

Abt Associates. 2002. *Impacts of HIV/AIDS on Education in Namibia.*

Education has been identified as one of the principal means of Namibia's socio-economic development. The nation's commitment to education is clearly laid out in Namibia's Constitution, which makes education a right of all Namibians, and makes primary education compulsory. Namibia has also ratified the UN Convention on the Rights of a Child, and the African Charter on Human and People's Rights, which create obligations to ensure education and other support for children. In 2001, Namibia's education sector comprised of 1026 primary schools, 378 combined schools and 129 secondary schools. The Government is the nation's largest single employer, and the MBESC employs the largest number of people with over 20,000 employees, including over 18,000 teachers. In addition to contributions by the public sector, substantial inputs are made by a variety of other players including households, communities, development agencies, NGOs, local authorities, churches and other responsible authorities.

The MBESC has made remarkable strides since independence towards Education for All, and its goals of access, quality, equity, democracy and efficiency. The focus of the sector after independence has been particularly on improving access and participation, and building capacity throughout the sector. Primary school enrolment rates have reached 93% and in addition to general extension of access, the sector has reached out to educationally marginalized groups including the San and Ovahimba. Other achievements include an increase in the number of primary and secondary schools particularly in economically disadvantaged areas in the country. In the later 90s Namibia witnessed an increase in primary and secondary schools at an average of 1.6% per annum. The education sector has also witnessed an increase in the number of trained teachers and individuals in management positions. Generally there is gender parity in enrolment levels with the exception of some regions i.e. Katima and Rundu, where secondary enrolment by girls is lower. The opposite is true in Ondangwa East and West where enrolment of boys is lower. At the same time, MHETEC has developed in-country capacity for tertiary and vocational education.

A number of challenges face further progress in primary, secondary and higher education. These include the ongoing need to reduce inherited inequities in access to education, particularly in secondary schooling, as well as the necessity to increase quality of education and its alignment with the economy's skills requirements. These needs have to be addressed in the context of limited managerial capacity, a relatively inexperienced and under-qualified teaching force, logistical difficulties due to large distances and sparsely populated areas, infrastructure backlogs, and challenges of sustaining employee motivation and morale. Obstacles tend to be greatest in the north and other areas of inherited disadvantage, where the majority of the population lives but the system is often already stretched simply to maintain basic aspects of education delivery for many communities. Another challenge is financial resource constraints. Education expenditure as a percentage of national income is already high when compared to other countries. Personnel account for around 80% of expenditure, limiting amounts available for other needs.

Progress towards effective education for all is challenged by the prevailing social and economic conditions. Although Namibia is classified as a middle-income country, its Gini coefficient is the highest in the world, reflecting high levels of poverty and income inequality. Community and households resources available to support education therefore vary widely. The society is also in a state of transition, with disruption of many traditional social systems and high rates of migration. The overall capacity to address any new challenge is limited by the small and relatively scattered population.

Namibia's HIV/AIDS epidemic and current responses

The HIV/AIDS epidemic presents a major new challenge to Namibia. In 2000, the HIV Sentinel Sero Survey reported HIV infection levels of 22.3% for pregnant women nationwide. HIV infection levels vary widely between regions from around one in three women in Katima Mulilo and Windhoek, to 10% or less in sites such as Gobabis, Rehoboth and Opuwo. More remote and less densely populated areas seem to have lower levels of infection. To some extent, this may represent later development of the epidemic in some areas and

communities, but trends suggest that risk factors and thus the shape of the epidemic curves vary between regions. Importantly, in all sites infection levels are high enough to be a huge public health challenge. In addition, the national epidemic is still growing. In only a few sites are there signs that the epidemic may have reached a plateau, emphasising the important opportunities for prevention.

The AIDS epidemic lags behind the rise in HIV infection rates by 8-10 years. The relatively early stage of Namibia's AIDS epidemic creates important potential for pro-active responses so that the country is well prepared to manage the main burden of the epidemic when it arrives. Nevertheless, areas with more mature epidemics have already experienced a marked rise in the number of AIDS cases. Nationwide, AIDS deaths in the 15-49 year age group continue to increase and now account for around half of all deaths in hospitals.

HIV/AIDS is already massively increasing demands on social services such as health and welfare. At household, family and community level it is stretching coping capacity through its impact on income and costs, psychological effects of illness and deaths, and disruption of family structures. HIV/AIDS has cost implications for businesses and can seriously disrupt subsistence agriculture. The epidemic therefore is a major challenge to the resource requirements and capacity of key partners of the education system.

Namibia's response to the epidemic has benefited increasingly from commitment of political leadership at the highest and other levels. Political will is internationally recognised as a distinguishing feature of all successful and sustainable efforts to combat the epidemic. The national response to HIV/AIDS is being led by the National AIDS Committee and National AIDS Co-ordinating Programme (NACOP) situated in Ministry of Health and Social Services (MOHSS). A further important development is that initial concentration of responsibility and activities around HIV/AIDS in the health sector is now being replaced by promotion of a more multi-sectoral response. Various Sub-Committees of NACOP exist to cater for the specific needs of regions (RACOCs) and sectors (e.g. RACE'S in education regions). Civil society groups and development partners play key roles in the national HIV/AIDS response at all levels.

There is increasing recognition of, and response to, the critical role of the education sector in prevention, support of infected and affected people, and in maintaining service delivery despite AIDS impacts. The sector's roles have begun to expand from its earlier role as a partner of NGOs and the MOHSS in HIV prevention activities. Both Ministries of Education developed a groundbreaking strategic and operational plan on HIV/AIDS in 2001 and its implementation has been initiated. The strategy lays out processes to refine and implement strategy in particular areas that are consistent with, but extend beyond, objectives laid out for the sector in the National Strategic Plan on HIV/AIDS for 1999-2004. Prevention is the main focus of the plan, but it also covers various aspects of care, support, and mitigation of impacts on both employees and learners.

Terms of reference and methodology

The MBESC and MHETEC have recognised that the HIV/AIDS epidemic will have important effects on the education sector, its environment and its ability to meet objectives of equity, effectiveness and efficiency. The terms of reference of this study defined its objective as helping the education sector to assess the impact of HIV/AIDS on its ability to meet its mandate. Specific issues to be examined include effects on:

- 1) Demand for education and any changes in the scale or type of needs to be met by the sector;
- 2) Ability to supply education, through impacts on employees and trainees;
- 3) Costs of education;
- 4) The process and quality of education;
- 5) The content and role of education;
- 6) Planning and management in the education sector.

The study was also tasked with a review of current responses and asked to make recommendations to assist in refining strategy to address impacts.

The study employed the following methodology:

- *Qualitative data collection* through group discussions and key informant interviews with managers, educators and learners in seven education regions, as well as with other stakeholders in the Ministries, and other sectors.
- *A school survey* of a nationally representative sample of 103 primary, 51 combined and 24 secondary schools. Data was collected from school heads, guidance teachers and 734 Grade 10 learners.
- *Secondary data collection*, including EMIS data, policies, legislation, and other documentation.
- *Demographic projections* to assess current and future levels of HIV/AIDS impacts. These were produced with the Metropolitan Life/Doyle model, calibrated to the profile of the Namibian epidemic. Survey and region visit findings are expected to be quite indicative of current levels of HIV/AIDS impacts, responses and capacity. Data from all sources were integrated to inform interpretation.

Projections produced in this study can be expected to give a reasonable representation of the scale and types of HIV/AIDS impacts that need to be considered in education planning. However, projections involve many assumptions. Accuracy is limited by many factors, including limitations of the available data on the structure and trends in the underlying population, and the HIV/AIDS epidemic in Namibia.

Planning which uses the projections must therefore accommodate a number of possible scenarios, to limit the risk that any particular projection is not accurate. In this report point estimates of levels of impact are often presented. Planners should be aware that actual levels are likely to fall within a range around these estimates and at local level variation is likely to be large. Further, details of the range of possible levels of impact are provided in the main section of the report.

How will HIV/AIDS affect needs and demand for education?

International and Namibian experience has shown that the HIV/AIDS epidemic has substantial influences on the needs of learners and demand for education. Importantly, it also shows the potential for interventions to mitigate negative impacts.

Numbers of children requiring education

The HIV/AIDS epidemic is expected to slow growth in the number of children in Namibia for several reasons. These include death of women in childbearing ages, lowered fertility among HIV-infected women and death, usually before the age of five, of children who are infected with HIV around the time of birth or through breastfeeding.

Projections of HIV/AIDS impacts on the number of young Namibians indicate several important issues for planning:

- *Slower growth in the size of school-going age groups.* In the absence of the epidemic, the 5-19 age group would have grown from around 593,000 in 1995 to around 815,000 by 2010. But with HIV/AIDS the population in the age group of 0-19 is projected to be around 752,000 by 2010.
- *Earlier impacts on the size of the population in younger age groups.* Projections suggest that HIV/AIDS has likely to have resulted in levelling the absolute numbers of children in the 0-4 year old age band. The 5-9 year age group, which includes most children entering school, is likely to start declining around now, and will be around 14% smaller than expected in the absence of AIDS by 2010. A plateau in the numbers of children aged 10-14 and 15-19 year ages groups is expected to occur around 2009 and around 2015 respectively, followed by declines.

- *Robustness of projections to changes in many key assumptions.* The general trends that are projected seem relatively insensitive to changing key assumptions such as fertility of HIV-infected women and rates of transmission of HIV from mother to child.

Enrolment data for the Katima Mulilo region indicates that primary school enrolment has been declining over the late 1990s. Projections and EMIS data suggest that HIV/AIDS may explain some, but not all of this. An actual decline in 5-9 year old learner numbers is expected to only occur from 2001. Declining enrolment has also occurred in older age groups that would not yet be affected by declining fertility due to AIDS. Other factors (e.g. migration; general socio-economic conditions) are thus likely to be dominant factors, but HIV/AIDS impacts on children's households may also be a contributing factor.

The projected impacts of HIV/AIDS on learner numbers have important implications for planners. Education sector infrastructure and human resource planning has to anticipate changes in the expected number and age profile of learners. Analysis of the 2001 Census and close monitoring will be required to assess the accuracy of the projections. Importantly, changes in learner numbers, particularly at local level, will be difficult to predict and planning will inherently have to aim for flexibility to deal with uncertainty.

How does HIV/AIDS affect needs of learners and their education outcomes?

Needs for HIV prevention

Detailed evaluation of current prevention programmes was beyond the scope of this project. However, knowledge, attitudes and systems created by HIV prevention programmes are a key foundation for successful impact management. HIV prevention is also of central importance to avoid losing a large proportion of the education sector's investment in young people. Examination of dynamics of the epidemic, interactions at schools and at regional level, and the school survey provided important information for the Ministries' overall HIV/AIDS response.

The Challenge

New infections among people aged 15-25 are the main driving factor in perpetuating the HIV/AIDS epidemic. Estimated HIV prevalence is close to zero among Namibians in the early teens, and then rises rapidly from the mid-teens to over 20% in individuals aged 20. Higher levels of infection are experienced in many communities. In young men the rise in infection occurs later, as reflected in the older average age of men reported to have HIV/AIDS. However, levels among men probably rise to a peak similar, though lower, to those among women by the time men are in their 30s. For all males and females combined, young people rates are estimated to be below one in 5% in the 15-19 age group before leaping to around one in four in the early 20s. Importantly, the proportion of teenagers who are not infected is likely to be higher than assumed by many young people. This is an important message of hope.

Antenatal survey data indicates that rates of new HIV infection rates among young people in Namibia remain high. Among women aged 15-19 and 20-24, infection levels have stopped growing since 1996 but are too high (12% and 20% respectively) to produce anything near an HIV/AIDS-free generation. The 2000 DHS also shows that HIV/AIDS knowledge remains inadequate despite high levels of awareness. Less than a third of 15-19 year olds knew about all the three main ways to prevent HIV infection.

Current levels of HIV infection fundamentally challenge the mission of the education sector. Unless prevention is more effective, over one quarter of learners will become infected during or soon after their education. Most of these will die of AIDS before they reach the age of 40. This is not only a social and human disaster, but is a loss of investment in education that far exceeds most other system inefficiencies. More than any other sector, education has opportunities to influence levels of HIV infection among young people, through its direct contact with them in institutions and non-formal education.

Current Responses

In response to the need for prevention, the MBESC has infused HIV/AIDS education into the science curriculum. HIV/AIDS education has been included in life skills training by Guidance and Counselling teachers. However, "life skills" training as applied in Namibian schools seems not to have fully adapted its content and focus to ensure that it provides young people with the skills required to empower them to protect themselves against HIV/AIDS and cope with its consequences. Additionally, it has worked with UNICEF in the internationally recognised extracurricular "My Future My Choice" (MFMC) programme. This targets 15 to 18 years olds in and out of school, but younger learners have also participated. These actions have been complemented by initiatives of other development partners, NGOs, communities and pre-service programmes in teacher training colleges.

Coverage of HIV/AIDS prevention programmes in Namibia is quite extensive. However, it is clear that many schools have not been reached in any substantial way. In the school survey, 69% of Grade 10 learners answered at least one of three questions incorrectly on basic facts about HIV/AIDS. Alarmingly, more learners in the North had inadequate basic knowledge (74%) compared with learners in the South and Central areas (54%). Even in participating schools, key programmes like MFMC are voluntary and extracurricular, so they do not reach all learners. Many schools do not sustain programmes after initial activities. Large numbers of learners seem to know very little about the programme except that it distributes condoms. Particularly in rural areas, programmes are hampered by lack of equipped Guidance and Counselling or Science teachers, and of systems to support peer and other HIV education.

Even in schools with stronger programmes, there is scepticism among staff and learners about whether risk behaviour of young people is actually changing. Various reasons were cited for this including insufficient knowledge and skills to deal with the complex technical and psychosocial issues around sex, lack of availability of condoms and peer pressure.¹ Many broader factors which create HIV infection risk were noted that are not yet adequately addressed by school and extracurricular programmes. These include poor role modelling by teachers, families and communities; breakdown of certain protective cultural norms and persistence of others such as the subservient position of girls and women; poverty and unemployment; widespread inter-generational sex and relationships for material and other rewards; and sexual abuse and harassment in and outside schools.² Other environmental factors such as alcohol use and bars, proximity to security forces and development projects were noted in several regions. Children living in child-headed households or without adequate adult supervision were noted to be at particular risk.

Recommendations - HIV Prevention

Current HIV/AIDS prevention initiatives have laid key foundations for success. However, they must be strengthened considerably if they are to achieve the goal of an AIDS-free generation. A bolder, more holistic and long-term approach is needed. HIV prevention will be relevant for many years - an adequate vaccine seems unlikely to be available for at least 5-8 years, and may never be found. Prevention initiatives have to be seen as "core business" and an urgent priority across all components of the sector. Importantly, effective HIV prevention will help to address pre-existing problems facing education outcomes, including pregnancy among learners. The following recommendations are made.

1) Mainstream HIV prevention in education.

- *Develop a more effective strategy to integrate HIV/AIDS in school, teacher and learner assessments and timetables.* Most aspects of HIV/AIDS education are not examinable or assessed, so they are not prioritised.
- *Strengthen training and guidelines for school, hostel, circuit and regional managers (particularly RACE members).* They must see HIV prevention as a core education responsibility, understand requirements for effective prevention and be able to provide leadership, support and supervision.

- *Consolidate integration of extracurricular programmes (e.g. MFMC) into school routines.* These programmes will be a key component of the response for the foreseeable future. Resistance and lack of commitment by managers and teachers must be overcome.

- *Consider extending the length of the school day.* This could facilitate effective timetabling of HIV/AIDS activities and reduce unsupervised time, which exposes learners to risk. Extending the school day is already being considered by the MBESC independent of HIV/AIDS.

2) Enhance programmes in primary schools and Early Childhood Development. It is widely accepted that reaching children with HIV/AIDS related messages before they become sexually active is both essential and feasible for behavioural change.

3) Strengthen life skills teaching capacity and capabilities.

- *Ensure that dedicated posts are available to provide capacity in all schools* (with sharing of posts between schools where necessary) to perform life skills and other pastoral and guidance functions. Consider using resources such as secondary graduates, retired teachers, non-teaching staff and other volunteers to overcome capacity and skills limitations in the short and longer term.

- *Improve selection of life skills teachers.* This is often based on who is "left over" after other roles are allocated, rather than aptitude or need for continuity, coherent career pathing and programme development.

- *Improve ability to use participatory approaches and materials.* Stronger training and support systems are required so teachers can deal confidently with the diverse and evolving knowledge needs and risk situations confronting learners.

- *Strengthen peer education approaches.* These seem to be powerful and successful. However, particular models such as MFMC require further evaluation to ensure greater effectiveness. Structured, ongoing support of peer education groups by designated teachers must be seen as a critical contribution by schools and other education institutions.

- *Strengthen approaches and capacity for training and support.* Cascade approaches to training have been disappointing, and strengthened in- and pre-service training is critical.

- Teachers must become more than information disseminators. They should be confident facilitators of open discussion and problem solving within and outside schools.

- Reinforce theoretical training with practical training to increase confidence in flexible approaches, and in managing relevant social dynamics in the communities.

4) Prioritise life skills programmes aimed at staff as a way to reinforce learner prevention. HIV/AIDS raises unresolved personal issues and anxieties for many staff, making them less effective life skills teachers and role models.

5) Strengthen curriculum and content. Materials and the curriculum are widely considered to be repetitive, unchallenging and unable to respond to needs for more detailed, explicit information and skills. Greater variety and depth of materials is needed. Key issues that need greater emphasis include:

- *Life skills and behaviour change rather than factual knowledge.* Deeper factual knowledge is required, but programmes must resist educator tendencies to gravitate to technical issues and neglect building skills to confront issues such as socio-economic and peer pressure, gender relations and desire for status.

- *Resolving unnecessary conflict and confusion between abstinence and safer-sex messages.*

- *Reinforce positive messages.* Many staff and learners express despair and feel that HIV infection is inevitable. Many learners who are probably *not* infected assume that they are. In schools and in many materials, HIV/AIDS prevention is often characterised by "scare tactics" and learners get little input on positive living with HIV/AIDS. Such approaches have been shown to have limited effectiveness, undermine counselling and support particularly when the same teachers are responsible for prevention and support, and leave affected and infected learners feeling disempowered.

- *Care and support, and development of coping skills.* Many learners already face care and support issues in their own families. Active involvement in care and support can be very empowering.

- *Sensitivity to language and cultural variations.* Language barriers and failure to address cultural issues were often identified as a problem with current materials. Examples of culture as an under utilised resource to reinforce HIV prevention were also frequently cited.

- *Involvement of adolescents in material development and revision.* Adolescents' contributions are critical to ensure relevance and responsiveness of materials and approaches.

- *Education on human and children's rights and obligation,* to empower learners and deter abusers.

- *Strengthen infusion of HIV/AIDS into other subjects.* However, international experience emphasises that this can reinforce but not replace life skills programmes.

6) Actively address sensitive issues. Cultural, parental and staff sensitivities tend to be avoided rather than addressed, and often seem to be used as an excuse for inaction.

- *Create empowering policy and staff education on condom distribution.* Current confusion on policy around access to condoms in schools is a major problem in the context of widespread sexual activity of learners and inaccessibility of condoms from other sources.

- *Ensure that Circuit, Cluster and school leadership have the relevant knowledge, skills and policy support to engage communities to dispel myths and negotiate progress to protect children*

7) Involve learners in decision making through representative councils and other mechanisms.

8) Ensure safe and supportive Institutional environments. At a minimum, the education sector should intervene to ensure safety of learners in environments under its direct control.

- *Refine a policy on zero tolerance of sexual harassment and disseminate it to all staff and learners.*

- *Streamline reporting, management and discipline systems around harassment and abuse.* Provide practical information to all children and teachers on how to access these systems.

- *Assess safety of hostels, community boarding and school events and develop feasible responses to reduce risk.* Consider employing full time hostel managers to enhance supervision.

9) Address external community and family environments more effectively. These environments and norms often undermine rather than reinforce the HIV/AIDS messages promoted in schools. Particular challenges include intergenerational sex with older partners.

- *Reinforce engagement of parents and communities.* Enhance skills and mandates of educators to deal with issues such as cultural or other obstacles to HIV/AIDS prevention. Work with communities to build on traditional systems such as "Shinyanga" to change group norms.

- *Encourage the use of schools for community networking between parents, elders, NGOs etc.*

- *Ensure that schools actively address high-risk environments, e.g. trucking areas, kuka shops and bars, local construction projects and barracks.*

- *Develop national and local strategies to actively address risk of learners with absent parents.* These include those boarding in the community and living in child-headed households.

10) Enhance monitoring and evaluation of Implementation. Improved, ongoing monitoring and evaluation will be critical to enhance coverage and effectiveness of HIV/AIDS programmes.

- *Consider the roles of learner and community involvement in monitoring and evaluation, to increase ownership and provide qualitative data needed to understand successes and obstacles.*

- *Include routine reporting on resources and implementation in EMIS and other routine systems.*

- *Enhance dissemination of information to stakeholders at all levels.*

11) Strengthen co-ordination and inputs of other sectors and programmes. Other sectors and multiple programmes will be critical components of effective education responses for the foreseeable future.

- *Improve co-ordination between prevention programmes.* Even at national level, major programmes co-ordinate inadequately, limiting synergy across programmes and Directorates.

- *Ensure more efficient co-ordination and use of available resources of key role players at all levels.*

- *Engage health services more effectively to ensure youth friendly Reproductive Health Services, condom access and technical support.*

- *Strengthen NGO inputs through systematic cooperation.* Ensure that policies and systems support use of NGOs for training and support in addition to direct service provision.

- *Reinforce cross-sectoral capacity development and support.* Build on some regions experience of co-ordination with health services, social workers and NGOs.

- *Investigate potential synergies with voluntary counselling and testing (VCT) programmes.*

- *Reduce unnecessarily bureaucratic barriers to involving external partners.*

Orphans and Other Affected Children

The greatest impact of the HIV epidemic on pupils and students while they are in Namibia's schools and other institutions will be through impacts on their families and households. Orphans will be the most obvious affected group, but other children may be affected when their households take in orphans or support other family or community members. A number of communities, NGOs and other sector players are already responding to the needs of orphans and other vulnerable children, and can provide examples of best practice and opportunities to build on existing foundations.

Numbers of orphans

Projections indicate that the total number of children in Namibia who have lost at least their mother to AIDS, will rise five-fold from 2001, from around 24 000 to 132 000 by 2010. Orphans will be concentrated in school-going ages. For 2001, less than 5% of children of all ages are estimated to have lost their mothers to AIDS. However, rates among 5-9 and 10-14 year olds are expected to rise to almost one-in-six and one-in-four respectively by the end of the decade. There is potential for them to rise to levels of one-in-three among 10-14 year olds thereafter. In some regions, schools and classrooms, rates of orphanhood can be expected to be much higher than these average levels.

Empirical data on the number of orphans in Namibia is very limited. No systematic orphan enumeration has been conducted. Among Grade 10 learners in the school survey, around 13% of children in the sample reported that they were maternal orphans, and 8.5% were double orphans. Of the two-thirds of teachers who could provide estimates of maternal orphan numbers among learners, one half thought that rates were under 5%. A third estimated levels of 5-10% and one in 10 thought they were 10-25%. Levels were generally higher than projected, suggesting that orphanhood is already a significant issue in schools that warrants a response ahead of the projected increases in orphan numbers.

An important finding is that there is wide variation around average levels of orphanhood, with very high levels in some schools. The proportion of maternal and double orphans in Grade 10 ranged up to 50% and 30% respectively in schools, and median rates were markedly higher in the north (14.2% and 10%) than in southern and central areas (6.7% and 0%).

Impacts of Orphanhood on Education Outcomes

Orphans' schooling can be affected through economic stresses on their households, psychological impacts that are a result of changes in family structure and functions that involve new responsibilities to care for the sick, the elderly or siblings, as well as loss of parental guidance and interest in children's education.

Dropout or failure to enrol is the grossest manifestation of impacts of orphanhood on education. International evidence indicates that orphans tend to have lower enrolment rates than children with both parents alive and their disadvantage can be substantial - around 30% lower or worse. However, studies suggest that orphans do not always have substantially lower enrolment rates. Impacts seem to vary widely, depending on social, economic and cultural circumstances. Household incomes may be a stronger predictor of non-enrolment than orphan status per se.

In Namibia, there is limited data on orphan drop out and attendance rates. However, there are strong indications from qualitative work and the school survey that a significant number of orphans are affected by drop out. Twenty nine per cent of the learner sample knew children who had dropped out for over a month after a parental death and 26% knew of permanent drop-outs after parental death. Among teachers, 11 % said that parental death was an important reason for dropping out of school. Anecdotal reports of good learners who had dropped out after parents died were common. A previous survey found that significant numbers of drop-outs, independent of HIV/AIDS, are due to factors associated directly or indirectly with levels of parental support, a cause for concern.

Other impacts of orphanhood on education outcomes have frequently been noted, although understanding of them is still at an early stage. Many reports indicate that orphanhood, particularly due to a stigmatised disease such as AIDS, can substantially affect performance, completion rates and general development of learners. Contributing factors include erratic attendance due to household circumstances; poorer concentration due to hunger, household demands and psychological impacts; and emotional/behavioural disturbances. Effects of orphanhood on children may only manifest after many years but could have important long-term social consequences in many communities.

In the school survey, 46% of surveyed teachers said that learner performance drastically declines if a child is orphaned, and another 41 % said that performance declines somewhat. Informants gave many reports of children who were clearly severely stressed by loss of parents despite still being enrolled.

Girls may be at higher risk of adverse outcomes. Recent analyses of data from other countries suggest that impacts of orphanhood on enrolment of girls does not appear proportionately greater than among boy orphans in many countries, and tends to mirror general gender inequities in enrolment. The school survey, EMIS data analysis and qualitative data provided no clear indications of whether boys or girls were more heavily affected by orphanhood. However, focus groups often felt that greater household burdens, pressures for early marriage and/or parenthood, and risk of abuse, sex work or other high risk sex among female orphans make them vulnerable. Pregnancy has been identified as a major cause of drop out in Namibia, suggesting that these types of risks are significant considerations.

Vulnerability of orphans at different ages or stages of schooling may differ. There is relatively little information on these aspects of impacts. Data on drop out rates and causes, and other sources suggest that norms around schooling, household roles as producers and carers, and psychological vulnerabilities, differ according to age. So education of children at different ages may be affected differently.

Important underlying problems that create obstacles to education of orphans and other vulnerable children that emerge from Namibian and other data include the following:

- *Material needs.* These include temporary or longer-term inability to pay for school-related needs including uniforms, levies, fees and materials. However, lack of resources to meet basic needs such as food and shelter is also a common reason for learners to drop out or perform poorly.
- *Inability to pay fees* was seen as an important reason for drop out by 23% of secondary and 8% of primary teachers.
- In several areas, tendencies for orphans and vulnerable children to prioritise finding work to address basic needs was noted, particularly in households headed by children or grandparents. Need to earn money (35%) and work at home (23%) were commonly cited for secondary boys by teachers, with generally lower levels for girls.
- *Hunger* was noted to be a common problem that led to drop out or poor performance in many schools. Around 10% of surveyed teachers cited it as an important reason for drop out. Among Grade 10 learners, 32% reported hunger among children in their households. Rates were lower (27%) among children who lived with a parent during the term than for those who did not (35%).
- *Psychosocial problems.* These are due to stress, grief, self-stigmatisation, neglect and abuse, social isolation and discrimination. Studies and informants have often noted that impacts are often worse when children are separated from siblings and when they are given not given a clear idea of plans for their future. Stigmatisation and withdrawal affecting orphaned children were frequently noted. Around one third of learners surveyed felt that families affected by HIV/AIDS were treated badly. Non-physical maltreatment of children from AIDS affected families were most commonly cited, and included avoidance, teasing and neglect. Indications of inability to deal with psychosocial problems, such as lack of motivation, bad behaviour, social problems or substance abuse, though not specific to orphans, were frequently cited as reasons for drop out by teachers.

A number of informants and drop-out studies suggested problems related to loss of parental guidance and socialization to reinforce learning, school-going, and appropriate cultural and other value systems. Orphans and other HIV/AIDS affected children may also be predisposed to fatalism and focus on short-term fulfilment that made them more likely to drop out, perform poorly and engage in high risk activities.

Changes in household structure and greater household responsibilities. While many children already live with people other than their parents, new stresses related to orphanhood were frequently noted by informants. The school survey suggested further dimensions of vulnerability. Around 40% of all teachers were aware of children in their school or community who lived in child headed households, and 6% knew of learners in the school who lived on the streets. Among Grade 10 students, 39% reported that care giving or other household activities had caused them to be absent from school. This was more frequent among maternal orphans (50%) and children who did not live with either of their parents (47%).

Important conclusions about vulnerability of education outcomes to effects of AIDS orphanhood include the following:

- *Orphanhood is seen as a significant problem* by schools, particularly in areas with more advanced epidemics. Stress is affecting orphans, teachers and learners who observe effects on their peers.
- *Even in areas where the HIV/AIDS epidemic is still at low levels, vulnerable children are a significant problem* due to socio-economic and other factors.
- *Material needs of orphans are perceived as the most pressing issue* by most teachers and schools.
- *Orphans' vulnerabilities cannot, for practical purposes, be separated from those of other children in poverty.*
- *Impacts associated with orphanhood often occur before parents die*, due to effects of illness on their households and children's psychological state in the period leading up to the death of a parent.
- *Successful avoidance or management of short-term crises* can enable many orphans to continue successfully with schooling.
- *Pressures on orphans and other vulnerable children are putting them at high risk of HIV infection.* They may be more likely to resort to unsafe sex for material or psychological reasons and are at high risk of abuse and exploitation.
- *There is mixed evidence around whether girl or boy orphans are more vulnerable to educational problems*, but there are strong indications that sensitivity to gender issues should be maintained.
- *Current data may underestimate the impact of orphanhood on education outcomes* in Namibia, for several reasons:
 - *Many school-staff clearly have limited sensitisation and awareness around the issue* and probably under-report impacts. School based surveys may also underestimate numbers of orphans if many have already dropped out or attend erratically.
 - *Namibia is at a relatively early stage in its orphan epidemic.* At current rates of orphanhood effects may still be difficult to identify in many classrooms. Extended families and other support systems, which are already strained in many areas, may become increasingly strained in future, and important effects such as re-orphaning of children may become more common.
 - *More subtle effects may be difficult to identify at this stage* but may, nonetheless, be important in a schooling system that is striving to improve quality and access. For example, group psychological effects of the epidemic on learners and society may change norms around schooling unpredictably.

Current responses to needs of orphans and vulnerable children

Namibia was the first African country to complete a national Plan of Action for Children and to ratify the Convention on the Rights of a Child. The MOHSS along with NGOs have led most responses to the needs of vulnerable children. This has resulted in progress in many areas, but the overall response has been characterized by fragmentation, lack of co-ordination, duplication and limited coverage.

In the mid-1990's, the MBESC set up an inter-sectoral task force on educationally marginalized children including war orphans to increase their access to schooling. The policy on educationally marginalized children, which is now being implemented, pays limited specific attention to the impact of HIV/AIDS but stresses the need to train teachers to handle orphans' needs. A charter for primary and secondary schools has been developed, which outlines what every child should expect from the MBESC. The Ministry has produced guidelines and press releases to inform people of the right to exemption from school development funds and hostel fees. However, there is strong evidence that many families do not exercise their right to fee exemptions due to lack of knowledge and inefficient bureaucratic procedures. Feeding programmes exist in selected schools with learners from educationally marginalized groups.

At school, circuit and regional level there has been very limited official guidance on school roles related to needs of orphans and other vulnerable children. Most responses have been initiated by religious bodies and the MOHSS through its social workers. Some efforts have been made by regional Special Education Units particularly around fee exemption support, but these measures have generally occurred on an ad-hoc basis at the discretion of the Head of the Unit. In some regions there has been conflict over the high numbers of children that Social Services was referring to the MBESC for exemption assistance. School level responses have included:

- *Assistance with material needs.* These include obtaining funding for fees, referral of children to social workers and/or NGOs, and cooperation with communities in developing nutrition gardens. Some teachers give ad hoc assistance to children in the form of clothes, food, materials or uniforms.
- *Addressing higher level/comprehensive needs.* Some schools provided in-school counselling while some teachers simply gave children an opportunity to talk. Referral to regional counsellors, social workers and community elders in cases of abuse or other more gross problems occurred but was generally infrequent. Some peer groups had provided elements of support.
- *Flexibility to maintain vulnerable children's access to schooling.* This includes not excluding learners who cannot pay fees and accommodating periods of absence by children with household crises. Several key themes emerge of relevance to improving support to vulnerable children:
- *Schools lack of a tradition of responsiveness to vulnerable children.* Many teachers and schools do not see it as part of their responsibilities to identify or respond to needs of vulnerable children.
- *There is no standard system to identify orphans and other vulnerable children* to enable pro-active management of their needs. Teachers tend to recognise vulnerable children's problems late when they manifest as gross "discipline" problems or inability to pay fees. Opportunities to help children avoid crises and to manage issues such as transfer to new schools are lost.
- *A wide range of support functions are needed by vulnerable children and are feasible.* Needs of vulnerable children extend far beyond inability to pay fees or psychological problems. However, responses of a number of communities, NGOs and schools demonstrate that responses are possible.
- *A number of internal and external role players and resources are usually available* to most schools.
- *The capacity of schools and any other role players has to be assumed to be very variable* and no single role player has capacity to perform all functions that are required.
- *The capacity of other key role players, particularly social services, NGOs and communities is far too limited to meet the scale of needs* reported by schools. Small numbers of social workers often serve vast areas and populations. They are overwhelmed by multiple functions and administrative burdens and cannot cope with rapidly expanding demands related to HIV/AIDS. NGOs also have limited coverage and capacity.
- *Motivation, skills and capacity within most schools* to deal with vulnerable children is limited. It cannot be assumed that any particular cadre of staff (e.g. guidance teachers) will consistently be able to deal with all vulnerable children issues alone.
- *Broader support systems for vulnerable children within the MBESC are generally weak.* Regional counselling services are remote, have limited capacity and are not considered to be a real resource by most teachers. They have given limited attention to needs of orphans and similar vulnerable children.

- *Particular communities face extra constraints.* For example, community and NGO ability to support vulnerable children has been severely eroded due to the security situation in areas of northern Namibia.
- *Lack of systematic definition of roles, responsibilities, mandates and co-ordination between role players* in and outside of schools is a major obstacle to effective action.

Recommendations - Orphans and Vulnerable Children

Poverty and other social problems lead to poor education outcomes for large numbers of Namibian children. Increasing numbers of orphans and social pressures created by AIDS are already adding to vulnerability, and pose a substantial threat to the MBESC's ability to meet national development objectives. Effective responses will have relevance well beyond the end of the decade.

A more systematic education sector response to the needs of orphans and vulnerable children is clearly needed, even in areas with less severe epidemics. The education sector is strategically placed to interact with vulnerable children, as it has the nation's largest body of professionals and an organisational network throughout the county. This represents a major resource to the nation in reducing HIV/AIDS effects on the next generation.

A. Defining a realistic strategy to address needs of vulnerable children

Experience with needs of orphans in other African countries has led to calls for re-conceptualisation of the school as *"a multi-purpose development and welfare institution"*. This challenge is daunting to most education managers and staff. What seem to be realistic responses to this challenge in Namibia?

Guiding principles behind this study's recommendations include the following:

- *Focus on efficient use of existing resources* rather than solutions requiring substantial extra resources, wherever possible.
- *Focus on system developments that allow more efficient use of resources rather than relying on "capacity development"* which may be required on a huge scale.
- *Build on what has proved feasible* in Namibia and other settings.
- *Flexibility and decentralised approaches are needed* to deal with local or individual limitations, and the scale and diversity of needs.
- *A Human Rights approach to developing effective interventions has major advantages* in ensuring that children's needs are met holistically. The approach includes: making the best interests of a child the primary consideration; ensuring that there are defined, accessible points of entry for children to access support systems; ensuring holistic, inter-sectoral but prioritised responses to meet the full range of priority needs; participation of children; integration of responses with community, family and other key role players; and ensuring accountability at all levels.

Prioritisation of functions of the education sector to preserve education of vulnerable children is needed to make the challenge more manageable. The following basic priority functions are proposed based on their likely effectiveness, the sector's strategic advantages and constraints on it and other role players:

- *Keep children in school* through pre-empting (or managing) crises to stabilise vulnerable children. Bringing children back to education tends to be very difficult, and vulnerable children's needs are much easier to address while they are still integrated into a formal system.

Key education sector functions to keep children in school are:

- Early recognition of vulnerability.
- Timely response to prevent drop-out / performance problems.
- Referral to other resources when schools cannot provide support in-house.
- Monitoring of well-being.
- Tackle basic needs and assistance before complex services. Basic needs were consistently identified as priorities for orphans and vulnerable children. Children who do not have basics such as food, clothing, shelter

and fees are unlikely to have successful education outcomes regardless of other services. Many psychosocial problems can be resolved or avoided if stresses related to basic needs are resolved. Sophisticated aspects of psychosocial support and counselling need development but this tends to be a complex challenge and they should not be the immediate priority in responses.

Enabling drop-outs to re-access education is another important function. Although this is likely to be less efficient than helping children to stay in school, learner attrition is already a large challenge in Namibia. The MBESC needs to continue to make schools more receptive to re-entry and explore efficient use of non-formal, distance and vocational training so that learners who drop out can still acquire key skills.

B. Specific recommendations - improving support of orphans and other vulnerable children

1) Clarify overall policy and guidelines on the role and obligations of schools, other education institutions and other sectors in relation to orphans and vulnerable children. Policy and guidelines can build on those developed for marginalized children.

2) Develop systems to Identify vulnerable learners.

Schools should administer a social register system to all learners at least twice yearly to identify vulnerable children. The system should be action orientated and schools should ideally have plans for specific responses to vulnerability before it is implemented. Guidelines should be developed to assist teachers to assess learners' vulnerability, prioritise responses and be sensitive to potential gender-related vulnerabilities.

3) Develop "Circles of Support" for each school. This model for supporting vulnerable children is based on developing networks with available resources inside and outside schools. The network is intended to maximise use of available capacity to respond to the wide range of vulnerable children's needs, and ensure allocation of functions in the most manageable and efficient way. A key objective is to support and co-ordinate, but not undermine, community and other initiatives. Potential resources are described in the main body of the report. The precise resources that are incorporated into the circle from in and outside of a school may differ according to the capacities and logistical issues prevailing in the school and community.

4) Enhance capacity within schools to co-ordinate Circles of Support and provide specific support.

- **Strengthen the number and skills of Guidance and Counselling teachers** to address vulnerable children issues but avoid over reliance on guidance and counselling teachers alone.
- **Build class teacher sensitisation, skills and confidence** to recognise and manage vulnerable children. Consider using capacity of NGOs (e.g. Catholic AIDS Action) for basic training.
- **Refine roles of national and regional SEUs and regional counsellors** so that their expertise and capacity are used more effectively in programme development and school support.
- **Consider more formal integration of social workers into the education system**, to maximize use of their skills in support of vulnerable children.

5) Consider creation of a fund to finance direct costs of vulnerable children's education including fees, uniforms, and education materials. Namibia has formal Social Services grant systems and structures. These should ideally form the basis of support for vulnerable children, particularly as many children's most pressing needs extend beyond direct schooling requirements. However, it is clear that social service systems are overloaded and inefficient. Unless their performance can be improved urgently, there are likely to be significant benefits in education sector funds to meet at least school-related costs of vulnerable children, and possibly be a vehicle for more extensive support if necessary. Experience of initiatives such as the Basic Education Assistance Module in Zimbabwe provides some guidance on programme design.

6) Expand school feeding and nutrition programmes. School feeding schemes have proved effective in boosting enrolment and need for feeding is widespread in areas of Namibia independent of HIV/AIDS impacts. Morning meals have also been shown to be associated with better learner performance in some settings.

- Consider systematic support of income generating activities and nutrition gardens as they may also build solidarity and empower vulnerable children.

7) Enhance flexibility and responsiveness of school organisation and systems to vulnerable children's needs.

- *Ensure effective inter-school referral systems* to minimise disruption and support when learners have to be transferred after a parent dies.
- *Ensure adequate flexibility in scheduling and rules*, including school hours, responses to being late or erratic attendance, age norms, and facilitation of homework.
- *Review hostel and accommodation policy* to ensure support of the most vulnerable.

8) Involve learners in decision-making, planning and responses wherever possible. Learners often have better understanding of their needs and appropriate responses than educators and planners.

- Reinforce peer solidarity and develop means to communicate information on rights, responsibilities and support systems

9) Actively support Initiatives to strengthen capacity and efficiency of Social Services. Social services are currently challenged by major capacity constraints and organisational restructuring. Inflexible legislation, regulations and practices also lead to inefficient responses to vulnerable children.

- Support greater allocation of resources and capacity to social work functions.
- Advocate for review of restrictive legislation, regulations, procedures and practices to relieve social workers of bureaucratic burdens and create flexibility for schools or other role players to take on various functions (e.g. certification for issue of birth certificates; monitoring of children on grants).

10) Mobilise more resources for education sector initiatives. The MBESC should advocate for allocation of funding to support an expanded role in support of orphans and vulnerable children. Possible sources include MOHSS allocations to provide for school fees and other basic needs of children as well as other NACOP and donor funds.

11) Other issues

- Develop and disseminate a Code of Conduct on confidentiality and other issues in dealing with vulnerable children.
- Pay specific attention to gender dimensions of vulnerability in monitoring and response development.
- Simplify laws and policies and produce user-friendly booklets to inform children of their rights, and teachers of their mandates and responsibilities in relation to vulnerable children.

Needs of infected learners

Education institutions will contain significant numbers of learners who are infected with HIV through maternal transmission around the time of birth, sexual abuse or relationships in their teens. Most children infected at birth will die before the age of five but significant numbers will, over time, reach school age.

The proportion of children and youth who are infected with HIV will vary at different levels in the education system. Projections suggest that among children aged 5-9, less than 1 in 400 students are infected, rising to around 1 in 100 by 2010. Less than 0.5% of 10-14 year olds and around 5.5% of 15-19 year olds are estimated to be infected. Infection levels then rise to around 20% in the 20-24 year age group. Levels are expected to be quite constant over the decade if risk behaviour does not change.

The proportion of children ill with AIDS, even by 2010, is expected to remain below 0.5% in the 5-9 age group, and will be below 1 per 1000 among 10-14 year olds and 15-19 year olds. It will then rise (but still to fairly low levels) to 1 in 200 in the 20-24 year age group. Death from AIDS is likely to be substantially lower than deaths from other causes in Namibians between age 10 and 20.

The school survey and visits confirmed that AIDS illness among learners is not a frequent or priority issue in most schools. However, they also suggest great potential for stigmatisation, isolation and compromised education for chronically ill learners, including those who do not have HIV/AIDS.

Recommendations - infected learners

Significant numbers of learners in the education system will experience psychological stress and stigmatisation around HIV infection, and a small proportion will actually be ill with HIV/AIDS. Learners, who are under stress because they fear that they are, or will be infected, may often be more numerous than those who are actually infected. In any individual case the stress for individuals and institutions involved, and potential for violation of rights will be significant. In general, however, prevention of sexual transmission and management of other impacts of HIV/AIDS on learners are likely to be larger challenges and higher priorities.

1) Include learners who are infected, or fear that they are infected, in counselling and psychosocial support strategies. Networking with resources located in Special Education Units, and outside the sector with NGOs, religious groups, Voluntary Counselling and Testing programmes and other counselling services outside of schools is likely to be a key part of strategy.

2) Develop and disseminate policies and guidelines on the following issues:

- *Accidental exposure to HIV and opportunistic infections.* Universal precautions against accidental infection, and issues around TB and other opportunistic infections are important. However, risk of accidental exposure to HIV infection is likely to be very small.

Guidelines must thus avoid provoking unnecessary anxiety about accidental exposure, particularly as this can reinforce stigma and lead to poor care of injured children and staff.

- *Rights of infected learners' to education and well-being.* Guidelines and codes of conduct should cover issues such as stigmatisation, appropriate confidentiality and reasonable ways to reduce obstacles to continued education of infected or ill children.

- *Approaches to ensure medical and other support for children who are ill with HIV/AIDS in each school.* Relatively few learners will need major medical support, so approaches should be efficient and feasible and mainly rely on networks rather than in-school provision.

3) Develop communication and training strategies to build staff confidence in managing infected and ill students.

How will HIV/AIDS affect capacity to deliver education?

The education sector is the largest employer in Namibia and in the Government. The MBESC already faces substantial challenges to strengthen capacity to improve access and quality of education. There are shortages of capacity at all levels and learner-teacher ratios have remained quite constant at around 31 over the last decade, with significant inequity between regions. Much of the teaching force is relatively young, inexperienced and under-qualified.

Most HIV-infected educators and other staff can be expected to remain well and lead fulfilling, productive lives for many years before they develop more severe complications associated with AIDS. The length and quality of their lives can be enhanced by ARVs, other treatments and positive approaches to living with HIV/AIDS. With better understanding of impacts of HIV/AIDS on employees and the function of the education system, it is possible to actively reduce negative effects in both areas.

Susceptibility of staff to infection

Namibia's education sector employees are at substantial risk of HIV infection, like any other workforce in the country. As there is no HIV prevalence survey data for educators, it is uncertain whether they are at higher or lower average risk of HIV infection than other adults in Namibia. There is mixed evidence on educator HIV risk from other countries. Educators are often cited as having higher HIV infection rates than other adults. However, HIV risk is strongly determined by the age and gender profile of employees. This, rather than higher risk behaviour *per se*, may account for differences in HIV infection or death rates that have been found in some comparisons of teachers with other groups. Furthermore, other protective factors may put

teachers at lower average risk in Namibia. Teachers are a relatively well informed (the 2000 DHS found that HIV/AIDS knowledge was higher among more educated Namibians). They are also relatively empowered and probably more able than the average Namibian adult to reduce their risk once they are informed and recognise their own susceptibility to HIV infection.

Nevertheless, 63% of Namibia's teachers were aged under 40 in 2001, and of these 60% were female, suggesting relatively high risk of HIV infection. In addition, discussions during regional visits suggested that many education managers and staff still have inadequate basic knowledge and awareness around HIV/AIDS or are in denial. Concerns were identified about risks to teachers due to low access to HIV/AIDS messages, alternative entertainment and condoms in rural areas; relative wealth and status in the community; and separation from spouses or other partners.

Levels of infection, illness and deaths

Data on illness and death trends among education sector employees is limited. Anecdotal evidence from schools and the pension fund, particularly for northern regions suggested increasing occurrence of illness and deaths among younger staff. In the 116 schools that supplied data, the death rate averaged 1.5 % per annum over the previous 2 years, with a higher rate (2%) in the North. A rate of 1.2% for combined death and ill health retirements among educators was reported by the GIPF for 2001, and crude estimates suggest that around one quarter of deaths among public servants were AIDS related by 1999. Though a gross "HIV/AIDS pattern" of high death rates among young teachers has not yet emerged clearly across the whole system, survey data suggests that the median age of death was quite low at 37 years for women staff and 40 years for males.

Projected Impacts of HIV/AIDS on Educators

Projections of rates of HIV infection, AIDS illness and deaths were performed for teaching staff listed in EMIS data. Estimation of HIV/AIDS risk was based on their age; gender and geographic distribution profile and assumed that educators risk is no different to that of equivalent adults in the general population. A further scenario was produced to identify the effects if 85% of educators with AIDS access antiretroviral drugs (ARVs) after 1997, as current medical aid entitlements mean that there are few barriers to access these treatments by educators.

Projections suggest that around one-in-seven educators are HIV-infected in 2002. Levels reach one-in-four in Katima Mulilo, the region with the most advanced epidemic. In all areas rates have the potential to increase markedly if risk behaviour does not change among educators and trainees.

Projections indicate that the AIDS epidemic among Namibian educators is at an early stage. Projected annual total death rates without ARVs are equivalent to around 1.4% of educators in 2001, and reach almost 3.5% by the end of the decade. Under the ARV scenario, 2001 death rates for all causes would be around 0.7% rising to around 1.4% by 2010. Projections indicate that HIV/AIDS deaths accounted for between 60% and 20% (ARV scenario) of all deaths among educators in 2001. The cumulative loss of educators to AIDS between 2002 and 2010 under the ARV and non-ARV scenario could be 860 -3 360 respectively, equivalent to between 5% or 19% of the current workforce.

Key conclusions, which can be reached from projections, include the following:

- 1) There is potential for continued growth in infection rates among educators*** if prevention among educators and trainees is not effective.
- 2) Death rates could rise substantially over the decade and result in a cumulative loss of a high number of educators in the absence of ARV access.*** In the no-ARV scenario, replacement of staff who die of AIDS could absorb around half the expected graduates of teacher training colleges from 2002-2010.

3) ARV treatment can massively reduce the rise in death rates and cumulative loss of teachers. They can also narrow the range of uncertainty about AIDS death rates that have to be considered in planning.

4) Under ARVs scenarios, a rapidly expanding number of educators on chronic medication will accumulate. Due to reduction in the number of people who die of AIDS each year, up to 3000 educators could be on ARV treatment by 2010, and will probably require systematic support to ensure good treatment outcomes.

5) Considerably higher (or lower) than average rates of death and illness may occur in many schools, circuits and regions, either in a given year or over time.

Impacts related to infected and affected staff

HIV/AIDS impacts on staff of most Namibian schools have been relatively limited so far, as would be expected given the stage of the epidemic. Even in more affected regions, many schools have limited experience of death and illness among educators, although rising death rates in families and communities are having indirect impacts on many staff. In addition, while some managers and educators are deeply concerned by death and illness among staff and their families, others seem to be in denial or clearly have difficulty talking about the issues openly, particularly in relation to themselves or colleagues. In the school survey, schools that had already experienced staff deaths tended to report more difficulties associated with death and illness of staff.

Region visits, the school survey and experience in other countries suggest a number of impacts of illness and deaths on schools.

- *Significant anxiety and stress* of infected and affected staff. This results from combinations of grief, extra workloads, stigma, fear of personal infection or illness, and care of family members. Some teachers and managers expressed despair and desperation at rising levels of illness and death, as well as the lack of information on what the MBESC is doing about HIV/AIDS and its impact on educators. A number of informants suggested that female teachers bear a disproportionate burden due to traditional caring responsibilities in their families.

- *Higher levels of absenteeism.* Surveyed school heads reported rising trends in absenteeism for funerals (60% of heads in the north; 31% in south and central areas) but no clear trends emerged for absenteeism due to other causes. In Caprivi, 40% of heads cited funerals as the most common reason for absenteeism. However, the main reason cited overall by school heads for staff absenteeism was employee illness (55%), followed by funeral attendance (23%). About 3% of staff had reportedly taken more than 15 days sick leave in 2001 (range 0-40% between schools) with slightly higher levels in the north.

- *Poorer quality of teaching by chronically ill teachers.* A number of reports were encountered of teachers who continued to try to teach even when they were debilitated. Informants noted that some teachers perform poorly for more than a year before they die.

- *Loss of skilled teachers and complications in staff replacement, allocation and distribution.* Lack of qualified teachers was frequently cited as a problem independent of HIV/AIDS. Current rates of staff attrition from all causes in surveyed schools were 7.5% per annum, with higher rates of 8.5% in northern regions. Heads reported that it took an average of around 3 months, but went up to one year to fill vacant posts. Particular difficulties in replacing skilled teachers were noted in remoter areas and for certain subjects such as mathematics and science. Northern schools appear more vulnerable to loss of staff: 30% had at least two vacant posts.

- *Deaths and illness among managers were not frequently reported.* However, impacts of vacant management posts in and above schools were reported to be particularly disruptive to school function and have "multiplier effects". Difficulties filling posts for school heads and HODs were frequently noted, and 8% of surveyed schools already had no school head.

- *Greater complications of inadequate relief teacher system.* Most schools have difficulty funding relief teachers, as their Boards cannot afford to pay for them. Heads reported that when a teacher is absent learners are most often attended to in their class by another teacher (46%), but 34% of them reported that they join

another class. Around 14% of coping mechanisms included supervision by older learners, community members and support staff, or children staying in classrooms on their own.

Many informants suggested that these factors have significant impact on system function and quality of education. Many informants among students, teachers and managers indicated that continuity of learning was disrupted. Seventy two per cent of heads reported that staff absenteeism was a serious problem or sometimes a problem to the quality of education at the school. Absenteeism was considered a serious problem more in the north (43% of heads), and particularly Caprivi (60%), than in the south/central areas (23%). Twenty one per cent of surveyed learners reported that they had had no teacher in at least one subject for four or more days in the preceding two weeks. Some learners indicated that they were traumatised by illness and loss of their teachers.

At the Circuit and regional levels, several managers complained that they had much less time for strategic planning, working on academic issues and skills building because of the demands of finding replacements for teachers who were ill or had died, as well as identifying funds for destitute children.

Estimates of cost implications of HIV/AIDS among staff suggest several important conclusions.

- *Pension fund costs* as reported by the GIPF are unlikely to increase substantially due to HIV/AIDS. This is, broadly, because current benefit structures mean that earlier payments for illness and death of staff are offset by reduced payments for pensions in future.
- *Medical aid costs* are likely to be the single largest HIV/AIDS related cost. However, ARVs are a potentially affordable strategy for the education system. Projections of ARV costs are subject to many assumptions but suggest that, by 2010, an efficient programme could add the equivalent of NS\$ 28 million to the annual cost of employment for teachers, or around an extra 2% on expenditure on primary and secondary education. Cumulative costs between 2002 and 2010 would be of the order of N\$146 million.
- *Costs of extra teacher training to replace staff that die of AIDS need to be estimated* using the teacher provisioning model being refined by MBESC. However, if training college output has to be increased by the full number of projected teacher AIDS deaths from 2002-2010, the projected costs would be around N\$ 135 million under an ARV scenario and N\$ 35 million with ARVs.
- *Absenteeism costs* will often be hidden and manifest as declining quality of education. However, costs of well-managed *relief teacher systems* targeted at AIDS illness and schools in greatest need seem potentially affordable. If relief teachers cover all absenteeism due to illness among staff, estimates suggest that the cost would be unlikely to exceed the equivalent of 1.7% of teacher payroll even under a non-ARV scenario.
- *Other costs, such as those of transfers and delays in replacement of staff are likely to be lower than for illness related absenteeism.* However, with reported average delays of 3 months in appointment of replacement staff to schools, this could add a further 50% to the above estimates of costs of absenteeism due to illness.

Recommendations - Internal Impacts

Several important conclusions emerge from the experience in Namibia and other countries.

- *Effects of illness and death on staff impact substantially on many schools and classes.* The schools that tend to be most vulnerable are usually those in traditionally disadvantaged situations. They include those that are small or remote, in poor communities, and which have multiple sick members or affected members of staff.
- *HIV/AIDS alone is not destabilising the whole education delivery system thus far, and seems unlikely to have disastrous impacts on overall delivery in any given year.* HIV/AIDS tends to exacerbate pre-existing challenges to quality and access, but is not necessarily a dominant factor at system level. However, many schools and classes may be much more severely affected.
- *Cumulative effects of unmanaged HIV/AIDS impacts on staff threaten to be a significant obstacle to system performance.* The epidemic will be a further drain on the skills base, institutional memory and morale.

- *Cost implications of HIV/AIDS among staff and important response strategies are significant but probably manageable.* Many important costs are likely to manifest as a gradual decline in accessibility and quality of education if financial and other resources are not allocated to managing them.
- *Many significant impacts may be difficult to pick up from macro-level and quantitative analyses and data.* This should not lead to complacency as it may hide subtle but important trends and severe impacts on education of significant numbers of learners.
- *As the nation's largest employer, the sector also has a critical contribution to make to the national effort to address prevention and impact management in workplace.*

Recommendations to consider on key policy, planning and management issues include the following:

1) Develop a clear workplace HIV/AIDS Policy and Programme. These should provide a framework for dealing with the many components required in the sector response. They should cover HIV/AIDS prevention, care and support, and managing impacts on education delivery in an integrated, holistic way. Impact management should focus in the first instance on *providing care and support to infected and affected staff*, both to respond to their needs as individuals, but also to create an environment that facilitates management of impacts on education delivery.

2) Develop an effective HIV prevention and life skills programme for educators, trainees, and other staff. The goal should be 100% coverage within as short a time as possible. Major spin-off benefits for learner prevention and support are likely.

- *Programmes should be holistic and built on a clear understanding of critical success factors for workplace prevention programmes.*

They should reinforce basic knowledge about HIV/AIDS risk and its impacts, address life skills to empower staff to protect themselves from infection, and deal with issues such as stigma, living positively with HIV/AIDS, care and support.

- *Structural risk factors related to employment should be addressed as far as possible.* These include quality of accommodation and work away from spouse or other regular partners.

3) Establish a Wellness or Employee Assistance Programme (EAP). This should assist infected and affected staff to deal with stresses created by HIV/AIDS by providing access to counselling, advice and services around issues such as life planning, accessing benefits, disease management, nutrition and positive living, coping with stigma, and testing and counselling. Wellness and EAP's can also provide a mechanism to inform managers and planners about the scale and types of HIV/AIDS related problems without compromising confidentiality of individual employees. Co-ordination with other Ministries, unions and private sector providers should be considered

to ensure development of an efficient, feasible and accessible system in all regions.

- *Voluntary counselling and testing* should be promoted to reinforce prevention and impact management. However, it will be difficult for the Ministries to actively encourage until they have clarified supportive responses.

4) Strengthen medical aid cover and access to ARV. The education sector should actively engage with processes that are reviewing PSEMAS. ARV treatment for teachers is a key strategy to meet employees' needs, preserve system function and limit risk of skills shortages. The extra costs are potentially "affordable" and teachers are likely to be a group in which treatment has relatively high success rates. However, costs and effectiveness of treatment depend heavily on efficient management of care. Under the current Act and regulations, PSEMAS benefits are unmanaged and cost control is already a problem independent of HIV/AIDS. Specific strategy may be needed to ensure ARV access for teachers in remoter areas.

5) Review pension benefits and administration. HIV/AIDS fundamentally changes the profile of needs to be met by the GIPF. Increasing numbers of much younger staff, often with short service, young dependants and very limited entitlements, will require support. Benefit structures should be reviewed to ensure that they meet social, employee and financial sustainability objectives adequately. A number of different benefit structures may be viable. Personnel officers must ensure that they can provide sound advice to managers and employees

on which pension option is best to meet beneficiaries' needs, and process claims efficiently to avoid hardship. Other key issues related to the pension fund's role in ill health management are highlighted below.

6) Review ore- and in-service training. These have a critical role in reinforcing prevention and impact management strategy. In-service training is likely to be increasingly important to supplement HIV/AIDS and general professional skills of new and existing educators.

- *Aggressively promote effective prevention programmes for trainees.* Current efforts should be reviewed and strengthened. Trainee prevention is likely to be one of the most cost-effective approaches to HIV/AIDS over the longer term, particularly as large numbers of staff become infected before they join the teaching service. Programmes should also provide skills related to managing HIV/AIDS impacts on staff and learners.

- *Review the number of teachers to be trained.* Projections should be used with the teacher provisioning model which is being refined by MBESC to more clearly define requirements for teacher training over the next decade.

- *Review the structure and content of training.* A substantial amount of investment in teacher training will be lost due to HIV/AIDS and there may be need for rapid training of teachers. Course duration, structure and content may warrant modification to ensure that they are *cost-effective and flex/We* to respond to these needs without compromising quality of outcomes. Curricula will need to consider *new competencies* that may be required of educators, for example HIV prevention, vulnerable children support, and possible needs for large-class skills. Greater emphasis on *management skills* may be required to equip more staff to take on management roles in view of attrition among current and future managers. *Other issues* for consideration include review of approaches to specialised training to increase flexibility to accommodate loss of specialist subject teachers, and training to address needs of out-of-school youth and adults who have had interrupted education.

- *Consider cost effective ways to build skills* of relief teachers and other resources such as community members who are used to cover for absent staff.

7) Strengthen management of absenteeism and ill health. In many instances, absenteeism and ill health are simply not managed. Absenteeism is a major problem independent of HIV/AIDS. School managers have difficulty enforcing controls. The current situation has negative implications for infected staff who face great uncertainty and work well beyond the time when they are severely ill. There are also negative impacts on education delivery and on their colleagues. Several issues need strong consideration as part of a coordinated approach to the problem.

- *Review sick leave entitlements.* Strongly consider reducing the routine amount of sick leave entitlements to ensure that an employee's health status is confronted and active management of ill health absenteeism begins before negative impacts result for learning and affected individuals. Granting of further special sick or disability leave should be possible after assessment, with further structured review. It is important to ensure that ill employees can continue to teach if they recover and are not permanently incapacitated.

- *Streamline medical Boarding and disability management processes* to ensure fair, assessment and review. Education should engage with the GIPF, MOF, MOHSS and OPM to:

- *Review the Medical Boarding system* and consider development of a full disability management programme. Boarding is often too slow to protect employees and delivery. It is also uncertain whether appropriate decisions are being taken in cases of complex and fairly unpredictable diseases such as HIV/AIDS.

- *Ensure that pension entitlements do not obstruct timely application for ill-health retirement.* Currently, some of the staff has a financial incentive to keep working well after they are disabled. Options such as full pay during the initial months of retirement may resolve this and could be affordable.

- *Review and monitor compassionate leave and funeral attendance entitlements and systems.* These are clearly becoming major issues for managers in Namibia.

- *Create effective relief teacher and other systems to cover for absent staff.* Efficiently managed relief teacher systems seem potentially affordable and respond to a major problem in education delivery. They should be responsive to shorter-term, unpredictable and intermittent absenteeism and needs to boost skills of relief teachers. Consider development of new budgetary mechanisms, pools of relief teachers, preferential access of relief teachers to career development, and targeting of available resources to vulnerable schools.

8) Strengthen HR and other management systems and capacity. To a large extent, the education system currently provides for personnel administration rather than human resource management. Training to build confidence and competence of line and HR managers in basic human resource management and development will help them to deal with many of the impacts of HIV/AIDS in addition to improving general system performance. Specific systems that need to be strengthened include the following:

- *The Cluster system.* This can be expected to reinforce schools' ability to manage various impacts of HIV/AIDS on staff through sharing and building capacity and expertise.
- *Succession planning.* This is a key approach to facilitate skills transfer and avoid unnecessary delays in appointments to reduce service disruption due to absence or death of staff.
- *Efficient recruitment, appointment, redeployment and transfer systems and practice.* These become increasingly important. Incentives and other systems need to be considered to fill key managerial and technical posts as well as vacancies in remote or "unattractive" schools.
- *Other innovative means of skills sharing and transfer.* These include teamwork approaches and improving routine and other communication.
- *Performance appraisal systems.* Consider possibilities for targeted or general performance appraisal systems. These can help to ensure fair assessment and management of incapacity among infected staff and reward exceptional effort by colleagues who cover for them. Systems need to deal with potential for fairly rapid decline or fluctuations in performance.

9) Identify vulnerable workplaces and work processes for targeted interventions. All levels of the MBESC, MHETEC and institutions should undertake a systematic review to identify workplaces and work processes that are most vulnerable to absence or loss of staff due to HIV/AIDS. Specific strategies should be developed to address these vulnerabilities.

10) Improve information. Many aspects of HIV/AIDS impacts on the education system capacity remain unclear and better information is required.

- *Active tracking of illness, death, absenteeism and medical aid/ARV use* among staff is critical.
- *Consider an anonymous, unlinked HIV prevalence survey* among teachers and trainees to clarify levels of infection and help to mobilise positive responses.
- *Regional, circuit, cluster and institutional level monitoring and analyses* will be important to ensure quality data, identify impacts that are not apparent from aggregated data, and facilitate quick responses.

11) Capacity and co-ordination of employee impact management. Personnel Administration should inherently take a major role in developing the HIV/AIDS policy, programme and review of conditions of service. The process will require dedicated capacity as well as involvement of stakeholders such as the Staff Advisory Committees.

- *Co-ordination with other stakeholders* such as the PSC, OPM, Health, Finance, other departments, unions and the pension and medical aid schemes will be important in defining overall strategy and to develop and implement specific components of the response.

HIV/AIDS effects on the role of other specific education components

Special Education

Special education has key expertise in programme planning and responding to special needs of learners including providing guidance and counselling services, networking with other sectors and HIV/AIDS education. The MBESC should consider ways to strengthen, utilise and possibly integrate special education and DATS resources more effectively in HIV/AIDS initiatives and structures at all levels. Several issues warrant particular attention.

- *Reviewing and reprioritising roles of SEU capacity in the regions.* At present regional counsellors are seen as very inaccessible by many schools and teachers. It seems critical that their skills are leveraged more effectively into schools through system development, teacher training and support for early recognition and management of vulnerable children. There seems to be great potential for counsellors to focus more systematically on prevention and early intervention rather than on learners referred at stages when they are severely stressed or manifest "discipline and behaviour problems". There also seems to be room for some

shift of emphasis from psychological counselling towards intervening proactively on basic social, economic and family issues that predispose to psychosocial problems.

- *Counselling and Support Groups* in schools should be evaluated and used to develop a more effective platform for response to orphans and vulnerable children, as well as life skills education.
- *Proposals for full time guidance and counselling /life skills posts* in schools made by the Presidential Commission should be resuscitated and refined in line with new strategy to meet the substantial needs of orphans and other vulnerable children, as well as HIV prevention.
- *Particular vulnerability of children with disabilities to abuse and HIV infection, as well as neglect when orphaned* should be considered in planning and service development.

Adult Basic Education and NAMCOL

The Directorate of Adult Basic Education (DABE) covers the National Literacy Programme (NLPN), the Adult Upper Primary Education programme (AUPE), Community Learning and Development Centres (CLDCs) and Adult Skills Development for Self-Employment (ASDSE).

A further, but independent programme is NAMCOL which provides secondary level education to out of school youth and adults. Issues raised by HIV/AIDS for adult basic education include the following:

- *The HIV risk of target clients is likely to be particularly high, as is their vulnerability to HIV/AIDS impacts.* This is due to social circumstances of out of school youth and less educated adults, and because women, who traditionally make up most candidates, are generally more vulnerable than men.
- *HIV/AIDS is likely to increase demand for AUPE and NLPN* above levels that would otherwise have been expected if it results in lower enrolment and completion among orphans.
- *The tradition of voluntarism and participatory community linkages* in DABE programmes are a potentially powerful resource in HIV/AIDS prevention and mitigation. Examples of literacy groups that had developed HIV/AIDS prevention activities were noted.
- *Income generating activities are a key intervention* to support HIV/AIDS affected individuals and households.

DABE programmes and NAMCOL are important resources in HIV/AIDS prevention and mitigation, due to their unique linkages into disadvantaged and vulnerable communities and client groups. Key recommendations for consideration by DABE include the following.

- *Increase emphasis on effective HIV prevention programmes for learners.*
- *Develop a comprehensive strategy to integrate HIV/AIDS into all programmes activities* to benefit clients directly and to enhance prevention and mitigation in broader communities. Consider linkages with, for example, home based care and voluntary counselling and testing initiatives.
- *Explore ways to expand the ASDSE programme* to contribute to support for people infected and affected by HIV/AIDS.
- *Consider possible changes in the age profile and educational needs of the DABE and NAMCOL client base.* More candidates may be younger or need of support for education in higher grades.
- CLDCs can play important roles as hubs for community activities. Ways to enhance their role in HIV/AIDS prevention and care among their clients and communities should be explored further.
- *Possible over-extension of school staff who also work as NAMCOL tutors* should be monitored more closely in view the potential for HIV/AIDS to deplete school staff compliments, at least temporarily.

Consideration should also be given to strengthening *distance learning materials and techniques* both for adult basic education programmes and to support learning in schools and classes where teachers are absent. NAMCOL distance learning materials were noted to be widely used by school learners.

Hostel management

Hostels are an important means of ensuring access to education and are a high cost component of the education system. The hostel system already confronts significant challenges including limited capacity, skills and enthusiasm of staff, infrastructure deficiencies and limited administrative controls. HIV/AIDS raises several challenges for the hostel system.

- Many hostel environments clearly put learners at high risk of HIV infection due to poor infrastructure and security, limited control and supervision, abuse of learners by staff, and limited condom access.
- Children boarding out in communities around schools are subject to poor adult supervision, high risk of abuse and HIV infection, and generally poor living conditions.
- HIV/AIDS orphans will increase the need for hostel accommodation for vulnerable children.

The Directorate should consider the following recommendations:

- *Develop a policy on HIV/AIDS* that clearly identifies roles and responsibilities of schools and staff at all levels in regards to prevention, mitigation, and care and support. Include clear policy on condoms and condom distribution in hostels.
- *Urgently improve hostel safety and security*, including infrastructure and systems to report and act on problems.
- *Reinforce accountability and skills* of hostel managers, inspectors and school heads to ensure safety.
- Develop mechanisms to *increase the safety and accessibility of community boarding* where expanding hostel accommodation is not viable. This may include accreditation systems.
- *Review hostel staffing and management*. Supervision should be available at all times after school hours. Strongly consider full time hostel management posts for non-teachers and involvement of responsible community members or groups to enhance supervision, quality and safety.

NIED

NIED has already developed several initiatives to integrate HIV/AIDS more effectively into the curriculum and syllabus development for teacher training and schools. HIV/AIDS issues are seen as a major consideration in the Curriculum Review. Full evaluation of HIV/AIDS curricula and syllabi was beyond the scope of this project. However, several important challenges for NIED have emerged. These include:

- *Incorporating a broader range of HIV/AIDS issues in curricula*. These include greater emphasis on positive HIV/AIDS messages, care and support, positive living, counselling and other support of vulnerable children, and ethical and legal issues around teaching and children.
 - *Working with National Examinations and Assessment, as well as partners such as the schools Inspectorate and Training Colleges to improve ability to examine or otherwise assess performance in HIV/AIDS education*. This is critical to reinforce prioritisation of HIV/AIDS in the education system.
 - *Developing guidelines on processes that facilitate more effective introduction of new curricula and HIV/AIDS related interventions* into schools and overcoming resistance particularly around sexuality education.
- *Working with teacher training partners to:*
- Evaluate implementation and effectiveness of HIV/AIDS curricula for teacher trainees.
 - Introducing effective life skills programmes for trainees.
 - Increase practical rather than theoretical training in areas such as counselling, support of vulnerable children including intersectoral collaboration, and management skills.
 - Re-orientate in-service training from upgrading of qualifications to practical professional skills development in order to strengthen basic education delivery and HIV/AIDS related skills. In service training is likely to be a very critical in developing teacher capacity to deal with HIV/AIDS issues.
 - Develop short course curricula to upgrade teaching skills of relief teachers and volunteers with limited or no formal training.

Planning and development

Planning and development is responsible for overall planning in MBESC, the Ministry's development budget, collection and analysis of EMIS and other data for planning and monitoring purposes, as well as donor co-ordination.

The Directorate has a key leadership role in co-ordinating the plans of the many other directorates and units which will need to respond to HIV/AIDS issues identified in this report and integrating them into overall Ministry and sector strategy. Several specific challenges to the directorate due to HIV/AIDS are raised in this assessment.

- *Infrastructure planning* needs to consider projected HIV/AIDS impacts on learner numbers in different age groups, and has to factor in uncertainties around levels of impacts at more local levels. Plans also need to consider new or more urgent needs of learners such as counselling rooms and secure hostel or alternative accommodation. HIV/AIDS may influence the desired size and shape of classrooms and schools to reduce vulnerability to staff absenteeism and loss.
- *Human resource planning* needs to factor in HIV/AIDS impacts on staff and learner numbers. Staffing norms warrant review to incorporate strategy on issues such as: need to increase dedicated capacity at cluster and school level overtime to address HIV/AIDS and guidance and counselling; possible complications if certain schools or workplaces have disproportionately large numbers of ill staff; relief teacher financing and resource allocation mechanisms.
- *EMIS* needs to track HIV/AIDS related impacts on learners and staff. It should also consider building in elements of tracking of key HIV/AIDS programme resources and implementation as part of routine management information. Strategy needs to consider more decentralised, disaggregated analyses and use of information to identify trends and problems that may not be apparent at aggregated level.
- *Research*. Routine EMIS data and analyses will often not provide adequate information to guide planning and allow interpretation of trends in a period of growing changes and uncertainties due to HIV/AIDS. More non-routine and qualitative information will be required to inform planning and monitoring on HIV/AIDS issues that are not amenable to quantitative analysis alone. Opportunities to use projects such as SACMEQ to improve understanding of key determinants and trends of quality in schooling should be explored.
- *Donor co-ordination*. The Directorate will have a key role to ensure that appropriate HIV/AIDS dimensions are built into support programmes, including raising sufficient funding and technical assistance, where necessary, to initiate and support key aspects of the sector's response.

Sports and Culture

Sports and culture can play several important roles in the HIV/AIDS response. These include promoting prevention by providing alternative entertainment to reduce HIV risk, active promotion of HIV/AIDS prevention and impact mitigation messages through sports events and role models. Sports and cultural activities can also facilitate stress management, socialisation and positive peer interaction for orphans and vulnerable children. Heritage and culture programmes can also play a key role in mobilising communities around HIV/AIDS issues, reinforcing cultural and other norms that enhance prevention and support, and engaging with those norms that may increase HIV/AIDS risk and vulnerability of women and orphans. Within schools sports and culture can play key roles in creating nurturing environments for children who are at risk of HIV or made vulnerable through HIV/AIDS impacts.

Early Childhood Development

MBESC is responsible for training and curriculum development for Early Childhood Development (ECD) with other aspects falling under other Ministries. ECD has relatively low coverage in Namibia for cost reasons. Training and curriculum development, and discussion with implementing partners, should consider that ECD has important roles in: laying foundations of HIV prevention from early ages in its curriculum; nurturing, caring and socialising young orphans with limited

parenting at home due to HIV/AIDS impacts; and relieving older children of sibling support roles so that they can attend school. ECD should also be aware that a significant proportion of their target age group will be HIV-infected and make appropriate responses in terms of support and precautions. Reliance on community funding for aspects of ECD may become more difficult due to economic impacts of HIV on households.

Higher education

Higher Education represents a major investment by Namibia. This sector is the Government's leading agency for human capital development, national technical capacity building and knowledge creation. The major components of the sector include University of Namibia (UNAM), the Polytechnic of Namibia, Youth Development and Employment Creation, Vocational Education and Training, and the four Colleges of Education. Specific issues related to the latter two components are discussed in other parts of the report. Most of the institutions are relatively young and face challenges of rapid expansion and ensuring quality preparation of students for work in the Namibian economy.

Many challenges of HIV/AIDS in higher education are similar to those discussed in relation to impacts on needs and capacity to deliver for the schooling system. Recent reports of impacts at UNAM and other institutions suggest relatively low rates of deaths among students and staff. Some deaths of skilled staff had been disruptive. Projections and experience of tertiary institutions in other countries with advanced epidemics suggest that illness and death rates from HIV/AIDS among students and staff are unlikely to be debilitating to the institutions in any one year. However, over time, the cumulative impacts on higher education staff and students will be substantial.

There are several distinguishing features of the challenge of HIV/AIDS to these institutions.

- *Levels of HIV infection among students have to be assumed to be in around 20-25%* based on national prevalence rates. Reports suggest that the environment in many higher education institutions, particularly in relation to hostels, residences and alcohol, puts students at high risk of HIV infection.
- *The main impacts of HIV/AIDS on the effectiveness of the institutions is hidden* as most student deaths and illness will occur after graduation.
- *Lost investment in students will be substantial.* At current infection rates it has to be assumed that roughly one quarter of investment in higher education could be lost to HIV/AIDS deaths, or massive unnecessary human and ARV treatment costs will be incurred. Costs are particularly significant due to high unit costs of education in these institutions and the opportunity cost to Namibia of losing individuals from small pools of highly skilled people.
- *Needs for support of students who are infected and affected can be significant.* Although the number of students who actually have AIDS will be relatively small, the demands and stress on the institutions for care of even individual students with AIDS can be considerable.
- *Cumulative impacts of death and illness on academic skills and knowledge creation,* due to loss of specialist staff (and promising students), may have significant implications for education quality and attempts to reduce reliance on external staff.
- Particular financial issues may arise in relation to *loans and financial aid* for students.
- *Higher education students and staff are a key resource to the nation in terms of skills to support national and community initiatives* around HIV/AIDS as well as research. Graduates also will need to provide leadership in a society and workplaces that are profoundly affected by HIV/AIDS.

Thus, despite its relatively low impact so far, HIV/AIDS needs to be embraced as "core business" for all institutions.

Despite studies and attempts by higher education institutions to organise responses to HIV/AIDS, progress has been slow and its effectiveness uncertain. Institutions have generally not had holistic, co-ordinated or sustained strategies to deal with the range of HIV/AIDS issues.

HIV/AIDS programmes for staff have been a notable gap. The main limitations on action seem to be difficulties mobilising academic staff in particular, combined with limited capacity and capabilities, and

substantial stigma and denial. The current Education HIV/AIDS Strategy covers development of an HIV/AIDS course for all students in higher education; an inter-institutional structure to co-ordinate efforts; research on HIV/AIDS; and primary health care and social welfare services to staff and students.

Successful responses are likely to require further refinement of Higher Education components of the HIV/AIDS strategic plan, to cover emerging priorities and give more detailed guidance on what is expected of each institution. Particular recommendations for consideration include the following.

- *MHETEC should provide decisive ongoing support and inducements* to assist institutional leadership to drive an effective HIV/AIDS programme and overcome inertia of staff and students. Co-ordination with MBESC programmes particularly at regional level should be explored.
- *Ensure that the new HIV/AIDS curriculum is "world class" and is implemented effectively.* Complementary prevention activities and messages to reinforce the programme should not be neglected. These may include issues such as campus safety and harassment, alcohol control, condom access, peer driven programmes and infusion of HIV/AIDS into other courses.
- *Strongly consider institutionalising involvement of all students in outreach prevention and support programmes.* Active involvement and training is likely to strongly reinforce prevention and other skills. Targeting *feeder schools* could have major benefits for the institutions.
- *Consider options such as challenge funds* for students and staff to develop innovative interventions and research.
- *Review planning of student output and curricula.* Pay particular attention to scarce skills areas, teacher training, and courses that face increasing demands due to HIV/AIDS e.g. health sciences and social work. Financial support and incentives to do courses such as social work should be reviewed. Also consider options for altering course structure, duration and content to meet any increased needs for outputs rapidly and cost effectively.
- *Reinforce development of a comprehensive workplace strategy and programme* covering all relevant aspects of prevention, care and support and impacts on institutional function. *Initiate a formal life skills/prevention programme* for staff at all levels and consider *targeted HIV/AIDS training for all academic and management staff* so that they become more effective supporters and managers of programmes.
- *Explore strategy to ensure ARV provision to staff and students.*
- *Review the student loan and international bursary systems to ensure that sustainability is not threatened by HIV/AIDS impacts on students.* Ensure that systems and responses respect human rights of students, and that HIV/AIDS induction training for recipients is in place.
- *Consolidate a framework for routine monitoring of HIV/AIDS impacts and responses* including a representative *anonymous HIV prevalence survey* of students and staff.
- *Ensure ongoing networking with other SADC higher education institutions to share learning.*

Vocational Education and Training

Vocational Education and Training falls mainly under MHETC. However, pre-vocational skills are also taught at primary through to senior secondary schools, with agriculture as the most prominent component. In addition to training in Vocational Training Centres which target school leavers, Community Skills Development Centres target unskilled youth with competency-based short courses. Demands for VET have been rising, particularly among Grade 10 leavers and other out-of-school youth. So far, VTC prevention programmes have been limited and attention has mainly been on care and support of sick staff.

VET has been suggested as an important part of responses to orphans and vulnerable children as it may be an accessible way to provide them with economic skills when they are unable to complete formal schooling. However, vocational subjects in schools are not popular with schools or learners, and all levels of vocational training tend to be subject to relatively high costs and shortages of equipment and skilled staff. Particular issues for consideration in relation to VET include the following:

- *Needs for vocational skills in the economy are likely to be increased by HIV/AIDS attrition,* and adequate output of VET should be assured. Private sector training output should also receive attention. Anecdotal

reports from SADC countries suggest that some private employers are reluctant to invest in training due to concerns about loss of investment due to AIDS deaths among trainees.

- *Increasing access to short competency-based and vocational courses in formal schools* may be part of strategy to equip vulnerable children for the world of work.
- *Particular attention should be given to prevention programmes* for COSDEC and other students who may not have been reached by school based programmes and may be at high risk of HIV infection.
- *Scarcity of vocational teaching staff* requires that particular attention is paid to prevention and treatment initiatives for staff, as well as training and incentives to teach if labour market demands become more acute due to AIDS attrition.

Since independence, Namibia has made important achievements in economic and human development. The HIV/AIDS epidemic threatens to obstruct further progress and undermine gains already made by society and the education sector. Impacts of HIV/AIDS are expected to increase and accumulate well beyond the end of this decade.

The HIV/AIDS epidemic has profoundly changed the internal and external environment of the education sector. Most importantly, at current infection rates, over one quarter of the nation's investment in education could be lost through premature AIDS illness and deaths among today's learners and students. HIV/AIDS is also exacerbating negative socio-economic and other influences on learners, and compounding weaknesses in ability to deliver quality and accessible education. Impacts are likely to disproportionately affect communities and individuals that are already disadvantaged, obstructing attempts to improve equity. Future assessments of the adequacy of Namibia's response to the epidemic are likely to be based largely on whether it has preserved the lives, development potential and rights of the current generation of children and youth. The education sector represents the nation's largest investment in development, and is uniquely placed and essential to ensure a successful national response to these challenges.

In any single year, HIV/AIDS alone seems unlikely to destabilize the whole system. However, this hides insidious effects on quality and access, as well as severe impacts on many schools and many thousands of infected and affected employees and learners.

There is urgency to act on opportunities not only to mitigate the current and immediate impacts of the epidemic, but also to lay foundations to combat longer-term impacts, that may not be visible at present.

- *HIV/AIDS has to be recognised as "core business" for the whole education sector for the foreseeable future.* All components of education are affected and have roles to play to protect the sector.
- *"Mainstreaming" of HIV/AIDS within all components of the education sector and at all levels* is imperative to address HIV/AIDS effectively. All Directorates and institutions must actively integrate HIV/AIDS into their strategies and actions. Responsibility cannot be abdicated to the proposed HIV/AIDS Unit, other HIV/AIDS programmes or other sectors.

Importantly, *HIV/AIDS presents opportunities not just a threat.* Many aspects of HIV/AIDS responses are consistent with existing priorities, programmes and initiatives to strengthen education independent of HIV/AIDS. HIV/AIDS can reinforce the urgency of need for them and creates opportunities to mobilise support to implement them more efficiently.

The following overall recommendations are made around developing a more effective sector response.

1) Leadership. Sustained, high profile political, managerial and professional leadership in all components and levels of the education system is critical for effective responses to HIV/AIDS. Leadership needs to inspire staff, give guidance and ensure that action happens. Levels of leadership awareness and commitment vary across the sector, but are often too limited to ensure success.

2) Actively combat stigmatisation, secrecy and denial around HIV/AIDS. These problems are widespread at all levels and profoundly undermine response to impacts on the system or individuals. This requires active

participation of leadership as often as possible, as well as systematic creation of opportunities for open discussion of HIV/AIDS issues at all levels.

3) Define roles and accountabilities of various education components and players, and develop guidelines on various aspects of action. Many HIV/AIDS challenges, including critical issues such as HIV prevention and support of vulnerable children, are new additions to traditional roles. Many role players are unlikely to act without clear definition of their responsibilities. Development of practical guidelines is an urgent priority to guide decentralised action in many areas as soon as policy and strategy are confirmed.

- *Review education and other regulations, legislation and codes* in a number of areas. This will often be a prerequisite for appropriate action by officials.

4) Disseminate knowledge across the sector and Include positive messages. Basic knowledge of educators and managers is often inadequate and many have little ideas of what can be done even if they are motivated. Communication of information on key aspects of HIV/AIDS prevention, impacts, planning, strategy and best practice is needed to mobilise and sustain responses. Fatalism around HIV/AIDS and other stresses on education stakeholders make it critical to communicate positive messages of commitment, hope and practical steps that can be taken.

- *Establish mechanisms for networking and sharing of experience and best practices* between schools, clusters, regions and MBESC/MHETEC planners.

5) Ensure decentralised approaches. Avoid a "top down" approach to developing and implementing responses to HIV/AIDS. Effective action on HIV/AIDS requires clear guidance from a central strategic framework to co-ordinate role players and clarify expectations. In addition, many specific aspects of action require solutions planned or led from the MBESC.¹¹ However, the overall response depends on motivation and action at school, cluster and regional level. Also, centralised capacity, capabilities and models are unlikely to be able to cope with the diversity of circumstances in schools and the scale of the challenge.

- *A major part of initial strategy should be to focus on facilitating cluster and school level responses.* This may build on initiatives such as the Basic Education Project (BEP).

- *Address organisational culture.* A successful sectoral response to HIV/AIDS will to a large extent depend on cultivating caring and willingness of individuals and groups to embrace the challenge, and respond to needs of colleagues and learners. Bureaucratic traditions and tendencies to avoid personal initiative should be combated.

6) Ensure flexibility to deal with uncertainty. Many aspects of HIV/AIDS impacts and appropriate responses remain uncertain. "Least risk" scenario planning approaches should be used in areas where important uncertainties exist, for example, around levels of impacts on teacher and student numbers. In addition, a key consideration in planning and practice should be how to ensure flexibility in many aspects of education system management to facilitate creative, service orientated responses to unforeseen needs or circumstances.

7) Inter- and infra-sectoral co-ordination and partnerships. Many aspects of the responses to impacts of HIV/AIDS on educators and learners require co-operation across education components and with other sectors. It is critical that education sector role players avoid a "silo" mentality in approaching HIV/AIDS issues, and are bold in approaching other role players. However, they must also avoid tendencies to simply "pass the buck" to others.

- *Co-ordinate with other sectors,* particularly NACOP, MOHSS, Local Government, OPM, PSC and Finance. This will be critical at all levels for efficient strategy and use of available resources.

- *Co-ordinate better across Directorates and units within the MBESC and higher education.* For example, co-ordination is needed on the role of Human Resources in workplace programme development and of the role of SEU in the programme and school responses.

- *NGOs and community organisations are key partners.* They often have capacity and expertise that is not available within government, as well as flexibility to respond rapidly. Improved co-ordination and integration of strategy at all levels is required with them, as well as stronger support from government to ensure their sustainability. The education sector may be a good locus for functional co-ordination of partnerships with NGOs on youth HIV prevention and vulnerable children issues.

- *Co-ordinate with unions.* Namibia's teacher and other public service unions are increasingly aware of the impact of HIV/AIDS on members and society and are important allies in confronting the epidemic. However, their members may resist important aspects of change and new roles required, and certain aspects of workplace policy and programmes may need to be negotiated.

- *Strengthen MBESC HIV/AIDS resources, mandate and management systems for effective inter- and infra-sectoral action.* More effective high-level participation in fora such as RACOC is needed to strengthen co-ordination with other sectors, enforce decisions and ensure effective reporting. RACEs need adequate capacity and support to define solutions within the sector and with other sectors before presenting proposals to RACOC.

8) **Refine the HIV/AIDS strategic and operational plans.** The current Education Sector HIV/AIDS Strategic Plan defines key processes and actions in many areas. However, more knowledge of HIV/AIDS issues and experience of implementation barriers is now available.

- *Review the Strategic Plan* with particular emphasis on a) strengthening its approach in certain areas such as support for vulnerable children, and responses to impacts on employees and system function, and b) giving new details on strategy in various areas to enable it to be a practical guide for decentralised action and implementation.

- *All MBESC and MHETEC Divisions and Units* should refine or commence development of their HIV/AIDS strategic and operational plans.

- *School, Cluster and Regional HIV/AIDS plans* should be developed or refined with adequate guidance and support.

9) **Reinforce existing programmes and activities that are relevant to managing HIV/AIDS, and adapting them where necessary.** Many current initiatives (e.g. management development, reinforcing skills of teachers, BEP, medical aid review) will enhance ability to respond to the challenge of HIV/AIDS and are critical to stabilize the overall education system to deal with HIV/AIDS and other stresses. However, HIV/AIDS introduces new vulnerabilities and needs in many of these areas that need to be factored into planning.

10) **Improve information and monitoring of impacts and responses.**

HIV/AIDS prevention and impact management is hampered by lack of good information.

- *Review and strengthen EMIS and other routine information and reporting systems* to address HIV/AIDS issues and monitor implementation of HIV/AIDS programmes. Consider possibilities for more decentralised management information generation and use.

- *Use participatory approaches, qualitative information gathering and specific research projects* in addition to routine statistics.

11) **Develop strategy on resource allocation and mobilisation.** In the short term, investment in dedicated budgets and capacity at schools, cluster, regional and Ministry level is required to mobilize, support and co-ordinate effective responses to HIV/AIDS. In the medium to longer term, it should be possible to incorporate most HIV/AIDS-related activities into core budgets and functions. Some costs particularly related to management of staff impacts, may become significant extra demands on budgets. However, they do not seem likely to be extremely large as a proportion of education expenditure and will climb gradually. They should thus be amenable to

gradual re-prioritisation of programmes and expenditure within and across sectors.

- *The education sector should be bold in motivating for funding from donors and government* for its HIV/AIDS initiatives. An effective response by education is likely to have more effect on the epidemic and development outcomes than many competing initiatives.

- *Consider targeting* of resources to address the most vulnerable stakeholders and aspects of delivery. Targets may include rural and other disadvantaged communities and schools.

- *Focus on interventions and resources with multiplier effects* such as activities to disseminate examples of best practice and transport to facilitate co-ordination of resources.

- *Consider innovative approaches such as an incentive fund programme* to support planning and implementation of HIV/AIDS activities by individual regions, clusters or schools.

12) **Strengthen HIV/AIDS programme capacity and structures.** This is a priority to ensure an effective response to the epidemic.

Provisional HIV/AIDS programme structure and functions at each level
Several issues should be considered in assessing the proposed structure:

- *Care must be taken in selecting staff.* No structure is likely to function effectively if its staff are not appropriately skilled and motivated. There is often a tendency to allocate HIV/AIDS responsibility to educators or managers who are "left over" after other functions are allocated.
- *The structure is expected to interface with a series of committees and focal persons* at all levels, including national ministry HIV/AIDS committees, RACE, cluster committees, and Counselling Support Groups. This is critical for the programme to obtain adequate support from other units, managers and staff. *Also consider more formal integration of key existing capacity and expertise with the structures,* An important example is SEP capacity.
- *Costs of the programme structure* should be considered in the light of it being a key investment to lay foundations of an efficient national response to a major, enduring problem. Capacity should also reflect the scale and complexity of its task - comparison of the size of the proposed structure with other programmes with similar or lesser mandates may be useful. Finally, the largest component of costs is likely to be due to dedicated guidance and counselling/ life skills capacity at school level, and this has already been proposed by the Presidential Commission. Nevertheless, phased implementation with initial focus on cluster level capacity may be necessary.

Initially, at the *Cluster level*, a full time skilled Guidance/HIV/AIDS Co-ordinator should be appointed to provide technical support coordination and direct services to schools until they have adequate in school-capacity.

At *school level*, the Head should specifically be held accountable for implementation of HIV/AIDS responses. As soon as possible, dedicated posts should be created for a Guidance and Counselling/ Life skills Co-co-ordinator, responsible for co-ordination, referral activities and aspects of service delivery and technical support within the school. The Head should have discretion in allocation of HIV/AIDS responsibilities, provided that outcomes are achieved, and should ensure that all functions are not left to the Guidance teacher. For smaller schools, or to relieve short-term resource constraints, part time posts and sharing of guidance posts may be appropriate.

Regional Offices require a full time HIV/AIDS Co-ordinator responsible for inter and intra agency co-ordination, and to facilitate and provide technical support when necessary. *Circuit offices and inspectors* should facilitate communication between the Regional Office and Clusters, and monitor progress, but with no extra capacity.

At *national level*, the HIV/AIDS Unit Director should report directly to the Permanent Secretary and be a member of the senior management team to enable communication, authority and input into policy and strategy formulation. At a minimum, full time positions should be created for three Technical Programme Leaders responsible for each of the workplace, prevention and life skills, and vulnerable children programmes, plus an education officer and secretary to support the Director and the technical programme leaders.
