my school, I have one person who is now HIV/AIDS positive and known to all staff members but I think for us we have assisted her to live with it and she is now working normally. Well, she is offered special care at school. She comes to school the day she feels like. She can leave any time, the workload that she used to take before is now sliced. She is now taking about a quarter (Head Teacher, Mukono).

As for the work load, when a teacher is infected and actually bedridden, other teachers take up the load depending on the decision of the administrators (District Official, Kamuli).

Seeking HIV/AIDS care and support services

It was further noted that some teachers have joined the existing HIV/AIDS care and support organizations (TASO, AIC JCRC) as well as public and private health care facilities both at national and district levels. Through these organizations and facilities, teachers were access HIV/AIDS care services such as HCT, ARVs, septrin, psycho-social and nutrition support, condoms, PMTCT as well as treatment of opportunistic infections.

The teachers here are aware of the effects of HIV/AIDS and where to get the services. So they have registered with TASO and are receiving care and support services (FGD, Masindi).

Some of them have joined HIV/AIDS support groups and are helping each other while some have taken on income generating activities (District official, Masindi).

Teachers go for HIV/AIDS counseling and testing services in government health facilities and TASO centers (FGD, Mbarara).

Teachers are often encouraged to visit health centers for HIV/AIDS Counseling and Testing (HCT) services and other support services like drugs (FGD, Mukono).

Teachers have also adopted protected sex; protected sex is a strategy that is widely used by teachers because they say that abstaining is not easy (FGD, Mukono).

Formation of Associations

The survey established that teachers living with HIV/AIDS have formed a national Association in the name of *Teachers Anti-AIDS Action Group (TAAG)*, an advocacy organization aimed at increasing HIV/AIDS awareness, access to HCT services, disclosure and encouraging positive living, linking teachers to HIV/AIDS care and support services. Currently, TAAG has got a membership of about 200 teachers with branches at some districts.

In addition, most of the teachers reported to be members of money '*pooling-groups*' for the benefit of teachers who may be in immediate financial need. For instance, when a teacher falls sick he/she may borrow from the pool and refund it at a later date. In some cases, teachers reportedly borrow money from micro- finance institutions and banks.

In our school, we have formed a financial saving scheme to cater for teachers' economic interests in times of crisis. At the end of every month, every teacher pools a specified amount of money that can be borrowed by a teacher who is in need at a reasonable interest rate. This particular saving scheme has greatly impacted on the lives of teachers given the fact that almost every teacher has a dependant (FGD, Kamuli).

We take up small loans to supplement our incomes but the terms are not favorable. (FGD, TAAG).

Some teachers have accessed loans from financial institutions although many teachers fear to do so due to attached high interest rates. (FGD, Iganga).

HIV/AIDS sensitization

It was further found that teachers are not only recipients of HIV/AIDS information through various channels as already pointed out earlier but they are also involved in dissemination of the same information to pupils/students in schools. The PIASCY program for instance has been instrumental in training primary school teachers to implement HIV/AIDS control and prevention activities in primary schools. In addition, it was reported that teachers talk about HIV/AIDS and its consequences among themselves.

We have a teacher who lost her husband to what was suspected to be HIV/AIDS. But because of the discussions they had at school she got encouraged to go for HIV/AIDS test. She turned positive and is now living positively. Those who are married overcome temptations and remain faithful to their spouses (Head teacher, Nebbi).

Income Generating Activities (IGAs)

The survey also revealed that teachers engage in various income generating ventures in order to boost their meager income. These include small scale farming and petty trade as earlier mentioned. This endeavor was reported to be in view of their ever increasing challenges of meeting basic needs including the costs of medical care.

They carry out farming to get food to eat at home as their meager salary goes on other things that they cannot produce for themselves (Head teacher, Mukono).

HIV/AIDS Services Available in Schools

A number of strategies through which schools have been supportive in addressing the impact of HIV/AIDS among teachers were reported. Provision of HIV/AIDS information was the most widely mentioned service offered by the schools reported by (47%) of the teachers. Other services reported included: campaigns against stigma and discrimination (10%), linking teachers to HCT (9.5%) and avoiding unfair dismissal (9.5%). It is also worth noting that quite a number of teachers (33%) said their schools were not providing any support in relation to HIV/AIDS. Table 3.14 presents HIV/AIDS services available in schools.

Table 3.14: HIV/AIDS Services Available in Schools

Ways supportive	Frequency	Percentage
Provide HIV/AIDS information	114	47.3
None	79	32.8
Discourages discrimination / stigma	25	10.4

No unfair dismissal on account of s	23	9.5
Link teachers to HCT services	23	9.5
Offers a sick leave with payment	16	6.6
Advocate for loans for teachers	15	6.2
Link to support groups	9	3.7
Support teachers to access ARVS	6	2.5
Advocate for reduced man hour for teachers	2	0.8

3.11 Challenges in Addressing the Negative Impact of HIV/AIDS on Teachers

The survey findings show that the main challenges faced in addressing the negative impact of HIV/AIDS among teachers were: limited information (42%), limited access to HIV/AIDS care and support services (36%), poor pay (32%), and stigma and discrimination (31%) as indicated in Table 3.15.

Table: 3. 15 Challenges in Addressing the Effects of HIV/AIDS on Teachers

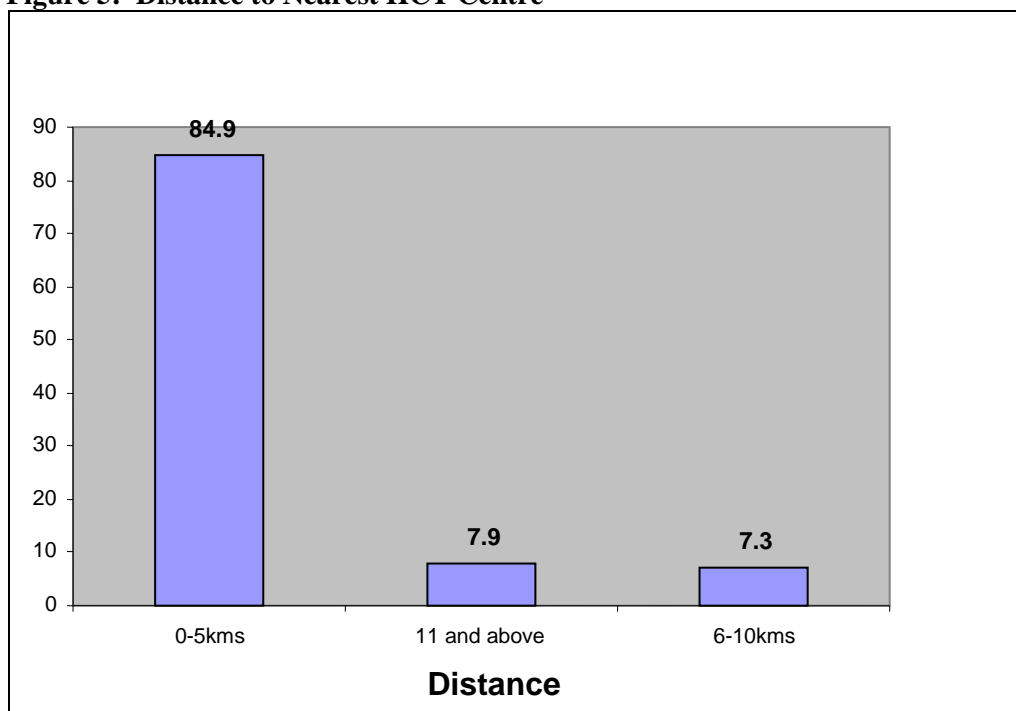
Problems	Frequency	Percentage
Low information	94	42.3
Lack of access to HIV/AIDS care & support services	80	36.0
Poor pay	70	31.5
Stigma and discrimination	68	30.6
Poor policy implementation	24	10.8
Unresponsiveness	23	10.4
Increased work load	18	8.1
Fear of dismissal	7	3.2
Lack of disclosure	6	2.7
Lack of HCT	6	2.7

Totals may exceed 100% due to multiple responses

3.11.1 HIV/AIDS Counselling and Testing (HCT)

The majority (98%) of the teachers had heard about HCT. Government health facilities were the leading source (75%) of HCT, followed by NGO/mission health facilities (15%) and private/drug shops (8%). Eighty five percent of the teachers live within a distance of 5kms to the nearest HCT centre as depicted in Figure 5.

Figure 5: Distance to Nearest HCT Centre



3.11.2 Utilization of HCT Services by Teachers

Awareness of HIV/AIDS status can motivate individuals to further prevent HIV infection. Survey data revealed that 65% of the teachers reported to have tested for HIV/AIDS which was very high compared to the national figures, 13% for women and 11% for men as documented by the HIV/AIDS Sero Behavioral Survey 2004/5.

More teachers in private schools had reportedly tested for HIV/AIDS compared to those in public/government schools. There were no variations across the different regions, gender and type of school. The study revealed a significant relationship between age and testing for HIV/AIDS. More young teachers aged below 39 years had tested for HIV/AIDS compared to older teachers. Of those who had tested for HIV/AIDS, 47% went to government health facility. A similar proportion (18%) reported to have taken the test in private clinics, NGO hospitals and HIV/AIDS support organizations as indicated in table 3.16. Results in Table 3.17 show that 55% of respondents reported to have taken the test more than one year before the survey while 21% tested less than a year. A similar percent (12%) tested within 3 and 6 months before the survey.

Table 3.16: Point of HIV Test

Place for HIV testing	Frequency	Percentage
Govt health facility	72	46.8
Private clinic	28	18.2
NGO/mission hospital	27	17.5
HIV/AIDS support organization	27	17.5

Table 3.17: Reported Time Lapse since HCT was Taken

Time	Frequency	Percentage
More than one year ago	85	55.2
Less than a year	32	20.8
Within the last 3 months	18	11.7
Within the last 6 months	18	11.7
Can't remember	1	.6

3.11.3 Reasons for Taking an HIV/AIDS Test

A number of reasons were given by teachers for taking an HIV/AIDS test. Table 3.18 indicates that 64% of those who tested wanted to know their HIV Sero-status without any specific purpose, 9% were going to get married and similar proportion said they were pregnant.

Table 3.18: Reasons for Taking an HIV/AIDS Test

Reasons	Frequency	Percentage
To know my status	98	63.6
I was going to get married	14	9.1
I was pregnant	14	9.1
Donation of blood	10	6.5
I was sick	7	4.5
Was advised by my health provider	3	1.9

Lost my partner	1	.6
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About half (48%) of those who had ever tested for HIV/AIDS went with their partners. Among those who did not go with their sexual partners, 47% reported that their partners were not around, 19% did not have partners, 17% did not want their partners to know and 10% said their partners refused as shown in Table 3.19.

Table 3.19: Reasons for not going with Sexual Partner

Reasons	Frequency	Percentage
Was not within reach	34	47.2
Have no partner	14	19.4
Did not want him to know	12	16.7
He /she refused	7	9.7
Wanted to prove whether am safe and we go jointly	3	4.2
Partner had died	2	2.8

3.11. 4 Reasons for not taking an HIV/AIDS test

Results in Table 3.20 indicate that low self risk perception was the main reason given for not taking HIV test reported by 47% of the teachers, followed by fear to know the outcome (29%) and unfriendly health facility staff (16%).

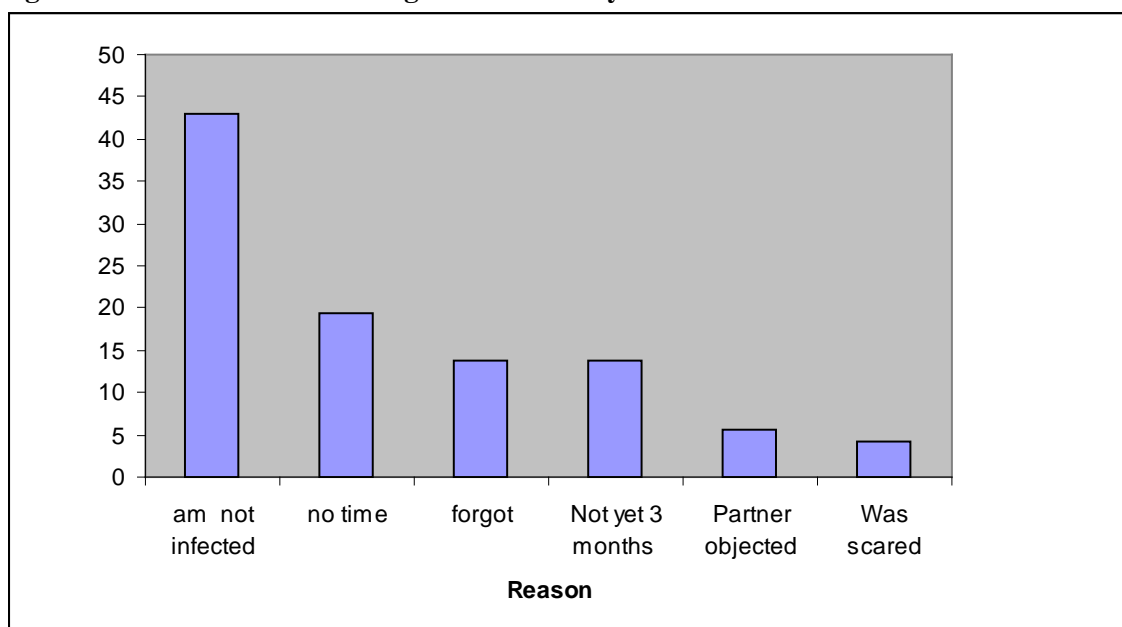
Table 3.20: Reasons for not taking an HIV/AIDS test

Reasons	Frequency	Percentage
Low self risk perception	39	47.0
Fear to know the outcome	24	28.9
Facility staff/unfriendly	13	15.7
Lack of confidentiality	3	3.6
Does not know where to go	2	2.4
Fear of rejection by society if positive	1	1.2
Facility too far from home	1	1.2

3.11.5 Disclosure of Results

The majority (99%) of the teachers who tested for HIV/AIDS received the results and 91% shared their results with other people. More female teachers shared their results with other people than the male teachers. Sharing of HIV/AIDS test results was more common among married teachers than the unmarried with no significant variations by school ownership, and age. Of those who shared their results 83% shared with partners/spouses, 8% with friends and 7% with relatives. Fifty one percent of the teachers who tested went back for a confirmatory test. The number of teachers who reported taking confirmatory test was highest in the north western region and lowest in central. The reasons for not taking a confirmatory test varied among respondents as illustrated in Figure 6. Forty three percent said they were sure of their status, 19% had no time, 14% did not care to go back and an equal proportion, (14%) said it was not time yet to go for the confirmatory test since they had taken the test less than three months before. Table 3.23 below summarizes the reasons for not taking a confirmatory test.

Figure 6: Reasons for Not Taking a Confirmatory Test



In contrary, results from the qualitative dimension of the survey show that many teachers have not tested for HIV. As a result, due to late diagnosis and lack of counseling infected teachers die prematurely.

Most teachers are not willing to test for HIV/AIDS in order to know their status early in time. They instead seek assistance when it is already too late. When someone is still strong despite their involvement in risky behavior such as having unprotected sex they don't go in to test until their immunity has been damaged beyond repair (District official, Iganga)

HIV/AIDS presents the biggest challenge in the education system where a considerable proportion of the teaching force is faced with incapacitation or death due to the pandemic. A lot of appeals have been passed to teachers to access HCT services, but many of them have not taken the appeals seriously. As a result the district has lost many teachers to HIV/AIDS. (District official, Iganga)

3.11 Available HIV/AIDS Care and Support Services

From the group discussions and key informant interviews it was evident that while a number of HIV/AIDS programs exist, none of these programs were said to be targeting teachers in particular. It is worth noting that these programs/services are open to the general public and therefore teachers are not excluded. These include government and non government-initiated programs. As earlier noted, PIASCY was the most prominently cited in the surveyed districts/schools. Others mentioned are TASO, AIC, UPHOLD, CHAI project, CARITAS, JCRC, AFFORD, CEFORD, World Vision, Action Aid, and UNDAFE.

Teachers under PIASCY were trained so as to pass on the information to the pupils hence they have directly benefited from the program, because they cannot teach what they have not comprehended (District Official, Iganga).

There is PIASCY, teachers benefit from it in so many ways. The benefits include facilitation and knowledge (FGD, Masindi).

Teachers have greatly benefited from PIASCY even though they are not directly targeted. It was noted that while teachers are passing on the PIASCY information to pupils they also benefit. Due to this, teachers now are bolder and are actively involved in the various interventions. Teachers reported that currently many of their colleagues go for HCT.

Some have been involved as counselors who deliver the information to fellow teachers and the pupils as well (FGD, Mukono).

Teachers are now bold and free when talking about HIV/AIDS yet they used to shy away before the interventions (FGD, Mukono).

Actually, the type of seminars that they are getting is how to handle these little ones and they just pass on the message to them (District Official, Mukono).

We are making sure that the PIASCY program for secondary schools will also have a teacher's component (District Official, Kampala).

3.12 Challenges Schools Face in Addressing the Impact of HIV/AIDS on Teachers

In order to identify existing gaps in HIV/AIDS programs in the schools the survey respondents were asked about the challenges the schools face in trying to reduce the negative impact of HIV/AIDS programs in the schools. As Table 3.21 below illustrates lack of funds was the most frequently mentioned (46%), followed by stigma and discrimination (27), lack of HIV/AIDS services (16%) and limited involvement of teachers (15%).

Table 3.21: Challenges Schools face in Addressing the Impact of HIV/AIDS on teachers

Challenges	Frequency	Percentage
Limited funding	101	45.7
Stigma and discrimination	60	27.1
Don't know	35	15.8
Lack of HIV services	35	15.8
Limited involvement of teachers	34	15.4
A few teachers targeted/limited coverage	21	9.5
Lack of interest by teachers	13	5.9
Weak administration	10	4.5
HIV not on curriculum	5	2.3
Lack of accommodation	4	1.8

Multiple responses percentages are more than 100%

Long distance to HIV/AIDS service centers was mentioned as one of the limitations to their utilization. It was observed that teachers have to travel long distances in order to access ARVs.

“Some teachers spend up to two days going to the nearest health unit to get ARVs this means that the pupils have to spend some time without being attended to by a teacher”
(District Official, Nebbi).

Teachers leave school to seek medication or for counseling services and it takes 2 to 3 days to reach the centers, there by causing absenteeism in the class (UNATU Official, Kampala).

We spend a lot of time in lines waiting for drugs; I wish we could have a window where we could get drugs faster (FGD, TAAG).

Another limitation reported is that some HIV/AIDS programs are designed to suit the interests of the funding bodies. In Mukono district, a catholic founded NGO was said to be running a behavioral change program but does not promote use of condoms. This leaves a gap in service in that the beneficiaries are left with limited options for HIV prevention.

3.13 HIV/AIDS Workplace Policy Implementation

In Uganda an HIV workplace policy was developed to mitigate the impact of HIV/AIDS at the workplace. The MoES adapted the HIV workplace policy and tailored it to the needs of the education sector and teachers in particular.

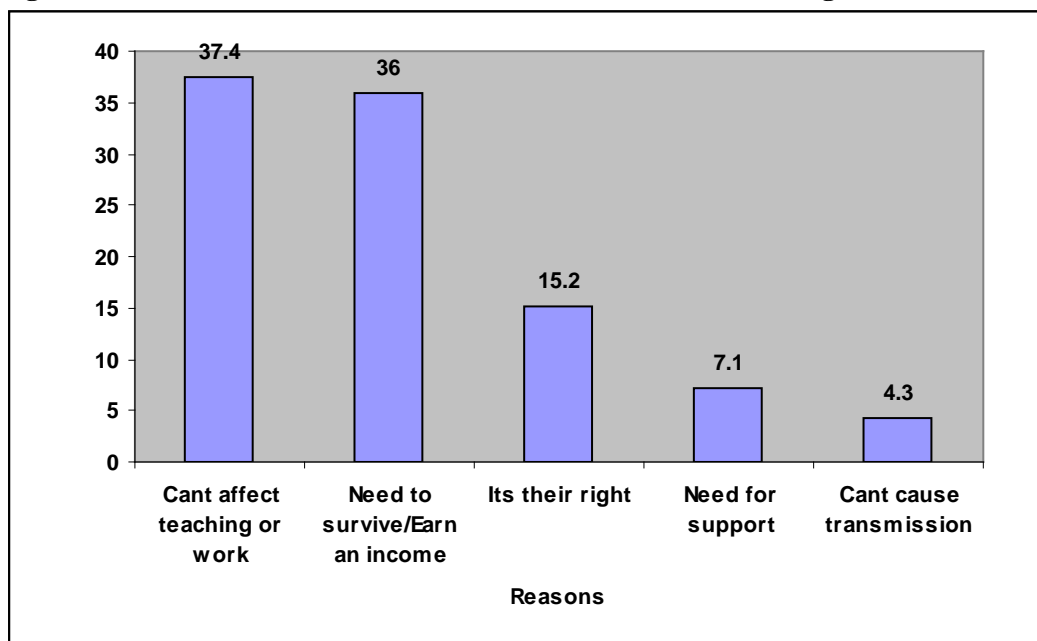
In partnership with development partners such as World Vision and USAID, the MoES developed a package of innovative interventions and strategies that constitute the Education Sector Workplace HIV policy to ensure HIV/AIDS prevention, care and support services for its employees at different levels. The survey sought to generate baseline information on teachers' knowledge and perceived benefits of the policy and envisaged implementation challenges.

3.14.1 Knowledge on the Right to Work

One of the provisions of the workplace policy is to guard against unfair dismissal of teachers who are living with HIV/AIDS from service. All teachers interviewed were asked if they think a teacher with HIV/AIDS should be left to teach. Ninety eight percent of the teachers agreed that an HIV positive teacher should be left to teach.

Figure 7 indicates that the main reasons teachers advanced included: teachers living with HIV can still teach (37%), they need to earn an income to survive (36%) and it is their right to work (15%).

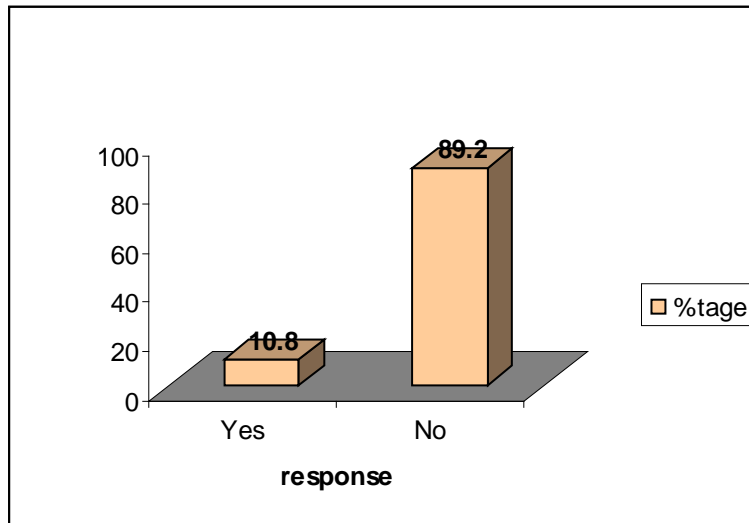
Figure 7: Reasons for HIV Positive Teachers to Continue Teaching



3.14.2 Knowledge and Perceived Benefits of the HIV/AIDS Workplace Policy

Whether teachers had heard about the HIV workplace policy for teachers, Figure 8 illustrates that only 11% of the teachers had heard about the policy. Awareness of MoES HIV/AIDS Workplace Policy was highest in the central region (23%) followed by North Western (12%), south western (5%) and lowest in the eastern (3%).

Figure 8: Knowledge on HIV/AIDS Workplace Policy



All the teachers who had heard about the policy were asked what they knew about it. Fifteen percent knew that the policy is meant to protect teachers from discrimination and 13% said the policy provides for HIV counseling and testing. The survey found that the same percentage of teachers interviewed (11%) were aware that the policy protects teachers against unfair dismissal on the account of being HIV positive, supports teachers to access ARVS and advocates for reduced man hours for HIV positive teachers. Similarly, qualitative findings indicate that there was limited knowledge on the HIV workplace policy among teachers.

HIV policy for teachers I have not come across but I am aware of the workplace policy for all civil servants which provide that a civil servant should not be unfairly treated like being dismissed from service because of HIV/AIDS status (Key Informant, Nebbi)

On elaboration however, a few participants acknowledged to have heard about the policy. Though, on probing, they were not conversant with specific issues pertaining to the policy. Those who reported to have heard about the policy had known about it mainly through newspapers and the radio.

It was reported in the newspapers that some organizations were fighting for the rights of teachers living with HIV/AIDS(District Official, Mukono).

I have heard adverts to that effect on radio (District Official, Kampala).

What you are saying I have ever heard about it but I never knew it was a policy (District Official, Mukono).

In as much as there still remains limited knowledge among the surveyed population, it turned out that teachers living with HIV/AIDS who are members of TAAG were more knowledgeable about the HIV/AIDS workplace policy. They were able to point out the objectives, strategies and perceived benefits of the policy. In addition, they were aware of the current status of its implementation and challenges.

“The policy is not disseminated and it is more on behaviour change advocacy and less on the teachers who are on ARVs, so they are more on prevention yet there is need for direct assistance to the teachers and those who are young positives and those who need palliative care”(Teacher Living with HIV/AIDS).

3.14.3 Perceived Benefits of the HIV Workplace Policy to Teachers

Teachers who knew the policy were asked to state ways in which they would benefit from the policy. Results in Table 3.22 indicate that 47% of the teachers said the policy would link them to support groups and 24% reported reduced stigma and discrimination. A similar percentage (21%) of teachers reported that the policy would guarantee sick leave with pay and eliminate unfair dismissal. Other perceived benefits reported included: supporting teachers to access ARVs (18%), provision of HIV/AIDS information (16%) and increased access to HCT (11%).

Table 3.22: Anticipated Benefits of the HIV Workplace Policy

Reasons	Frequency	Percentage
Link to support groups	6	47.4
No discrimination	9	23.7
Reduce unfair dismissal on account of HIV status	8	21.1
Guarantees a sick leave with payment	8	21.1
Support teachers to access ARVS	7	18.4
Provide HIV/AIDS information	3	15.8
Provide HCT to teachers	4	10.5
Advocate for loans for teachers	4	10.5
Advocate for reduced man hour	3	7.9

Totals may exceed 100% due to multiple responses

Similarly, data from FGDs and key informant interviews indicates that teachers anticipate benefiting from the policy as presented below.

Job Security

Teachers noted that the MoES HIV/AIDS workplace policy would help them keep their jobs even when they are HIV positive.

I think it will help teachers to keep their jobs even if they are infected (FGD, Mukono).

Protecting a teacher’s job even when he/she is infected with HIV is an incentive that would have multiple positive effects due to the HIV workplace policy (Teacher Living with HIV/AIDS.)

There are some teachers who are HIV positive and could be harassed especially in private institutions. So they need to be protected through the policy (District Official, Mukono).

Access to HIV/AIDS services

Teachers reported that the policy would benefit them by linking them to HIV/AIDS services such as HCT, ARVs and other care and support services.

One of the reasons as to why teachers do not go for HCT is because there is no incentive. It will therefore be beneficial if teachers know that even when the school administration gets to know their status there is a policy that protects them. Therefore, this policy could work as away to motivate teachers to seek HCT services (Teacher Living with HIV).

It would also help those who would want to come for treatment and get support from the school and community” (District Official, Nebbi).

Reduced workload for HIV positive teachers

Another benefit that emerged was that the policy will lead to reduction in workload for HIV positive teachers whenever they are not able to teach lessons assigned to them.

It would help teachers who are infected from being given too much work (District Official, Nebbi).

Sick leave will easily be given by the CAO because he will be guided by such a policy (District official, Nebbi).

3.14.4 Anticipated Policy Implementation Challenges

Survey respondents felt the implementation of the policy was likely to be affected by a host of factors. In the first instance, it was observed that follow up and supervision was expected to be deficient due to lack of funds and bureaucratic delays.

Secondly, it was noted that the implementation of the policy was likely to be hampered by the fact that quite a number of teachers who test for HIV/AIDS never disclose their sero-status to the school administrators. This, it was argued may make it hard for the administrators to intervene and appreciate the situation of teachers living with HIV/AIDS and offer necessary assistance.

Sick teachers do not come up to test. Even when they do so, they do not disclose their results hence continue to infect others (FGD, Iganga)

Fears were also expressed that the school administrators might not comply with the policy provisions. This means that teachers will not refer to the provisions of the workplace policy even if they know they protect them. In this instance, the policy will be rendered meaningless as it will not have served the purpose it was designed for. However, this kind of scenario participants noted might be more common in private schools than government aided ones since proprietors of private owned schools always want to maximize output from their teaching staff.

Some of the teachers are harassed, yet they cannot report their bosses to higher authorities (District Official, Mukono).

Again, it was observed that the implementation of the policy is likely to put the schools in a compromising situation since they may be faced with the question of reconciling the work place policy provisions and performance expectations.

It was reported that primary schools in some districts sign performance agreements to realize some set academic targets. This however, calls for full time commitment of the teaching staff, which in reality will not be possible to achieve in case of sickness of a teacher.

The policy which the government and the individual school head teachers have signed impacts negatively particularly on the teachers who are infected and affected by HIV/AIDS (FGD, Iganga).

Teachers were also worried that some teachers might take advantage of the policy to fake excuses of sickness when actually they are going on other business. It was noted that a teacher living with HIV/AIDS might take advantage of the condition to keep a way from school even when, she/he is still strong enough and able to teach.

Other teachers may abuse their rights for instance instead of going for support services for which he has asked will go else where to do other things. (District Official, Nebbi).

3.15 Respondents' Suggestions to Address HIV/AIDS Needs for Teachers

Respondents suggested ways to address teachers' HIV/AIDS needs in schools. Results in Table 3.23 show that 55% of the teachers suggested provision of HIV information, 50% HCT, 49% support and care services and 39% ARVs. Other services suggested included: income generating activities (27%), treatment of opportunistic infections (16%), school fees support (13%) and advocacy for rights (12%).

Table 3.23: Suggestions to Address HIV/AIDS among Teachers

Ways	Frequency	Percentage
HIV/AIDS information dissemination	133	54.5
HCT	119	49.6
Support and Care services	118	49.2
Provision of ARVs	93	38.8
Access to loans / IGAs	64	26.7
Treatment of opportunistic infection	39	16.3
Provision of school fees	31	12.9
Advocate for teachers rights	29	12.1
Reduce on workload	11	4.6
Form an association for teachers living with HIV/AIDS	6	2.5
Increase in salary	4	1.7
Others	3	1.2

Totals may exceed 100% due to multiple responses

Similarly, in the focus group discussions and key informant interviews participants raised more or less similar suggestions as to how teachers' HIV/AIDS needs can be addressed as presented.

Income generating activities

Teachers expressed the need to have extra sources of income to supplement their meager earnings.

The monthly pay for the teachers is meager thus they need to be helped financially particularly with soft loans which do not carry high interest. This will not only help them to cover medical costs but will also enable them to take their children to good schools (DEO, Iganga).

Teachers need to be empowered economically and this can be done by improving their incomes and life skills (FGD, Kamuli).

Job retention

Teachers were concerned that there is need for fair treatment of those who are living with HIV/AIDS. They should not be dismissed from their jobs on account of their health status.

Teachers should be left on the payroll to enable them live positively (District Official, Iganga).

Protection on job is paramount in that some head teachers tend to dismiss teachers who are infected with HIV/AIDS. They are removed off the payroll and quite often victimized with transfers because of their inability to disclose. The DEO only finds out that the teacher was unfairly transferred later on when the teacher appeals and yet the transfer has already been effected. Surely, there is need for the teacher to be protected since some of them innocently get the infection through their partners (District Official, Kamuli).

Care and support services

There was emphasis on the need for care and support for teachers living with HIV/AIDS in terms of: provision of ARVs; septrin prophylaxis; treatment of opportunistic infections; psychosocial support; nutritional support; and HCT.

There is also need to encourage them to go for HIV test because when they get to know their status, they can plan better their lives (DEO, Nebbi).

The infected teachers need to be counseled so that they are brought to a realization that they are still useful to the society and can live longer (positive living). If TASO could continuously come to the schools with all their facilities so that teachers are counseled and tested. This in the long run will ensure positive living to the infected persons as well as “stay away” from the infection to those not yet infected (FGD, Iganga).

There is need for HIV counseling and testing so that teachers take it upon themselves to find out their sero- status. This is vital with regard to future planning for dependants and above all for positive living (FGD, Kamuli).

Food should be given to the infected and affected teachers since most drugs need to be taken with food (District Official, Iganga).

Improved remuneration

The need for increment in teachers' salaries was the most commonly mentioned recommendation in the discussions. This was attributed to the fact that poor pay was said to be one of the major pre-disposing factors to HIV/AIDS especially among female teachers. It was observed that improved remuneration would reduce involvement in risky behaviors that exposes them to HIV/AIDS.

In addition improved remuneration would enable infected and affected teachers access relevant HIV/AIDS services such as ARVs and proper nutrition.

There is need for increment in teachers' salaries. This is even needed because there are many dependants whose parents died of HIV/AIDS. The government should increase salary to at least 350,000/= (FGD, Iganga).

The government should also fix a salary ceiling for private schools. This is because they pay less than government schools (FGD, Mukono).

Improve conditions of service

There was a general appeal for improved working conditions for teachers including proper accommodation and avoidance of unfair transfer of infected teachers.

The working environment of teachers is also not attractive. A teacher reports to the school but has no accommodation. So, teachers end up renting in places that are either close to busy drinking joints or lodges with all sorts of evil operations thus exposing them to HIV/AIDS infection (District Official, Iganga).

I am pleading on behalf of all the teachers' in Uganda if a married teacher has to be transferred; arrangements should be made to transfer the partner as well to avoid infections through infidelity (FGD, Kamuli).

Provision of HIV/AIDS information

Whereas this survey established high awareness levels about HIV/AIDS among teachers, the need for continued sensitization was noted. This would help teachers make informed decisions regarding their actions. Teachers suggested use of all available channels of communication.

They need sensitization, we need to talk to these teachers and sensitize them on HIV/AIDS (District Official, Nebbi).

The District can also plan and have a forum for all head teachers under one co-ordinating centre for providing HIV/AIDS information (District Official, Nebbi).

Teachers need continuous sensitization. Knowledge is important. Knowledge is power. Counseling is needed in groups and individually. However, it is better individually because there a person can express himself more freely (Head Teacher, Nebbi).

Film shows especially in the rural areas are important. Many youth and teachers love to watch films. It follows hence forth that if slides like those of syphilis are shown, chances are that one may fear and hence refrain from promiscuity (Principal, CORE PTC).

Well, I think the biggest weapon to fight HIV/AIDS is information. They need to get updated. Teachers have been ignored. You see they are the trumpets outside there. (Head Teacher, Mukono)

First of all there should be refresher courses for these teachers especially on current information concerning HIV/AIDS (District Official, Mukono).

Apparently what teachers need is counseling and sensitization. Teachers need to be equipped with knowledge on what to do for a positive living. This is because when one finds him/herself infected, they tend to look at themselves as outcasts (District Official, Kamuli).

Strengthening Teachers Code of Ethics

It was suggested that there is need for reviving and upholding teachers' code of ethics. The participants were of the view that, if teachers strictly followed their code of conduct it would greatly reduce the chances of risky behaviors that would otherwise expose them to HIV/AIDS.

If teachers go by their professional ethics, they would not be in position to run from one partner to the other including their own pupils. There is need to add value and quality to education and letting all the stake holders know what education is for (District Official, Mbarara).

Reduction of work load

Teachers also suggested that there is need to reduce on the amount of work assigned to teachers living with HIV/AIDS. Teachers were of the view that less work would reduce stress and allow them time for rest and to seek relevant HIV/AIDS services which are usually not within the school environment.

Consider a situation where a teacher is expected to teach the entire subject to a class of 150 pupils. This puts teachers to tension and if one is already infected, his/her health deteriorates faster due to exhaustion and stress. There is therefore need for reduced workload (FGD, Iganga).

Constantly on daily basis teachers must prepare for lessons after normal teaching hours, which is strenuous. There should be advocacy for less working time and then other benefits such as gratuity (District Official, Mbarara).

Implementation of the HIV/AIDS Workplace Policy

There is need to implement the HIV/AIDS workplace policy as a way of protecting the rights of teachers living with HIV/AIDS. It was reported that teachers would benefit from proper implementation of the work place policy in various ways such as protection from unfair dismissal, reduced stigma and discrimination and access to other HIV/AIDS services. It was recommended that the policy should consider teachers in the private sector as well.

Teachers in private schools should also be considered by policies on HIV/AIDS. This is because government has not considered them, so the government should put a policy considering private school's teachers too in regard to HIV/AIDS (FGD, Mukono).

Protection against Stigma and Discrimination

Also strongly suggested was the need to protect teachers against stigma and discrimination both within the school environment and the community where they live. It was said that it is important to ensure that teachers living with HIV/AIDS are accepted and supported to live positively.

If there is an HIV/AIDS positive teacher who has done an interview and excelled and the teacher is known to be infected with HIV/AIDS, obviously, the head teacher would not take him/her up on the excuse that he/her is to die anytime. They forget the fact that some people have lived with HIV/AIDS for more than 10 years (FGD, Iganga).

Provision of Sick Leave

Teachers further felt that it is important for teachers living with HIV/AIDS to be granted adequate sick leave to allow them seek medical care and recover. In case of a sick leave the teacher should be granted sick leave with pay to enable him/her survive.

There is need for sick leave. The head teachers should assess the situation of the sick teacher and provide the leave accordingly. (District Official, Kamuli).

Terminal benefits and gratuity

There was concern that teachers who are terminally ill should be able to access their terminal benefits and gratuity before they die. It was reported that there is need to quicken the process of accessing terminal benefits and gratuity with special consideration for teachers living way from the centre. Further more, it was suggested that teachers living with HIV/AIDS should be allowed to retire early with all the benefits they are entitled to.

There is need for early retirement for teachers infected with HIV. The teachers requested UNATU to come up with a way of reducing the bureaucracy involved in processing terminal benefits (FGD, Teachers Living with HIV/AIDS).

It is really sad for a teacher who is seriously ill not to be allowed to retire and when he/she dies it becomes too difficult for his/her family to access the benefits/gratuity (District Official, Kamuli).

In addition, the government should bear in mind teachers terminal benefits and gratuity before they die in order to help the dependants of the affected teachers (DEO, Iganga).

4.0 Selected Indicators for the EFAIDS Project

A number of baseline indicators were selected from the study findings to form baseline indicators for monitoring and evaluating the EFAIDS program. These were identified in the areas of: knowledge on HIV/AIDS; perceptions and attitudes; behaviour in relation to HIV/AIDS; impact on education and teachers and available HIV/AIDS services.

Table 4.1: Selected Baseline Indicators

Indicators	Baseline results
Knowledge on transmission	<ul style="list-style-type: none"> 100% were aware of the main way of HIV transmission
Rejection of misconceptions	<ul style="list-style-type: none"> Majority of teachers rejected misconceptions on HIV transmission: 98% rejected HIV transmission through food 93% through mosquito bites 96% and 97% rejected sharing abed and a toilet respectively 90% rejected the view that HIV is a curse from God
Knowledge on prevention ABC strategy	<ul style="list-style-type: none"> 89% were knowledgeable on abstinence as way of prevention 73% on use of condoms 75% on being faithful
Knowledge on HIV services	<ul style="list-style-type: none"> 99% know there are drugs to prolong life if one has HIV/AIDS 69% knew of ARVS 17% knew about septrin prophylaxis 49% had correct information on how long to take ARVs
Knowledge on HIV work place policy	<ul style="list-style-type: none"> 11% were aware of work place policy
Behavior indicators	<ul style="list-style-type: none"> 90% of teachers consider themselves at risk of acquiring HIV 10% of teachers hers had non regular partners in the last 12 months 87% said they had used a condom with the non regular partners 87% of teachers interviewed take alcohol 65% of teachers interviewed had tested for HIV 99% received results 91% disclosed
Impact of HIV on teachers	<ul style="list-style-type: none"> 92% said HIV had affected teachers 74% Absenteeism 71% Time lost caring for sick ones 51% Inefficiency in teaching 38% said they had lost a teacher to H IV in last 5 years
Available services	<ul style="list-style-type: none"> 37% said HIV/AIDS information 25% no intervention at all.
Source of information	<ul style="list-style-type: none"> 83% access information through radio 45% access HIV/AIDS information at health centres 21% access information through HIV/AIDS school program 26% Most preferred source of information was radio

4.1 Discussion of Results

This study set out to investigate the impact of HIV/AIDS on the education sector with particular focus on teachers. It covered the districts of Kampala, Mukono, Iganga, Kamuli, Mbarara and Kasese. The findings will guide planning, implementation, monitoring and evaluation of the EFAIDS project implemented by UNATU. In this section we discuss the results of the study.

The survey revealed very high knowledge levels on HIV/AIDS among teachers. This is not surprising because even earlier studies such the UDHS, (2001) had found similar high knowledge levels among the general population. One would expect teachers to be more knowledgeable given their education levels and exposure to HIV/AIDS information compared to the general population. Most teachers have been involved in HIV/AIDS dissemination to pupils in schools under the PIASCY program and through the inclusion of sex education in school curriculum. In addition, high levels of knowledge could be attributed to mass education campaigns by Ministry of Health and Civil Society Organizations.

The radio emerged as the most common source of information on HIV/AIDS as well as the most preferred by the teachers. This is not only because it is convenient but it is easily accessible following liberalization of mass media industry resulting into the proliferation of local FM stations. The HIV/AIDS campaign has exploited this opportunity and HIV/AIDS messages and programs feature commonly on the FM stations in local languages. Earlier studies such as Media Survey by Steadman (2005) and Uganda National Population and Housing Census (2002) also found that the radio is the main source of information on health issues.

Sex with irregular and multiple sexual partners as well as taking alcohol were considered risky sexual behaviors that expose teachers to HIV/AIDS. One out of every ten teachers interviewed reported to have had sex with a non regular partner within the last 12 months preceding the survey. Regional disparities revealed that sex with non regular partners and alcohol consumption were reported most in the north - western region a situation that could be attributable to instability in the neighboring districts that have disrupted the communities.

Majority of the teachers considered themselves to be at risk of contracting HIV/AIDS. Overall teachers perceived HIV/AIDS to be a disease that any body can get irrespective of socio-economic status. However a number of risk factors unique to teachers were raised including; easy access to adolescent girls, poor salaries, delay to get on payroll and transfers to distant schools away from their regular sexual partners. Other factors that expose teachers to HIV/AIDS include alcohol consumption, having unprotected sex and being unfaithful.

The teachers were aware that there are drugs that can prolong the life of a person living with HIV/AIDS. A fair majority knew about ARVS while only few knew of septrin prophylaxis and yet this is equally a very important service for people living with HIV/AIDS.

The high awareness levels could be attributed to the emphasis currently being given to HIV/AIDS treatment, care and support. This presents an opportunity for interventions aimed at mitigating the negative effects of HIV/AIDS among teachers.

It was evident from the findings that HIV/AIDS presents a major challenge to the education sector and teachers in particular. A considerable percentage of the teachers interviewed reported that their schools had lost at least a teacher to suspected HIV/AIDS within the last 5 years. Similarly, qualitative evidence confirmed this claim. Teachers in the urban areas were said to be more vulnerable than their rural counterparts.

Almost every teacher reported to have been affected by HIV/AIDS either directly or indirectly. Key of the effects of HIV/AIDS on the education sector and teachers in particular were reported to be increased absenteeism, loss of time caring for the sick, inefficiency in teaching, stigma and discrimination, unfair transfers, unfair dismissals without terminal benefits. All the above factors have had a bearing on the performance of teachers and ultimately on quality of education.

Although the impact of HIV/AIDS on the education sector and teachers in particular was enormous, teachers had limited ways of coping. The coping mechanisms reported were mainly teachers' own initiatives that included; sharing workload incase a teacher is weak and financial contributions towards the welfare of an infected teacher. Other coping mechanisms included involvement in HIV/AIDS sensitization, seeking HIV counseling and testing services, joining psychosocial support groups and uptake of ARVs from government health facilities and non governmental service organizations.

Worth noting is the fact that teachers living with HIV/AIDS have formed a national Association named *Teachers Anti-AIDS Action Group* (TAAG) in their effort to fight the pandemic. The purpose is to increase HIV/AIDS awareness, access to HCT services, disclosure and encourage positive living, linking teachers to HIV/AIDS care and support services. The association has current membership of about 200 teachers with branches at district level. This provides a great opportunity for teachers themselves to act collectively in an effort to mitigate the negative impact of HIV/AIDS. This association can as well serve as an entry for other HIV/AIDS interventions that target teachers.

The results of this study put the percentage of teachers who have ever tested for HIV much higher than the national average according to the HIV/AIDS Sero Behavioral Survey (2004/5). However, the national average is not disaggregated according to occupation. Comparison across school categories indicate that more teachers in private schools had reportedly tested for HIV/AIDS compared to those in government. Whereas government health facilities were the main source of HIV counselling and testing services, there was also a considerable number of teachers who tested from mission health facilities and from HIV/AIDS support organizations such as TASO and AIC as well as private clinics. To scale up this service, there will be need to utilize all these service points.

The survey noted good practices among teachers regarding HIV/AIDS that should be consolidated. They include not only being able to receive the results but also to share the results with other people mostly sexual partners. Female and married teachers shared their results with other people more than their male counterparts.

A number of challenges were reported in addressing HIV/AIDS among teachers. Lack of disclosure due to fear of the response from the school administration was the most commonly mentioned challenge. It was revealed that when a teacher is known to be HIV positive such a teacher faces the risk of dismissal, transfer and denial of any opportunities such as further studies. Teachers also fear to disclose their HIV status due to associated stigma and discrimination. Other challenges were poor pay and limited access to HIV/AIDS services.

Although only a few teachers had heard of the HIV/AIDS workplace policy for teachers, it was anticipated that operationalization of the policy will go along way to address the above challenges. Overall, most teachers were optimistic that the policy would link them to HIV/AIDS support services, reduce stigma and discrimination, encourage disclosure, guarantee sick leave with pay and guard against unfair dismissal.

However, compared to government aided schools, there was concern that the HIV/AIDS workplace policy may not benefit teachers in private schools because these schools aim at maximizing profits and therefore they are less likely to implement the policy. Private schools for example will not pay for days a teacher has not worked. Furthermore, the government does not directly oversee the operations of private schools.

5.0 Conclusions and recommendations

5.1 Conclusions

Survey findings revealed that teachers are highly knowledgeable on HIV transmission and prevention, although knowledge on HIV/AIDS services was not as high. The main source of information on HIV/AIDS is the radio.

Overall teachers perceived themselves at risk of acquiring HIV/AIDS and that the main predisposing factors reported were easy access to girls, poor remuneration and poor working conditions.

With regard to social behavior the survey found that most teachers consume alcohol which was reported as a predisposing factor to HIV. However a few teachers reported to have multiple sexual partners. It is evident from the survey findings that HIV has negatively affected the education sector and teachers in particular in a number of ways. While the survey did not establish HIV prevalence among teachers, it was reported that teachers have died of suspected HIV related conditions and others are living with HIV/AIDS. This has resulted in teacher absenteeism, loss of time, inefficiency at work, stigma and discrimination, increased workload and dismissal from work.

Teachers cope with the HIV/AIDS pandemic in various ways. A considerable number of teachers reported to have tested for HIV and are seeking HIV/AIDS related services such as HCT, ARVs, treatment of opportunistic infections and PMTCT and use of condoms. In addition teachers have formed and others have joined care and support groups. Other coping mechanisms teachers reported include sharing workload, starting income generating activities and giving HIV information.

There were no HIV/AIDS programs in schools particularly targeting teachers. However teachers were involved in HIV/AIDS programs targeting students/pupils such as PIASCY. Teachers access HIV/AIDS services mainly from government and NGO health facilities and care and support organizations such as TASO.

The HIV/AIDS workplace policy for teachers was not being implemented at the time of the survey and therefore most of the teachers were not aware about it. Although teachers were positive that the policy would benefit them in various ways including protection of unfair dismissal, reduction of stigma and discrimination, linkage to HIV care, treatment and support services.

The major challenge of addressing HIV problems among teachers was reported to be lack of disclosure to the school administration. This was attributed to fear of dismissal, unfair transfers and discrimination manifested in denial of opportunities for teachers living with HIV. Other challenges were reported to be lack of funds, limited information, unresponsive school administration, poor pay and lack of HIV services in school environments.

5.2 Recommendations

1. There is need to introduce HIV/AIDS services in schools so as to increase access and utilization. The services should be made tailored to the needs of teachers in terms of privacy and confidentiality, affordability and quality. This could be done in two ways either using the schools as out reach centers or linking teachers to HIV/AIDS service centers.
2. The survey also recommends that teachers should be encouraged to go for HCT and disclose their status to access HIV/AIDS services. This would also lead to better management of the condition through positive living at individual level. Disclosure would also lead to increased support by the family, fellow teachers and school administration.
3. The HIV/AIDS workplace policy should be operationalized in order to help school administration support teachers living with HIV/AIDS. There is need to disseminate the policy widely and build capacity in terms of training, funding and provision of materials to facilitate district and school administrators to be able to implement the policy effectively and efficiently. Implementation of the HIV workplace policy is expected to address HIV work related challenges including absenteeism, workload, sick leave, gratuity, terminal benefits and unfair dismissal and transfers due to HIV status are addressed.
4. There is need to explore avenues and the viability of implementing the HIV workplace policy for teachers in private schools. This is because the survey identified a number of challenges with regard to pursuing implementation of the HIV workplace policy in private schools.
5. The HIV/AIDS programs targeting teachers should address spouses and biological children of teachers living with HIV/AIDS or who have died of HIV/AIDS. Similarly HIV/AIDS programs targeting teachers should build capacity of teachers to manage HIV positive children within the school. This will ensure holistic HIV management for teachers and their families.

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APPENDIX 1: List of Schools Visited

District	Sub county	Name of School
1. Kampala	CENTRAL	BUGANDA ROAD PRIMARY SCCHOOL
2. Kampala	MAKINDYE	KIBULI MUSLIM TEACHERS COLLEGE
3. Kampala	RUBAGA	MENGO S S
4. Kampala	MAKINDYE	NAKINYUGUZU PARENTS SCHOOL
5. Kampala	MAKINDYE	NANGANDA PRIMARY SCHOOL
6. Kampala	MAKINDYE	ST CATHERINE COLLEGE NAKINYIGUZI
7. Kampala	MAKINDYE	SUNLIGHT PREPARATORY NURSERY SCH
8. Mukono	MUKONO T/C	BISHOP WEST PRIMARY SCHOOL
9. Mukono	NABAAL	KALAGI ISLAMIC ORPHANAGE CENTRE
10. Mukono	NABAAL	NAKANYONYI DAY AND BOARDING SCHOOL
11. Mukono	NKOKONJERU	SANTA MARIA NKOKONJERU PTC
12. Mukono	NABBALE	ST JOSEPH S S NAGALAMA
13. Mukono	NKOKONJERU	ST PETERS NKOKONJERU SS S
14. Kamuli	BALAWOLI	BALAWOLI PRIMARY SCHOL
15. Kamuli	KAMULI TOWN COUNCIL	BEZALLE PREPARATORY SCHOOL
16. Kamuli	NABWIGULU	BUSOGA HIGH SCHOOL
17. Kamuli	KAMULI TOWN COUNCIL	KAMULI TOWNSHIP PS
18. Kamuli	TOWN COUNCIL	KIIRA PARENT'S JUNIOR SCH
19. Kamuli	NABWIGULU	REV NAYEGA P S
20. Kamuli	NABWINGULU	ZAIDI AL HAGIR EDUCATIONAL CENTRE
21. Iganga	BULAMAGI	BISHOP WILLIS CORE PTC
22. Iganga	IGANGA TOWN COUNCIL	BUTT VILLA KINDARGATEN NURSERY
23. Iganga	IGANGA TOWN COUNCIL	DAWN PRIME ACADEMY P S
24. Iganga	TOWN COUNCIL	IGANGA TOWN COUNCIL PRIMARY SCHOOL
25. Iganga	BULANGI	KIRIBAKI SEC SCH
26. Iganga	KIGULU NORTH	KUGULU COLLEGE NAMUNGALWE
27. Iganga	NAMUNGALWE	NAMUNGALWE PRI SCH
28. Iganga	IBULANKU	NKUUTU MEMORIAL SEC SCH
29. Masindi	MASINDI T/C	ASABA P/SC
30. Masindi	MASINDI TOWN COUNCIL	EXCELL BOARDING SCHOOL
31. Masindi	MIIRIA	JUNCTION STAR SS
32. Masindi	BURULI COUNTY	KAMURASI CORE PTC
33. Masindi	BURULI	KAMURASI DEMO PRI SCHOOL
34. Masindi	NYANGAI S/C	KAMURASI P/S
35. Masindi	MASINDI TOWN COUNCIL	LIGHT KINDERGATTEN
36. Masindi	MASINDI T/C	MASINDI PUBLIC
37. Nebbi	KUCWINY SUCOUNTY,PAYERE COUNTRY	AKABA PRIMARY SCH
38. Nebbi	NEBBI/FOREST WARD	NEBBI S S S
39. Nebbi	NEBBI TOWN COUNCIL	CITY STAR NURSERY P/S
40. Nebbi	NEBBI T/C	CLASSIC
41. Nebbi	NEBBI TOWN COUNCIL	NEBBI PROGRESSIVE SS
42. Nebbi	FOREST WARD,NEBBI TOWN COUNCIL	NEBBI TOWN SS S
43. Nebbi	PAIDHA, OKORO COUNTY	OTURUGANG BOYS PRI SCH

44. Nebbi	PAIDHA-OKORO COUNTY	PAIDHA CORE PTC
45. Nebbi	PAIDHA	PAKADHA SEED SEC
46. Nebbi	PAIDHA ,OKORO COUNTY	PAKADHA PRI SCH
47. Mbarara	NYAKAYOJO	BISHOP STUART CORE PTC
48. Mbarara	RUGANDO	KINONI HIGH SCHOOL
49. Mbarara	RUGANDO	KINONI INTEGRATED P/S
50. Mbarara	KAMUKUZI	MBARARA KINDERGATTEN
51. Mbarara	KAMUKUZI	NTARE SCHOOL
52. Mbarara	RWANYAMAHEMBE	RUTOOMA MODERN P/S
53. Mbarara	RUBINDI	ST ANDREWS S S
54. Mbarara	RWANYAMAHEMBE	WAGGA WAGGA P/S
55. Kasese	BWERA	BWERA DEMONSTRATION SCHOOL
56. Kasese	BWERA	BWERA SEC SCHOOL
57. Kasese	BWERA	BWERA TEACHERS COLLEGE
58. Kasese	KASESE TOWN COUNCIL	EQUATOR KINDERGATTEN
59. Kasese	KASESE TOWN COUNCIL	KASESE HIGH SCHOOL
60. Kasese	KASESE TOWN COUNCIL	KASESE SEC SCH
61. Kasese	KASESE TOWN COUNCIL	ROCK PRIMARY SCHOOL
62. Kasese	RUKOOKI	RUKOOKI MODEL P SCHOOL

APPENDIX 2: Study Tools

A SURVEY ON THE IMPACT OF HIV/AIDS ON EDUCATION AND TEACHERS IN UGANDA Individual Teachers' Questionnaire

Introductory Remarks

Good morning /Afternoon, my name isam here on behalf of Uganda National Teachers Union (UNATU) – an organization that promotes and protects the rights and interests of teachers in Uganda. We are conducting a survey on the impact of HIV/AIDS on the education sector and teachers in particular.

The survey findings will be used to design HIV/AIDS programs targeting teachers. You have been selected to participate in this study because we feel you have the experience and information that can be used to design appropriate HIV/AIDS programs that target teachers.

Participation in this study is voluntary. You are free not to respond to any question you feel uncomfortable with and you can withdraw from the interview. This will not have any negative implication on you and your job. However, I wish to assure you that the information you give me shall be kept confidential and will only be used for purposes of the study. I therefore kindly request you to share your honest opinions on this subject. Our discussion will last approximately 40 minutes.

Do you agree to participate? 1. Yes 2. No (**Terminate the interview**)

Date of interview ----/02/07

Time interview started -----

Interviewer's name-----

SECTION A: IDENTIFICATION PARTICULARS OF THE RESPONDENT		
1	REGION	1. Central 2. South –Western 3. Eastern 4. North Western
2	LOCATION	1. Rural 2. Urban
3	DISTRICT	1. Kampala 2. Mukono 3 Kamuli 4. Iganga 5. Masindi 6. Nebbi 7. Mbarara 8. Kasese
4	SUB COUNTY/DIVISION	
5	SCHOOL NAME	
6	SCHOOL OWNERSHIP	1. Public / Government 2. Private
7	SCHOOL CATEGORY	1. Nursery / kindergarten 2. Primary 3. Secondary 4 Core PTC
SECTION B: RESPONDENT'S SOCIO-DEMOGRAPHIC CHARACTERISTICS		
	Question	Response
8	Sex of the respondent (tick as appropriate, do not ask)	1. Male 2. Female
9	How old are you?	In complete years.....
10	What is your highest level of education attained?	1. Licensed 2. Grade II 3 Grade 3. Grade 5, 4. Graduate Teacher 5. Masters' degree, 6. Nursery teaching certificate 7. Other (<i>specify</i>)...
11	Apart from teaching what other professional training have you undertaken?	List responses 1. None _____ 99 None
12	For how long have you been teaching?	Number of years-----
13	What subjects do you teach?	1. Sciences, 2. Art/Social Studies 3. Languages 4. Pre-primary
14	What other responsibilities do you have at school apart from teaching?	1. Class teacher, 2. Head of department, 3. Senior woman teacher 4. Senior male teacher, 5. Sports/ games master, 6. None 7.Music Dance and Drama 8. Secretary 9. Bursar 10.Deputy Head teacher 11. Director of Studies 12Others (<i>specify</i>)-----
15	What else do you do for a living apart from teaching?	1. Farming, 2. Trade, 3. Other formal employment (<i>specify</i> -----), 4. None 5.Others (<i>specify</i>)-----
16	What is your religion?	1. Anglican, 2. Catholic, 3. Muslim, 4. Seventh Day Adventist, 5. Orthodox, 6. Pentecostals, 7. Traditional, 8 None 9. Other (<i>specify</i>)
17	What is your marital status?	1. Married\Cohabiting 2. Single/Never married 3.Divorced\Separated, 4. Widowed
18	How many are you in your household?	1.Yes 2.No (skip qn. 20)
19	How big is your family?	Number-----
20	Do you stay with your family?	1. Yes 2 No
21	Are you a member of any organization, association, group, club etc?	1. Yes 2. No (Skip to 23)

22	If yes, which one(s)	<ol style="list-style-type: none"> 1. Economic 2. Social 3. Religious 4. Professional 5. Political 6. Charitable 7. Others (<i>specify</i>).....
SECTION C: KNOWLEDGE ON HIV/AIDS PREVENTION		
23.	Where do you get information about HIV/AIDS?	<ol style="list-style-type: none"> 1. Radio 2. Newspapers 3. TV 4. Health facility/ Health workers 5. HIV/AIDS school program 6. Seminars / workshops 7. Posters/leaflets/brochures/banners 8. Friends/Other teachers 9. Internet 10. Books 11. Drama 12. Other (<i>specify</i>).....
24	Where would you prefer to get information about HIV/AIDS from?	<ol style="list-style-type: none"> 1. Radio 2. Newspapers 3. TV 4. Health facility/ Health workers 5. HIV/AIDS school program 6. Seminars / workshops 7. Posters/leaflets/brochures/banners 8. Friends/Other teachers 9. Internet 10. Books 11. Drama 12. Other (<i>specify</i>).....
25	How is HIV/AIDS transmitted from one person to another?	<ol style="list-style-type: none"> 1. Sexual intercourse with an infected person 2. Mother to child transmission 3. Breast-feeding 4. Sharing sharp piecing instruments(razor blades) 5. Transfusion with infected blood 6. Use of unsterilised needles 7. Accident 8. Don't know 9. Others (<i>specify</i>).....
26	What is the main way through which HIV/AIDS is spread from one person to another?	<ol style="list-style-type: none"> 1. Sexual intercourse with an infected person 2. Mother to child transmission 3. Breast-feeding 4. Sharing sharp piecing instruments(razor blades) 5. Transfusion with infected blood 6. Use of unsterilised needles 7. Others (<i>specify</i>) 8. 9. Don't know
27.	What can a person do to avoid contracting HIV/AIDS?	<ol style="list-style-type: none"> 1. Abstain from sex 2. Use Condoms 3. Zero grazing/Stay faithful to one partner 4. Avoid Blood Transfusions 5. Avoid getting Injections from none qualified medical staff 6. Avoid Sharing sharp piercing instruments 7. HCT 8. Other (<i>Specify</i>)..... 9. Don't Know
28.	Have you heard of any drugs that can prolong/extend the life of a person who has HIV/AIDS?	<ol style="list-style-type: none"> 1. Yes 2. No (skip to qn 31)
29.	What drugs do you know about?	<ol style="list-style-type: none"> 1. ARVS 2. Septrin

		3. Traditional Medicine 4. Other (<i>specify</i>).....
30.	For how long should a person with HIV/AIDS take ARVs?	1. Life time 2. Only when feeling sick 3. Don't know 4. Others (<i>specify</i>)
31	Do you consider your self at risk of contracting HIV/AIDS	1. Yes 2. No (skip to qn....)
32	Why do you think so?	
33	Can HIV/AIDS be transmitted through the following ways?	1. Yes 2. No
a	Sharing food	1 2
b	Mosquito bites	1 2
c	Bewitching	1 2
d	Sharing a bed	1 2
e	Sharing toilet facilities	1 2
34	Is HIV/AIDS a curse from God?	1. Yes 2. No
35	Can HIV/AIDS be cured?	1. Yes 2. No
<p>SECTION D: SEXUAL BEHAVIOUR Now I would like to ask you a few questions about your sexual life. Some of the questions may be personal and you may not be comfortable with. Please I request you to give me your honest opinions as they will remain very confidential and be used for only the purpose of this study.</p>		
36	Have you had sexual intercourse with a non regular sexual partner (s) in the last 12 months?	1. Yes 2. No (skip. qn 41)
37	How many casual or non regular sexual partners have you had sex with in the last 12 months?	Number-----
38	Did you use a condom the last time you had sex with a non regular sexual partner?	1. Yes (skip to qn. 40) 2. No
39	Why did you not use a condom?	1. I do not like condoms 2. Partner did not like it 3. I trust my partner 4. We did have condoms 5. Condoms are expensive 6. I wanted to have a child 7. My partner would suspect me 8. It reduces sexual pleasure 9. Others (<i>specify</i>)
40	Where did you get that condom from?	1. Govt. facility 2. Private clinic / drug shop / pharmacy 3. Community distributor 4. NGO / Family Planning clinic 5. Ordinary shops 6. Bars/lodges 7. Others (<i>specify</i>).....
41	Do you take any of the following?	1. Yes 2. No
a	Alcohol	1 2
b	Drugs (Opium, Mairungi/Qat.)	1 2
c	Cigarettes	1 2
<p>SECTION E: PERCEPTIONS ON THE IMPACT OF HIV/AIDS ON TEACHERS</p>		
42	Has HIV/AIDS affected your job as a teacher in any way?	1. Yes 2. No (skip to 44)
43	Has HIV/AIDS affected your job in any of the following ways?	Read out
		1. Increased rates of absenteeism from class 2. Dismissal from school 3. Stigma and discrimination from students, fellow staff and general public 4. Inefficiency in teaching due to reduced energy 5. Time lost caring for the sick and attending burial ceremonies 6. Indiscipline in the school 7. Decline in academic performance

		8. Loss/Reduction of salary/wages 9. Others (<i>specify</i>).....
44	Has this school lost a teacher(s) to HIV/AIDS in the last 5 years?	1. Yes 2. No (Skip to 46) 3. I don't know
45	What was the sex of the teacher (s)?	1. Male: Number..... 2. Female: Number.....
46	In your opinion, has HIV/AIDS affected teachers in this school in any of the following ways?	Read out 1. Increased rates of absenteeism from class 2. Dismissal from school 3. Stigma and discrimination from students, fellow staff and general public 4. Inefficiency in teaching due to reduced energy 5. Time lost caring for the sick and attending burial ceremonies 6. Indiscipline in the school 7. Decline in academic performance 8. Loss/Reduction of salary/wages 9. Increased work load 10. No effect 11. Others (<i>specify</i>).....
47	What do you consider to be the major problems in addressing the negative impact of HIV/AIDS on teachers in general?	1. Low information awareness 2. Lack of access to care and support services 3. Poor pay 4. Unresponsiveness of school management 5. Stigma and discrimination 6. Poor policy implementation 7. Increased work load 8. Other (<i>specify</i>).....
SECTION F: HIV/AIDS CARE AND SUPPORT PROGRAMMES		
48	What are the teachers in this school doing in regard to HIV/AIDS prevention, care, support and control?	1. Start ARVs 2. Join psycho-social support groups 3. Give up teaching 4. Taking on more work load 5. Taking on less work load 6. Seek counseling services 7. Increased sensitization on HIV/AIDS 8. Other (<i>specify</i>).....
49	Have you heard about HIV Counseling and Testing (HCT)?	1. Yes 2. No (skip to 64)
50	Where is the nearest area one can go for HCT ?	1. Govt. facility 2. Private clinic 3. NGO/Mission health facility 4. HIV/AIDS support organization 5. Others (<i>specify</i>).....
51	Have you ever tested for HIV/AIDS?	1. Yes 2. No (skip to 63)
52	When did you take the last test?	1. Within the last 3 months 2. Within the last 6 months 3. Within the last one year 4. More than one year ago 5. Can't remember
53	Where did you go for the test?	1. Govt. facility 2. Private clinic 3. NGO/Mission health facility 4. HIV/AIDS support organization 5. Others (<i>specify</i>).....
54	How far is the nearest centre offering HCT from this school?	1. Less than 2kms 2. 2-5 Kms 3. 6-10kms 4. More than 10 kms
55	If Yes in QN 51 what motivated you to take an HIV/AIDS test?	1. To know my status 2. Advise by Health provider 3. I was going to get married 4. I was pregnant

		5. Wanted to have children 6. Lost my partner 7. I was sick 8. Donation of Blood 9. Others (<i>specify</i>).....
56	Did you go with your sexual partner?	1. Yes (skip to 58) 2. No
57	Why did you not go with your sexual partner?	1. I did not want her/him to know 2. Wanted to prove whether am safe and we go jointly 3. He /she refused 4. Was not within reach 5. Other (<i>specify</i>).....
58	I do not want to know your results, but did you receive them?	1. Yes 2. No (skip to qn 64)
59	Did you share your results with any one?	1. Yes 2. No (skip to 61)
60	If yes, with who?	1. Partner / spouse 2. Friend 3. Relatives 4. Other (<i>specify</i>).....
61	Did you take a confirmatory test 3 months after the first test?	1. Yes (skip to 64) 2. No
62	Why did you not take a confirmatory test?	1. Was sure not infected 2. Could not get time 3. Partner /spouse objected 4. Was scared 5. Others (<i>specify</i>).....
63	If (No in Question 51) Why have you never tested for HIV/AIDS	1. Fear of rejection by society if positive 2. Low self risk perception 3. Thinks already has HIV/AIDS why then test 4. Facility too far from home 5. Expensive services 6. Does not know where to go 7. facility staff unfriendly 8. No privacy at the nearest facility 9. Lack of confidentiality 10. Fear to know the outcome 11. Others (<i>specify</i>).....
64	Which of the following other HIV/AIDS treatment, care and support services are available in this area?	Yes No Not sure
A	PMTCT	1 2 3
B	ARVs	1 2 3
C	Treatment of opportunistic infections	1 2 3
D	Septin prophylaxis	1 2 3
E	Provision of condoms	1 2 3
F	Treatment of STDs	1 2 3
G	Other (<i>specify</i>).....	1 2 3
SECTION G: HIV/AIDS WORKPLACE POLICY		
65	Do you think a teacher with HIV/AIDS should be left to teach?	1. Yes 2. No
66	Why do you think so?	Write the response
67	Have you heard about the HIV/AIDS workplace policy for teachers?	1. Yes 2. No (skip to qn 70)
68	What do you know about it?	1. Provide HIV/AIDS information 2. Guarantees a sick leave with payment 3. No discrimination 4. No unfair dismissal on account of sickness 5. Provide HCT to teachers 6. Support teachers to access ARVS 7. Advocate for reduced man hour for TLWA 8. Advocate for loans for teachers 9. Link to support groups 10. Not sure 11. Other (<i>specify</i>).....

69	What do you consider to be the benefits of this policy to teachers?	<ol style="list-style-type: none"> 1. Provide HIV/AIDS information 2. Guarantees a sick leave with payment 3. No discrimination 4. No unfair dismissal on account of sickness 5. Provide HCT to teachers 6. Support teachers to access ARVS 7. Advocate for reduced man hour for TLWA 8. Advocate for loans for teachers 9. Link to support groups 10. 10. Other (<i>specify</i>).....
70	How supportive has the school been to reduce the negative impact of HIV/AIDS among teachers.	<ol style="list-style-type: none"> 1. None 2. Provide HIV/AIDS information 3. Offers a sick leave with payment 4. Discourages discrimination / stigma 5. No unfair dismissal on account of sickness 6. Link teachers to HCT services 7. Support teachers to access ARVS 8. Advocate for reduced man hour for TLWA 9. Advocate for loans for teachers 10. Link to support groups 11. Other (<i>specify</i>).....
71	What are some the challenges/limitations the school is facing in trying to reduce the impact of HIV/AIDS on teachers?	<ol style="list-style-type: none"> 1. Limited involvement of teachers 2. A few teachers targeted/limited coverage 3. Limited funding 4. Stigma/discrimination 5. Denial 6. Don't know 7. Others (<i>specify</i>).....
72	In your own opinion, how can we address HIV/AIDS needs for teachers?	<ol style="list-style-type: none"> 1. Provision of ARVs 2. Treatment of opportunistic infections 3. HCT 4. HIV/AIDS information dissemination 5. Provision of school fees 6. Support and Care services 7. Access to loans/IGAs 8. Other (<i>specify</i>).....
	Time interview ended/.....

THANK YOU VERY MUCH FOR YOUR CO-OPERATION

A SURVEY ON THE IMPACT OF HIV/AIDS ON EDUCATION AND TEACHERS IN UGANDA

Key informant Interview Guide – Head Teachers, Principals, DEOs, MoE and UNATU Officials.

Introductory Remarks

Good morning /Afternoon, my name isam here on behalf of Uganda National Teachers Union (UNATU) – an organization that promotes and protects the rights and interests of teachers in Uganda. We are conducting a survey on the impact of HIV/AIDS on the education sector and teachers in particular.

The survey findings will be used to design HIV/AIDS programs targeting teachers. You have been selected to participate in this study because we feel you have the experience and information that can be used to design appropriate HIV/AIDS programs that target teachers.

Participation in this study is voluntary. You are free not to respond to any question you feel uncomfortable with or withdrawal from the interview and this will not have any negative implication on you and your job. However, I wish to assure you that the information you give me shall be kept confidential and will only be used for purposes of the study. I therefore kindly request you to share your honest opinions on this subject. Our discussion will last approximately one hour.

Do you agree to participate? 1. Yes 2. No (**Terminate the interview**)

Date of interview ----/02/07

Time interview started -----

Interviewer's name-----

District	
Name of school/dept/ministry/sector	
Title of Key informant	
Length in service	
Age	
Sex	
Highest education level attained	

INTERVIEW THEMES

A: IMPACT OF HIV/AIDS ON EDUCATION SECTOR

1. What is your comment on the impact of HIV/AIDS among teachers?
2. In your view what factors account for HIV infection among teachers?
3. In what ways has HIV/AIDS affected teachers? Probe: Prevalence, academic performance, work load and absenteeism.
4. How has of HIV/AIDS impacted on the quality of education?
5. What are the teachers' needs in relation to HIV/AIDS?

B: EXISTING HIV/AIDS PROGRAMS FOR TEACHERS

6. What are teacher's coping mechanisms in response to the HIV/AIDS pandemic?
7. What interventions/programs are in place to reduce the impact of HIV/AIDS on teachers? Are there any that target teachers in particular? (Probe for strategies by MOES, schools/district local government/existing NGOs and CBOs, strengths, weaknesses/gaps, opportunities and challenges
8. What has your dept/ ministry/organization done to reduce the negative impact of HIV/AIDS among teachers? (Probe: strengths, weaknesses/gaps, opportunities and challenges
9. How have the programs involved teachers?
10. How have teachers benefited from these interventions?
11. Who do you collaborate with?
12. In your opinion what can be done to improve the interventions/programs?

C: HIV/AIDS WORK PLACE POLICY

13. What do you know about the MoES HIV/AIDS Work place policy?
14. What is the role/mandate of your office in its implementation?
15. What do you consider to be the benefits of this policy to teachers? (Probe for the benefits so far)
16. What are the challenges to its successful implementation? (probe for cost implications to the sector, schools, capacity, awareness, participation, guidelines)
17. In your opinion how can the implementation of the policy be improved to the advantage of the teachers?
18. Any comments\Questions?

**END OF THE INTERVIEW
THANK YOU VERY MUCH FOR YOUR TIME AND VIEWS**

A SURVEY ON THE IMPACT OF HIV/AIDS ON EDUCATION AND TEACHERS IN UGANDA
Focus Group Discussion Guide - Teachers

Introductory Remarks

Good morning /Afternoon, my name iswe are here on behalf of Uganda National Teachers Union (UNATU) – an organization that promotes and protects the rights and interests of teachers in Uganda. We are conducting a survey on the impact of HIV/AIDS on the education sector and teachers in particular.

The survey findings will be used to design HIV/AIDS programs targeting teachers. You have been selected to participate in this study because we feel you have the experience and information that can be used to design appropriate HIV/AIDS programs that target teachers. We therefore kindly request you to share your honest opinions on this subject. Every body will have an equal chance to contribute to the discussion. So please speak one at a time and feel free to express your views even if you feel that there are different from what other participants think.

Participation in this study is voluntary. You are free not to respond to any question you feel uncomfortable with or withdrawal from the discussion at any point. This will not have any negative implication on you and your job. However, we wish to assure you that the information you give us shall be kept confidential and will only be used for purposes of the study.

Our discussion will last approximately one hour. We also kindly request you to allow tape record the discussion and this will enable us capture everything you say.

Do you consent to be tape recorded?

1. Yes 2. No (**Abandon the tape- recording and take only hand-written notes**)

Identification:

Name of school -----

School ownership-----

School category-----

Background characteristics of the participants

Number of participants-----

Names -----

Sex-----

Average age -----

DISCUSSION THEMES

A: HIV/AIDS impact on education sector

1. What are the major health problems that teachers face in this school/community? Probe for HIV/AIDS.
2. What category of teachers is most affected?
3. In your view what factors account for HIV infection among teachers?
4. In what ways has HIV/AIDS affected teachers? Probe: Prevalence, academic performance, work load and absenteeism.
5. How has HIV/AIDS impacted on the quality of education?
6. What are the teachers' needs in relation to HIV/AIDS?

B: HIV/AIDS CARE AND SUPPORT PROGRAMS

7. What are teacher's coping mechanisms in response to the HIV/AIDS pandemic?
8. What interventions/programs are in place to reduce the impact of HIV/AIDS on teachers? Are there any that target teachers in particular? (Probe for strategies by MOES, schools/district local government/existing NGOs and CBOs, strengths, weaknesses/gaps, opportunities and challenges)
9. How have the programs involved teachers?
10. How have teachers benefited from these interventions?
11. In your opinion what can be done to improve the interventions/programs?

C: HIV/AIDS WORPLACE POLICY

12. What do you know about the MoES HIV/AIDS Work place policy?
13. What do you consider to be the benefits of this policy to teachers? (Probe for the benefits so far)
14. What are the challenges to its successful implementation? (probe for cost implications to the sector, schools, capacity, awareness, participation, guidelines)
15. In your opinion how can the implementation of the policy be improved to the advantage of the teachers?
16. Any comments\Questions?

END OF THE DISCUSSION