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***HIV AND AIDS IN CONTEXT:
THE NEEDS OF LEARNERS AND EDUCATORS***

The following 'think piece' is a collection of observations selected principally from a very rapid September 2003 tour of Malawi, Kenya, Mozambique, Tanzania and Uganda, recent fieldwork in Botswana, Rwanda and Zimbabwe, and UNESCO Nairobi cluster workshops on education and teachers held in Kigali and Kampala early in 2003. The 2003 tour confirmed previous impressions about where we are and where we need to go.

Many of the observations and comments on HIV and teacher education are personal: they are meant to challenge our perceptions of what we are doing and how we are doing it. I hope they will lead to a more precise analysis of the content, implementation, and outcomes of our preservice and inservice HIV and teacher education programmes, and indeed of the priorities we have designated in the fight against HIV/AIDS over the past 20 years. I hope they will help us to 'think outside the box' in order to be more creative in saving lives and protecting our communities.

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Because this problem is so big, and the potential consequences so vast and dreadful, as individuals we all feel overwhelmed by it. Our intellectual, emotional and material resources seem too finite, too meagre to confront this monster. We all hope that a medical solution will present itself, and save us and the next generation from doom. A medical solution is not going to happen, at least for those who are already infected. Our generation is compromised and our children are in immediate danger. We are all, individually and collectively, responsible for ameliorating our predicament. If we stop pretending there is not a war to be fought against AIDS, we can start turning to confront the enemy and save our children for the future. It will take guts and determination, and great leadership. Each one of us is capable of leadership in our domain, and each one of us is accountable for giving what we can (Coombe (2001), SADC).

INTRODUCTION

HIV/AIDS is affecting every aspect of our lives in Africa. This short note examines some of the principal concerns for educators, and what can be done to respond to the challenges of HIV/AIDS to education provision and quality.

1. What does 'HIV and education' mean? (concepts)
2. What aspects of the pandemic are particularly important for educators to understand? (issues)
3. What are the anticipated consequences of the pandemic for learners, educators and institutions, and therefore for the education sector as a whole? (situation analysis)
4. What principles should inform the response of the sector to the pandemic? (principles for action)

HIV/AIDS THE DISEASE VS HIV/AIDS THE PANDEMIC

The disease known as HIV/AIDS has been around for many decades. Responses to it have been largely biomedical, focused on preventing the spread of the disease and more recently on providing medical treatment to prevent and control infection. Teachers and community workers have sought to teach young people to practice safe sex – family lifeskills, the 'ABCs', zero-

grazing messages – in order to halt the spread of the virus.

Rising prevalence rates worldwide indicate that many strategies to contain the disease have not been effective. As HIV/AIDS spreads, individuals, families, communities and nations must learn to live with the disease. But HIV/AIDS is no longer just a disease. It is now a pandemic, an entirely different though clearly linked phenomenon. This is a complex set of related problems that together constitute a phenomenon that needs understanding in very broad geographical, demographic, environmental, economic and social terms.

Understanding of the complexity of the HIV/AIDS phenomenon is very recent. Governments and communities are only starting to define its characteristics. The fight against 'HIV/AIDS the disease' will continue while the battle with 'HIV/AIDS the pandemic' is joined.

THE EDUCATION SECTOR'S RESPONSIBILITIES

In this new context, education can no longer be 'business as usual'. Schools in an AIDS-infected world cannot be the same as schools in an AIDS-free world. Challenged by this pandemic, the paradigm of education is shifting. It is necessary to change educational planning and management principles

if the quality and level of education provision are to be sustained at reasonable levels, and the hard-won gains of Africa's education services sustained.

Educators must of necessity move from a narrow 'HIV education' curriculum campaign towards a broader 'HIV and education' paradigm. What does 'HIV and education' mean? The pandemic-as-phenomenon is vastly complex, and individual educators, researchers, policy makers and analysts, planners and funders each confront this plague from a different perspective, based on experience and training:

- Some are guidance and counseling specialists who are concerned about orphans and other vulnerable children in classrooms;
- Some are gender specialists concerned about violence against women and girls which spills into learning institutions and on which the disease thrives;
- Some are teaching service managers concerned about controlling and managing the impact of high levels of morbidity and mortality on educators and children, and keeping education quality at acceptably high levels;
- Others are education planners and practitioners who concentrate on the potential consequences of the pandemic for education subsectors like higher education, schools, or early childhood development;
- Others are curriculum and materials specialists;
- Most are simply teachers who are trying to cope with children in trauma, children who are abused or suffering emotionally from loss to HIV.

All are educators trying to understand in one way or another the HIV challenge. And all are affected by the pandemic.

A broad multidisciplinary approach by educators to the pandemic is essential. The following 'HIV and education' construct is a work in progress. It attempts to set out par-

ticularly significant issues for education practitioners and researchers coming to it from different perspectives. There are clearly more facets to be added, but this is the current state of understanding.

General issues: Learning to contend with the pandemic's impact on the education sector; identifying (1) the nature and extent of education's responsibility for fighting HIV/AIDS and caring for those affected; (2) at what point educators should transfer responsibility for learners in difficulty to social services; and (3) the extent to which schools and other educational institutions are (or should be) part of communities' response to the pandemic.

Education and training subsectors: In higher education (for example), protecting learners and staff as well as the institution itself; understanding within the university community how the pandemic will affect national and community life, and revising taught curricula in all faculties appropriately; creating a knowledge bank about the pandemic capable of serving national development and security; training for predicted labour shortages starting with teachers, health workers, and social welfare staff; undertaking research in priority areas, on orphanhood and thanatology for example, on the psycho-social roots of the pandemic, on economic impact.

Management, policy and planning issues: Understanding and predicting the pandemic's implications for management and development within the education sector; managing the pandemic in a way that protects learners, educators and institutions; developing appropriate policies and strategic plans, and implementing them; systematically collecting and disseminating information and data as a basis for informed decision-making; establishing partnerships for action; mobilising and allocating resources effectively within the sector.

Pedagogical issues: Mainstreaming life-skills curricula in all learning institutions,

and developing and evaluating appropriate materials; improving educator knowledge and skills; providing appropriate support to educators; evaluating content, implementation and outcomes of lifeskills curriculum; developing teacher competencies in care and counselling.

Psycho-social and care issues: Learning to be more sensitive to learner wellbeing, including children of trauma – those who are abused, harassed or victims of incest, who are vulnerable and at-risk, who are orphaned, who are heading households, or are caregivers; understanding adolescent sexuality, customary and imported behaviours, homosexuality and bisexuality and HIV/AIDS-related sexual behaviour; understanding ‘orphanhood’ and responding to it; learning from past experience with school hostels, institutional care, and homebased care; analysing and planning for homebased care and school feeding schemes; defining the school’s links with the community’s response to the pandemic.

Educator development and support issues: Establishing HIV workplace policies in all learning institutions; supporting educators infected or affected by HIV; creating and applying appropriate codes of conduct; understanding the limitations of teachers as mentors, care-givers and guides and supplementing their efforts from social and health sector resources; reconstituting a culture of care and respect in learning institutions. (See Uganda (2003), *School Health Policy*.)

Gender concerns: Keeping issues related to the girl-child at risk at centre stage; recognising schools as unsafe places for girls and taking action; closely linking gender and HIV programmes for maximum efficiency; continuing advocacy, research and action on violence, abuse and rape in learning institutions. (See Acquah-Dadzie, 2000.)

Values, and moral and ethical issues. Understanding how values and customary and religious beliefs can either profoundly in-

hibit understanding of this pandemic, or empower educators and learners to challenge the pandemic.

HIV and international agreements, legislation and application of the law, regulations, codes and human rights issues: Reviewing existing international and national conventions, education legislation and policy; establishing an appropriate legislative and regulatory framework; analysing issues of testing; identifying and protecting the rights and responsibilities of teachers; dealing rigorously with harassment and abuse, stigmatisation and discrimination in learning institutions; establishing codes of conduct and applying them.

Training, manpower and economic implications of HIV: Understanding the ramifications of HIV/AIDS for the teaching service including teacher attrition, replacement and deployment; identifying new teacher competencies required to cope with complex cohorts of learners; enabling training institutions to produce appropriately qualified teachers; helping to mitigate HIV’s consequences for economic growth through education and training.

This broader concept of HIV and education means in practice that each educator is responsible in his or her own domain to make sense of what is happening, and to react appropriately. Educators are moving into unknown territory here, for few of the right questions and answers have as yet been tabled.

AIDS IN CONTEXT: ISSUES FOR EDUCATORS

Why is HIV/AIDS spreading so rapidly in southern Africa? Is this an inherently more virulent form of the virus? The answer is no. HIV/AIDS viral strains in Africa appear to be no more infectious than those elsewhere. What southern Africa is confronting is a viral disease transformed into a pandemic

driven by social, cultural and political conditions (Gray et al, 2001; Stillwaggon, 2001).

HIV/AIDS is not alone the cause and effect of the SADC region's difficulties. Many of them started long before the virus arrived. HIV/AIDS is shining a bright light on long-standing latent social dislocations in southern Africa: inherited and imported cultural norms and standards antithetical to female security; the behavioural sink of inner city poverty and the distress of rural destitution; and the breakdown of family and community values under pressure from labour migration, apartheid, political instability, war and drought. These factors, combined with new kinds of violence and abuse driven by HIV/AIDS, lie at the heart of the pandemic in eastern and southern Africa.

The way teachers and other educators respond to HIV/AIDS must take account of deeply-ingrained economic, psycho-social and other complexities. Children and young people live not only in school, but are under the influence of the values of the street, the church or mosque, the family and community traditions.

COMMUNITIES AND PARENTS

AIDS awareness: No one doubts the existence of AIDS. But rural dwellers may not know much about the aetiology of the disease or universal precautions. Others are in denial, believe deaths are due to witchcraft, or cling to myths ('*condoms cause infection and are part of a conspiracy to wipe us out*'). Many education officers and teachers have a superficial understanding of the disease, and may have been given insufficient guidelines about how to cope with the virus or the pandemic.

The situation is very clear: no one doubts the existence of AIDS....People did not believe: we know now because deaths are rising. Education Officer

Customary behaviour: adults and children:

Adults and children are both strongly socialised not to talk to each other about taboo subjects like death and sexuality. Parents often find sexual terms '*abusive of the language*', and may be hostile to sexuality and lifeskills teaching in any language. So-called 'youth problems' are often in fact 'adult problems' caused by adults who do not believe there is a disease, rely on traditional healers, force children into early marriage, put pressure on girls to bear children, or abuse, harass or otherwise mistreat the young including family members.

Is AIDS is part of our culture? Does it derive from our lifestyle, our upbringing?
Community Elder

Condomising and testing: People who use condoms do so part-time because they are in denial, or because condoms are either in short supply or handed out indiscreetly. Where condoms are freely available they are as freely commandeered. It is generally unacceptable for women to ask or demand that partners use condoms, particularly in marriage.

Young people and adults alike are reportedly reluctant to be tested for various reasons: lack of confidentiality, fear of losing hope for the future, ignorance, fear of stigma and discrimination, or because there is no accessible VTC facility. They often believe – and rightly in most cases – that nothing much can be done anyway.

PUPILS AND STUDENTS

Poverty: Many African households still depend on river water, have no toilet facilities, and are headed by women. (UNDP, 1999). HIV/AIDS compounds the misery because it thrives on poverty, lack of nourishment and potable water, high levels of STDs, lack of access to drugs and medical services, and the ignorance or superstitions of rural communities about the virus. Economic hardship

drives significant numbers of women, including students, to prostitution and promiscuity (Stillwaggon, 2001).

Child welfare and general well-being: Many pupils and students live in families that, in terms of HIV risk, are dysfunctional. Inappropriate nurturing can spill over into learning in many ways:

- extended family members taking care of students may not discipline or socialise them adequately, or ensure that they go to school;
- students who stay alone or crowded together with others in a room in town may be poorly clothed, nourished and socialised, and may engage in risky behaviour to get money;
- female students staying with relatives may be subject to sexual abuse or harassment, or find themselves used as servants;
- children who walk long distances to school may be delayed or abused on the way, vulnerable to men and boys;
- girls get pregnant because of customary early marriage at the insistence of parents, or because they are expected to 'to bear children, in order to fulfill their role as women'.

Violence and harassment: HIV/AIDS has given impetus to examination of levels of sexual violence worldwide, and southern Africa particularly has come under close scrutiny (Morrell et al., 2001; CIET Africa, 2000; Human Rights Watch, 2001; see also Leach et al., 2000). Research in southern Africa consistently demonstrates a pattern of extensive sexual violence in which children and young people are raped or forced to have sex, young women live in anticipation of harassment, rape or coerced sex, and a miasma of fear too often permeates sexual relationships between young people. Evidence about sexual violence and abuse, bi-

sexuality and same-sex relationships, incest, and intercourse with young children profoundly complicates understanding of HIV/AIDS as a disease spread by heterosexual consensual sex reflected in lifeskills programmes.¹

Patriarchy is not only oppressive to females but even to males. A permissive culture that condones...multiple partnership for men has captured for example in the saying 'monna thotse oa nama', meaning 'like a melon creeper, a mean spreads over a large area (meaning as many partners as he can), does not favour the male species in any way. In the age of AIDS this is dangerous to any man who takes heed of the saying. District Multisectoral AIDS Committee, Botswana

There is much that is not understood about HIV and sexual behaviour. Whiteside and Sunter (2000) stress that, unfortunately, much of current understanding of HIV and its links to sexual behaviour is conjectural.

It does seem preposterous that we have so little pertinent data about a virus that is such a threat to our society. But then it is related to sex and people do not like talking openly about sex....The only way we will get a decent lock on the problem is to have better data. However difficult it is to undertake, we would recommend a proper survey of sexual behaviour...so that we can identify

¹ We understand very little about same-sex sexuality in sub-Saharan Africa, and need to know more. See Wanjira Kiama, *Where are Kenya's Homosexuals?* (*AIDS Analysis Africa*, Feb/Mar 1999, p 9): 'Networks of men who have sex with men can be found across the continent...[There is] a good number of men who are constitutionally homosexual, but socially heterosexual, so as to fit in the society....Men having sex with men is not only common among young people, but fashionable. Just as young men like to wear an earring, they are also opting to try out homosexual practice....The taboos surrounding men who have sex with men have meant that few, if any, attempts have been made to provide AIDS education and support to them.' See also Rex Winsbury, *AIDS in Prisons in AIDS Analysis Africa*, Oct/Nov 1999; UNDP, *Botswana Human Development Report: Towards an AIDS-Free Generation*, 2000.

where the points of leverage are in formulating strategies to stop the spread of AIDS (Whiteside and Sunter, 2000).

Child abuse: The South African Professional Society on the Abuse of Children (Sapsac) reports (*Pretoria News*, 15 May, 2001) that 'one in every three girls, and one in every five boys in South Africa are abused during their childhood'. There are three possible explanations for the apparent increase in child abuse:

- increased awareness of sexual abuse of children amongst the general public, with a concomitant increase in the number of children presenting for help
- improved services, resulting in numbers of previously undiagnosed cases being accurately assessed at health facilities, and
- the possible relationship between childhood sexual abuse and the HIV/AIDS pandemics.

Three theories link child sexual abuse and HIV/AIDS. The first – the prevention theory – is based on the assumption that all sexually active people are likely to be HIV infected and, in order to be 'safe', one must choose a partner who is not yet sexually active. The second – the cleansing theory – suggests that having sex with a child will cleanse the infected individual of the virus. Finally, the retribution theory describes behaviour which deliberately spreads infection to many others (Smart, 1999).

Orphans and other vulnerable children:

The trauma of children who are orphaned, and of others who suffer deprivation associated with poverty, morbidity and exclusion, is evident in classrooms as HIV/AIDS creates a generation of children profoundly vulnerable and at risk.²

²² Any person under 18 is, by international convention, defined as a child. An orphan is anyone below the age of 18 who has lost either a mother or both parents.

In July 2000, the *Natal Witness* gave a graphic description of children in distress:

The Sinosizo home-based care programme helps children aged nine to 14 who are the primary caregivers for parents dying of AIDS and for smaller brothers and sisters. The majority live in households with no incomes, many with parents who have been sent home from hospital -- sometimes comatose -- a day or two before they are expected to die. In the many homes where there are no beds, the children, often malnourished, struggle to lift and turn their parents and to help them to the toilet. Children from some of the 900 families with whom Sinisizo is working told ... the [13th International AIDS Conference, Durban, July 2000] about their difficulties. "They say waste disposal is the most difficult thing -- getting rid of soiled dressings and incontinence pads. They also have to find food for their families, cook for and feed their parents and younger siblings. They have to ask for food from the neighbours and it takes hours to get enough for one day. They have to cook on paraffin stoves and open fires while they are carrying smaller children on their backs or hips. They have to fetch water for drinking, cooking, bathing and washing clothes, and a small child can't carry enough." If there is any medication available, the children also dispense that, "but most of the time they can't even get aspirin". So, the children help their parents die; there is no time to mourn, because they must go and seek assistance to arrange a funeral.

Young people affected by HIV/AIDS are often not able to go to school or continue their education because they are caring for sick relatives or orphaned siblings, they themselves are sick or undernourished, their labour is needed at home, or there is no money for fees, school funds, books and uniforms (or soap to keep them clean). For similar reasons, if they do enrol, they may

be forced to drop out or be regularly absent. Enrolment, retention, transition and completion rates are expected to fall as a result of the pandemic. Because they cannot access education neither can these potential learners access resources that would lead them out of the cycle of poverty and dysfunctional behaviours that lead directly back to HIV infection for themselves: 'They will in effect become the next cohort of the HIV infected: a state of affairs which will permit the epidemic to continue and intensify' (Cohen, 2001).

Pupils and students affected by HIV/AIDS experience stigma and discrimination, teasing by other children, ostracism, and teachers' insensitivity to their loss and emotional deprivation. At the same time, customary socialisation mechanisms may not be operating as single-parent or child-headed households become the norm, and children tend to become alienated.

Psychosocial support for young people at risk is 'usually secondary to the provision of material support and other amenities' (Unicef *et al.*, April 2001). For the young, HIV/AIDS-related trauma comes in many guises:

- secrecy and silence about parental illness for fear of being stigmatised
- denial that the illness is related to HIV/AIDS, or culture-bound inhibition about discussing illness and death, even though a perceptive child knows what is wrong
- grief at witnessing the wasting sickness of a loved person in dehumanised circumstances and at the lack of opportunity to say goodbye
- frustration at the inability to express grief
- insufficient time to grieve and come to terms with loss
- confusion compounded after an AIDS death by continuing silence and denial, breakup of the family home, and separation from siblings, friends and community: confusion and distress about

family quarrels over disposal of family property

- anxiety about re-starting life in unfamiliar surroundings, in a new location, often in a new school, and about where or how HIV/AIDS will strike the family again (Devine and Graham, n.d.; Coombe, 2001a).

Children without emotional support may withdraw, resign and isolate themselves. They will have a strong sense of insecurity and instability, a sense that life is empty and that adults are not to be trusted (Kelly, 2000a).

The AIDS-orphaned child is not just another orphan, but a child who suffers from unique pressures and influences which may lead to depression, hopelessness and psychological trauma later in life. Because the concept of 'orphanhood' is relatively new in African communities (children without parents have customarily been incorporated into extended families) more needs to be learned about 'orphanhood', about AIDS orphans in particular, and how educators can work with social and health workers, sociologists and psychologists, and behavioural scientists and managers to identify and address their needs.

The people who are now falling ill and dying are the adults and role models in society, which means that a generation of children will grow up without much of the care and many of the role models they would normally have had. This means that South Africa could undergo further degradation of its familial and social fabric, already so severely damaged by apartheid. Unless the increase in the prevalence rate is curbed, South Africa will also experience a sudden and widespread breakdown of the main conduit for transmission of social values, the family (South Africa, National Population Unit, 2000).

The principal needs of all learners

Teachers in east and southern Africa have identified some of the principal needs of

learners, increasing numbers of whom may be children in trauma:

- a safe and healthy learning environment where there is zero tolerance for violence and abuse and adequate hygiene;
- appropriate knowledge and awareness about HIV and AIDS, even where parents or communities are hostile to sexuality or lifeskills education;
- effective pastoral counselling sustained by compassionate and sensitive educators, within the context of a culture of care in learning institutions;
- safe and informed home environments in which parents and guardians take responsibility for the wellbeing of their children ;
- effective material and emotional care for children at risk and orphans, with monitoring and support services provided by educators working in partnership with social and health workers;
- school hostels which are humane in terms of management, care, nurture and nourishment, as well as basic facilities.

Children and young people are not just people of the schoolroom or lecture theatre. They live a good part of their lives in learning institutions, but they also live and find their identities on the streets and in their homes. The response of the education sector to their needs must take this tri-partite identity into account in devising HIV/AIDS programmes which have a chance of success.

TEACHERS AND OTHER EDUCATORS

Educator skills, attitudes, behaviours and knowledge: Ministries of education have channelled substantial resources and energy into teaching lifeskills to halt the spread of the virus. Classroom materials have been developed, and in places mentors and school heads have been trained and sensitised to support classroom teachers.

Two recent South African studies³ have considered the strengths and weaknesses of lifeskills programmes but there has as yet been no comprehensive assessment of such programmes with regard to materials content, implementation or outcomes (behaviour change). This is urgently required before more money and teacher energy is poured into what might be a dead-end, or less-than-useful, exercise as it is presently conceived.

There is substantial evidence throughout east and southern Africa – from observation of practice, discussion of cultural norms and religious values, and comments by adolescents – that many educators feel uncomfortable talking about and teaching sexuality issues. They may be reluctant to discuss personal matters with young people when everything in their own upbringing rebels against such intimacy.

We call a spade a big spoon. We cannot talk the truth. Our vernacular language of intimacy cannot be used in front of young children by older people, so metaphors are now used. Principal Education Officer.

Too few teachers and lecturers have adequate knowledge about the disease and its transmission. There is a belief that as ‘teachers are well educated, of course they should have read the paper or heard about the disease on the news’. Testing this assumption would surely demonstrate its fallacy. Many teachers are *not* well informed about the aetiology of AIDS. They may have access to materials from clinics and social workers; they may invite NGOs and volunteers to work with peer groups in their schools; they may get active support from local campaigns, health clinics, and the STD unit or health team in the district. But they have to go out and get information and materials, and what they get is principally in the form of mass media pamphlets. Some listen carefully when children are learning from NGO support professionals. But there are as yet

³ By the national Department of Education (2000), and by the University of Natal (1999).

too few programmes targeted directly at the needs of teachers for more reliable, accurate and systematic information, even though there is anecdotal evidence that teachers who are exposed to peer education among students have changed their own behaviours.

How do teachers cope with the disease in their own lives? They watch the children learning, and we hope they absorb something for themselves. NGO Counsellor

Perhaps it was an inherently flawed assumption that, in the 1980s, led ministries and departments of education in the region to assume that, in coping with HIV/AIDS, teachers could become sensitive counsellors, mentors, guides and guards of learners in their care. Many teachers find guidance, counselling and lifeskills teaching problematic: they will not teach the subject at all, and leave it out, or go around it for a variety of reasons. Some feel they lack knowledge; they may be sensitive to sexuality issues; they do not relate well with young people; they may be sensitive to criticism from parents about the teaching of sexuality in classrooms; or they may find it morally wrong themselves to talk about such things.

There are few policies and guidelines for teachers on care and counselling, on the educator's scope of work relating to care, home visits, coping with children in difficulty. Specialist preparation of teachers for pastoral work in schools and other institutions is, in general, too often neglected. Where they are posted, teacher/counsellors are not well paid, and have poor promotion prospects. Where they exist, pastoral teams in schools receive little or no guidance in dealing with HIV/AIDS and related traumas. Badly-affected schools and other learning institutions may prefer to rely on the services of nongovernment (NGO) agencies and their trained staff where they are available.

What about male teachers who continue to abuse students or harass female colleagues?

Are they willing to turn and fight the disease? Why is it assumed that the complex nature of adolescent sexuality is correctly understood and reflected in lifeskills materials; that the classroom is an effective space for grappling with rape, assault and the often non-negotiable sexual relationships between young men and women? Why is it assumed that teachers – who already struggle to deliver the core curriculum under the most difficult circumstances – can take on yet another set of responsibilities? Why is it assumed that education sector teacher development and support programmes can turn on a tap and train thousands or hundreds of thousands of teachers in the intricacies of AIDS-related behaviours?

Teachers need to see themselves as both part of the problem, and part of the solution. They try to leave it to others to do everything but all teachers must feel part of this. Some teachers say it is an education problem. If a child is dying, it is a parent problem, or it is a health problem. It is not their problem. But it is the teachers' problem as well. Primary School Teacher

Many assumptions about the capacity of educators to deliver lifeskills to young people are erroneous and misleading. They need to be reviewed and adjusted, and lifeskills work assessed and realigned with a more realistic interpretation of teachers as guardians, and young people and children of all ages, in and out of school, as clients. Much more needs to be known about adolescent sexuality, rape, incest and same-sex sex; about child abuse and what children at primary school need to know; about the needs of young people out of school; and about teachers' capacity. It must be possible to identify teachers who are trusted by children, and are therefore appropriate candidates for upgraded counselling and guidance training. Leverage points – among school heads and in teachers' associations, embedded in teaching service regulations and codes of conduct, in education legislation, in preservice and inservice training pro-

grammes – need to be identified which can be used to change the way teachers serve the needs of children and young people, and provide appropriate counselling and care. It may be that direct interventions – control of STDs among older pupils and students for example – and student peer health education teams with para-professional training, can make a greater impact, given the managerial and structural challenges to the teaching service. (See Uganda (2003), *Communication Strategy*.)

Perhaps the most successful aspect of the [South African] National AIDS Programme has been to improve the quality of STD care and increase the public's access to that care. In fact, it appears to have been a classic example of "getting the small things right", argues Helen Schneider: Ensuring good STD care is simpler than organising peer education or doing outreach with marginalised groupings, and points to the kinds of prevention tasks that are within the capacity of the system to implement...If simple tasks are successfully managed, they will contribute to building an environment which will make more challenging interventions through government possible at a later stage. (Marais, To the Edge, 2000).

Educators affected by HIV: Schools report a drop in morale and performance – of both staff and students – among those who are infected or affected by AIDS. With prevalence rates among the general adult population in the region reportedly ranging between approximately 5% and 40% families in both urban and rural areas have been touched by the pandemic, and have lost, or are caring for, family members. For learning institutions this means that

- Teachers are attending more and more funerals, and in some places Friday is a day lost to teaching:
- School heads report teacher trauma – when they are infected, or when they are affected:

- Teachers who are ill are increasingly absent from class, for short or long spells, and as it is often difficult to find relief cover for them teachers who are not ill are having to cover for those who are:
- Teachers are reported in many places to be taking care of orphans in their own homes, and distributing money to needy relatives:
- Teachers who are ill and require treatment are transferring into main centres where there is medical care, so that schools in urban or peri-urban centres may have a higher proportion of chronically ill educators with consequences for school performance, housing stock, and general morale;
- Rural districts report shortages in specialist teaching areas (science and maths) which had previously been localised, and request contract teachers.

What is more difficult to measure is the influence such factors have on quality of education. What are the identifiable consequences for the classroom and learners, for the school, for home and community?

Management of the education service: Although the education service – teachers, officials and other professionals – constitutes the largest, most ubiquitous, and expensively trained cadre of workers in any east and southern African country, although the pandemic is at least 20 years into its cycle, and although prevalence rates among teachers are rising in some areas (reducing in others, after a time), management has yet to identify comprehensively the challenge to its employees. The private sector in countries like South Africa and Uganda, where businesses will fail or thrive according to their HIV/AIDS staff policies, is generally ahead of the public service in considering possible consequences of the pandemic. Account needs to be taken of a complex set of staffing issues:

- *Managing the service:* reviewing current policy, legislation, regulations, proce-

dures and codes which regulate the management and work of the education service, to determine the rights and responsibilities of the service, and of individual educators; systematically examining issues relating to human resource management, performance management, morale, legal rights and responsibilities, retirement benefits and pension costs and succession planning raised by HIV/AIDS; planning for managing HIV/AIDS in the education service at national, regional, district or institutional level; establishing workplace policies at headquarters, regional and district offices, and in all learning institutions; the role of teachers associations in securing the education service.

- *Establishing disciplinary procedures:* reviewing or establishing codes of conduct; reviewing and amending grievance procedures; handling cases of harassment or abuse in learning institutions through legal rather than administrative procedures.
- *Planning for cost-efficiency:* creating HIV/AIDS-related leave policies and entitlements for HIV positive educators; monitoring sick leave and providing for appropriate cover; developing policies and procedures related to termination of employment or boarding for reasons of ill-health.
- *Sustaining education provision and reducing attrition:* identifying educators at high risk, or service regulations or practices which expose educators to greater risk (single teachers, posting away from spouses); developing practice for dealing with HIV-positive employees; monitoring HIV/AIDS impact on educators in conjunction with government planning and manpower units; providing HIV/AIDS prevention training, counselling and care for affected and infected educators; monitoring changing skills requirements and shortages.

- *Improving educators' skills:* providing systematic preservice and inservice preparation for educators coping with HIV and AIDS in the system, and for teachers mandated to teach lifeskills through the curriculum.

Teacher misconduct: The South African Medical Research Council reported late in 2000 that one half of all schoolgirls had been forced to have sex against their will – one third of them by teachers. ‘We were shocked by the finding that teachers are the major perpetrators of child rape, but no one experienced in education seems to be surprised.’ The Minister of Education reported subsequently to parliament that there were perhaps 6-8 cases involving sexual abuse pending with the South African Council for Educators (SACE), and that in most cases the accused were still in the classroom. (Coombe, 2000a).

Sexual harassment of girls by teachers and other educators is pervasive in learning institutions. Students report love relationships with teachers, and pregnancies result. Other girls submit to teacher harassment because of fear of discrimination, punishment or failure. Some want the money or other gains (private tuition or leaked examination papers) that might ensue from such a relationship. Hostels are particularly unsafe places for children – both boys and girls – as they are reported to be places where teachers can prey at will on the young.

Communities may condone or overlook forced sex, at least so long as it does not extend beyond certain legally defined limits (Kelly, 2000b). Is there a rigorous determination among authorities to deal out discipline where there is misconduct? Many cases are not reported; those that come to the attention of authorities are handled administratively or customarily, by negotiation with parents or elders, rather than through the courts. Lack of parent-power and a failure of will on the part of school management encourage male teachers to flaunt rules of professional conduct: pay for ‘damages’ and

ask for a transfer. Laws relating to defilement or statutory rape, or regulations stipulating acceptable levels of professional behaviour are rarely brought into effect in such cases.

The culture of sexual violence, gender inequality, and male prerogative ultimately culminate in a climate of fear. Even in learning institutions, on the sports ground, in hostels, or walking to and from school, girl children and young women are not free of fear.

The principal needs of all educators

We would not even know where to point a gun to kill AIDS – if we had a gun. Principal Education Officer

Teachers, with medical professionals and social workers, are generally assumed to be the first line of the region's attack on AIDS. *They are not well prepared for this task – which itself has not been clearly defined.*

Teachers need *information* so they can help learners adequately. They need to know how to care for learners who are infected and affected by HIV/AIDS, to help them and others stay healthy and happy, to protect their rights, and to make them feel secure and safe. Teachers need to know how to take universal precautions at school, and elements of basic safety in the presence of HIV on the sports field and in the playground, especially where body fluids are concerned (blood, sputum, saliva etc). Teachers need to be able to give children information about how to give basic care to those who are sick, and the precautions that should be taken in doing so: what is dangerous and what is not.

Teachers need to have *referral procedures* in place for informing appropriate authorities in the social services (government and community workers) about families hit by illness or hardship, whatever its cause. Teachers – and those who work with them – need to be able to create a caring, safe and

secure environment, free from unnecessary fear and stigma, in all institutions of learning. What does it take in terms of knowledge, skills training, and regulation to do that?

For this to happen, teachers *need professional and systematic support*. They need materials – guidelines and manuals – which provide them with appropriate levels of knowledge. They need teaching and learning materials. They need better orientation on HIV-related matters so that they can help children at various stages of personal development – at primary, secondary and post-secondary levels. They need guidance from informed education officers and inspectors, along with continuing strong support from NGOs, CBOs, school peer groups, volunteers, parents, and other social sector workers.

All educators – school heads, officials, teachers and hostel managers – *need to have clear guidelines* on condom availability, distribution and use. How they are applied may vary from locality to locality, and there may be ways in which the community can help to take a decision on application of policy in schools and hostels.

Educators *need to define their relationship with social and health workers*. On one hand, without strong education support services, they are inclined to seek help from social sector partners. On the other hand, families may resist – through pride or fear – the idea that children for whom they are responsible require special care. Families may not want their problems to be noticed. Singling out one child or a family of children may 'dent family pride' in communities where everyone knows everyone else's business.

Teachers must report and refer children in difficulty, or they will be lost. Yes, families may be insulted; yes, it may make extra work for the teachers – but that's life! There must

be a caring environment for all children in school. Primary School Teacher

Teachers feel more could be done by social workers to help schools support children, and are critical of the time it takes for social workers to respond to school reports on children in difficulty, the lack of adequate support for teachers by social workers, and the absence of a clear relationship between educators, social workers, and health staff.

All educators *need to know their conditions of service reflect AIDS concerns*, that their employer has established workplace policy, guidelines, and administrative procedures with regard to learners and educators infected and affected by AIDS.

It is reported that many of those worst hit by HIV/AIDS in the sector are in the 'industrial classes'. It is posited that this is perhaps because of traditional behaviours and cultural beliefs ('taking care' of an older brother's wife during his absence, for example). While officials and teachers can be posted anywhere, industrial scale workers are usually local people, are often poorly educated and undernourished, hold to strong traditional values, and have no access to drugs. They are as a result at substantial risk.

ANTICIPATED CONSEQUENCES OF HIV/AIDS FOR EDUCATION

Assessments of the impact of HIV/AIDS on education have been completed, are underway, or are being planned in a number of east and southern African countries including Botswana, Kenya, Lesotho, Mozambique, Namibia, Rwanda, South Africa, Swaziland and Zimbabwe. They indicate that while governments have been concentrating on delivering lifeskills and sexuality education to children in school

- National HIV prevalence rates are still unacceptably high and still rising among young people in many areas;
- Teaching services are being infiltrated by the disease;

- Educators, especially those under 40 years of age, are being struck down;
- Universities and colleges are feeling the loss of students, as well as academic and administrative staff.

No significant analysis has yet been done on how education's core professional support institutions – the preservice teacher training colleges and inservice structures composed of inspectors, supervisors, primary education advisors and the like – are likely to be affected by AIDS, but infection rates among senior personnel are likely to be as high as among teachers.

Just as important as the impact assessment data coming from such impact assessments are the informed observations coming from educators in the region, based on observations of children in classrooms, students in colleges and universities, and families. They show that while the hard statistics, the numbers, are certainly useful, people's local experience of AIDS must also inform strategic responses to the pandemic. Local professionals talk about the physical and psychosocial traumas of HIV and AIDS that threaten communities, families and classrooms. Senior education officers report that although there used to be enough local science and maths teachers, foreign contract teachers now need to be hired to fill gaps (Botswana). School heads report that children arrive for class in trauma: perhaps because they have been abused, or they are caring for younger siblings in a parent-less home, or they have recently lost a parent or friend (South Africa). There is no one at school to help them: teachers, heads and even guidance and counselling staff are rarely if ever prepared to cope with the child's profound need for safety and comfort (Malawi). Incest, child abuse and same-sex sex may be on the rise, and yet there is little comprehension of how children, young men and women, are coping (Zambia and South Africa).

It is essential that available data, however meagre and sometimes inaccurate or mis-

leading, be combined with the richly intuitive information coming from local educators, parents and communities, to mould strategies for protecting education quality.

*Projections...are not predictions. They should not be regarded as Nostradamus-like efforts to foresee the unforeseeable. Rather, projections reflect the ways in which historical patterns and trends will work out, given the data available at the time the projections are made. When the real experience begins to depart significantly from projected values, a projection makes it easier to identify reasons and to modify views about system dynamics (Simkins, *The Jagged Tear*, 2002).*

In very general terms, how is HIV/AIDS likely to affect education?

- Fewer children are expected to enrol in school because HIV-positive mothers die young, with fewer progeny; infected children die of HIV/AIDS complications; and children who are affected by HIV/AIDS – those who are ill, impoverished, orphaned, or carers for younger children, or those who are earners or producers – do not go to school or college. For the same reasons, affected learners drop out, and retention, transition and completion rates fall.
- Qualified teachers and officials are being lost to education. Educators are thought to be particularly vulnerable to infection because of their comparatively high incomes, sometimes remote postings, and their geographic and social mobility. Other educators leave the service for better jobs in the private sector which is also losing qualified staff through HIV/AIDS. The capacity of teachers' colleges to keep up with educator attrition is likely to be undermined by their own staff losses. (There are likely anyway to be fewer tertiary students as secondary school output and quality goes down, and as higher education itself declines due to staff attrition.)

- Financial constraints are likely to make it more difficult for education ministries to provide formal education of adequate scope and quality. Sick and death benefit costs are already rising, along with additional costs for teacher training. Governments will come under increasing pressure to switch resources away from education to other social sectors like health and welfare. Contributions from parents and communities to education can be expected to decline, and HIV-affected households may no longer be willing or able to keep children in education, shifting more of the cost back to government.
- What is ultimately incalculable is the trauma that is starting to overwhelm individuals and communities. At the very least, in pragmatic rather than humanitarian terms, school performance will inevitably decline where 20-30% of all teachers, officials and learners are ill, and others lack morale and are unable to concentrate on learning and professional matters because their lives too are touched by HIV and AIDS.

RESPONDING TO THE PANDEMIC

African countries are in the stage now of learning how to respond to the challenges that HIV/AIDS presents to the education sector. Why has it taken such an apparently long time to develop appropriate strategies?

It has taken a long time to understand. It is difficult to see the devastating effects of HIV/AIDS on teachers, children and young people as, in aggregate and spread over an entire education and training system, the scourge of the disease may not be noticeable for some years. But in communities, homes, schools and other learning institutions, the consequences of HIV and AIDS are manifest daily.

Creating policy and plans is slow. HIV/AIDS was identified in the region about 20 years ago, but until recently, only

six countries in the SADC region provide lifeskills teaching through the curriculum at secondary level, and only two at primary level. Policy formulation – and elaboration of plans, regulations and guidelines to assist implementation – has been slow for a number of reasons: this is a new problem on top of many existing ones all clamouring for attention; no one has been accountable for developing policy and strategic plans; there is still an ethos of silence around HIV issues; and perhaps, most of all, the problem just seems too big.

There is a gap between policy and planning on one hand, and effective implementation on the other. It has been difficult to master the technical, social and ethical details of the struggle against AIDS. Governments – especially at local and national level – have not always been able to spend their official or agency-sourced HIV/AIDS allocations. It has been difficult too for governments at various levels to find ways of working effectively with and through NGOs at community level. It has taken some time to appoint officials at senior levels to take action on HIV/AIDS. Several countries in the region are still without an HIV/AIDS unit for education. Even where such staff have been appointed, ministries have had difficulty defining and assigning sufficient responsibility and authority to coordinate the HIV/AIDS response at various levels.

Finally, international development agency procedures have not always been sympathetic to newly-defined and very complex resource requirements – for both financial and technical support to HIV/AIDS programmes. Agency staff are increasingly aware that the systems and procedures within which they work are not conducive to flexible and creative response to this crisis.

Community-level responses are often effective on a small scale, but generally ad hoc and underfunded. Governments have been, in theory, committed to cooperation with NGOs. In practice, it is not clear how partners at national and local levels can be

strengthened, resourced and sustained so that they can support governments' strategies. At local level, nongovernment organisations, community-based organisations (CBOs), and faith-based organisations (FBOs) are making a difference in the lives of women and children. They provide support to teachers and heads as counsellors. They train children and teachers in peer counselling. They teach lessons of safe sex, work in communities to defuse violence, and care for the abused and violated. They are at the coalface. Their contribution is not just considerable, it is fundamental – however fragmented it may be. Strengthening education's response now depends on how the work of nongovernment partners is integrated in the sector's strategic planning and resource allocations.

The national HIV and education management framework is only now being realised. What lessons have the past twenty years taught about managing the response to HIV/AIDS in education? It is clear that government's national delivery systems must be complemented by 'around the corner and down the street' local decision-making about coping with AIDS. Why is this? Because HIV/AIDS is so deeply embedded in the customs and beliefs of each locality. Because, on a day-to-day basis, NGOs, CBOs, homebased care programmes, volunteer and faith-based support schemes, and individuals in the community, are already making a difference in alleviating distress.

Governments certainly have a role to play in coordinating and strengthening local responses, creating policy and establishing a regulatory framework, delivering health and social welfare services appropriate to community requirements, as well as improving school and clinic programmes to cope with changing demands, and ensuring that sufficient funds are mobilised and channelled to those who can make best use of them. Ultimately however, governments must work *in support* of communities, and national management strategies, especially in the social sectors, must reflect this balance.

No one underestimates the difficulties of creating mechanisms, structures and processes which can achieve this. There are few models from which to learn. Ministries of education are struggling to decentralise decision-making and executive responsibility. Now that lives depend on decentralising responsibilities to communities and schools, perhaps they will make faster headway in this regard.

What mechanisms are required, at national and local levels, for driving education's (potentially decentralised) response to AIDS? Many ministries in the region have tried to assign national responsibility to one or more senior officers (usually curriculum specialists) on a part-time basis (Zambia and Namibia). Some have established a coordinating committee with representatives from ministry departments (Botswana and South Africa). Full-time AIDS and education officers have been or are being appointed in several ministries (including Botswana, Malawi and South Africa), but their mandates, executive authority and accountability, and the structures and procedures through which they work, remain to be clarified in practice.

There is as yet no clear perception that the potential of HIV and AIDS to create havoc for education requires that senior, full-time and experienced executives be appointed. The challenge of five million AIDS orphans in the SADC region by 2010 is not a part-time responsibility for curriculum specialists. This is a crisis that deserves crisis management.

What principles and assumptions are emerging that would guide strategic response to the pandemic in the education sector?

- The time to counter-attack HIV is now.
- This is an emergency, and requires crisis management. Otherwise regional development gains will be swept away.
- HIV is a *virus* which infects people, and which spreads within a social context. The HIV/AIDS pandemic is a complex set of social, economic and behavioural factors. It constitutes a development problem, and requires a different set of responses.
- HIV cuts across the whole education sector and affects all learners and all educators.
- Not all learners and educators are at equal risk: vulnerability and susceptibility are not evenly spread.
- It is important to be positive about HIV: the greatest proportion of educators and learners are still healthy.
- Ministries of education are not fighting AIDS alone. They are working within an education sector comprising many partners willing to work with government in order to mount a holistic and integrated counter-attack on AIDS. There are partners too in other sectors, especially health and social services, as well as in the international development community.
- Ministries of education are responsible to ensure that resources for the sector are mobilised and coordinated in order to ensure that (1) the sector plays an effective role in helping the nation to fight the pandemic, (2) the quality of education and access to learning are protected, and (3) training is provided to overcome labour and skills shortages in the public and private sectors.
- Teachers have a complex role to play: in the classroom, in the education community, in the local community – as guides and guards, mentors and educators, role models and community resource people.
- The voices of teachers and headteachers, inspectors and education officers must be heard in developing HIV and education policy, setting targets, creating strategic plans, developing curriculum and materials, and monitoring performance. Likewise, the voice of children and young people need to be heard: they are roleplayers, not just beneficiaries.
- While teachers and schools are the focal point of education's response, they should not be overloaded. Their responsibilities in fighting the pandemic need

to be clearly defined as part of the community's response.

MOVING FORWARD

HIV/AIDS is compelling educators to adjust the long-standing perception on the part of government that the ministry of education *is* the education sector, or that 'education' is more or less the work only of the ministry of education. HIV/AIDS is assaulting both public and private sectors, and all education sub-sectors are vulnerable, from early childhood development to colleges and universities. In other words:

- Ministries of education alone cannot sustain education quality in the face of the AIDS assault: they will be held accountable for ensuring the quality and extent of education provision, but must work in partnership with other authorities in and out of government if they are to succeed.
- HIV and AIDS is not just a schools issue: the pandemics must be tackled at all levels of the education sector from early childhood development through to university; any strategic response must also include the concerns of out-of-school youth, and the creation of adult basic education, nonformal and distance education opportunities for children and young people disadvantaged by AIDS.

It is probable, after two decades of research, investigation, observation and discussion, that *what* needs to be done to make school-based prevention programmes work is known. There is general consensus about curriculum issues, about the profile of HIV-competent educators, about their role in creating a safe learning environment for children at risk, and assisting orphans, and sustaining the quality of education.

It is clear however, that insufficient capacity has been dedicated to the complex managerial, structural and procedural problems which inhibit and constrain *how* HIV/AIDS

programmes are delivered to millions of educators and learners.

Every education sector must ensure that it has the capacity to make its plans happen, that it can mount prevention programmes, institute a culture of care in all institutions, and stabilise the quality of the education service. The end result must be that

- The education system continues to be strong enough to provide education of appropriate quality for all.
- Teachers, managers and other educators play an active role in helping to contain the spread of HIV/AIDS.
- Teachers, managers and other educators play an active role in caring and supporting learners who are infected and affected by the disease.
- Schools and other learning institutions are part of the community response to the HIV/AIDS pandemic.

There are plenty of ideas about *what* must be done. What is much less clear is *how* priorities can be achieved, *how* leverage points which make a difference can be identified, and *how* education sector goals can be achieved.

It is essential now to understand *how* educators working together within the education sector and with other social sectors can create a managerial environment which ensures systematic, regular, intensive *and* extensive programmes for controlling HIV/AIDS in future, and assist in the socialization and care of millions of young learners already suffering from its effects. It is time for policies to be put into practice particularly with regard to teacher, headteacher, and teacher education training.

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