A HUMANITARIAN RESPONSE TO HIV AND AIDS IN EDUCATION? SHORT-TERM INTERVENTIONS TO SAVE LIVES AND SUSTAIN QUALITY

The Inter-Agency Working Group has proposed long-term strategies for improving child well-being and changing behaviours. Taking this development route will require many years before observable differences in behaviour appear. In the interim there are things that can be done by agencies and countries working together with will, competence, and commitment.

LIMITING SPREAD BY DECREASING RISK

(a) **STDs**: Offer to make it possible for every post-secondary institution, secondary school, upper primary school and school hostel to be visited by a health worker twice each month, to identify and treat young people with STDs, providing the correct medication and assisting with medical advice according to established protocol. Appropriate drugs will be available for distribution to those with STDs through the international community and whatever procedures it takes.

(b) **Condoms**: Offer to provide every post-secondary institution, secondary school and school hostel condoms for learners and educators. They will be provided in sufficient numbers to meet demand, they will be available in places which are easily accessed by students and educators, and information will be available on their use from the health worker who visits the school and from student and staff health volunteers.

(c) **Student health volunteers**: Offer to provide training – or to see that someone does it – for every post-secondary institution, secondary school and school hostel for a voluntary student health team, with support from local health and social workers, along the lines of well-established models from Zambia and Botswana, in the aetiology of HIV, safer sex practices, STD symptoms and treatment, physical care for those who are sick, counselling for those affected, and the use of condoms.

SUPPORTING VULNERABLE LEARNERS

(a) **School feeding scheme**: Offer to provide every secondary and primary school which is vulnerable or at high risk with a feeding scheme for all learners, irrespective of their individual socio-economic condition. In some cases a feeding scheme which covers all schools can be justified. Special provision must be made in school hostels to upgrade nutritional levels. School feeding schemes will be linked to **homebased care**, and **orphan supplementation schemes** as much as possible.

(b) **Potable water**: Offer to ensure that every school has a supply of potable water: a borehole, well or piped water.

(c) **Latrines**: Offer to ensure that every school has sufficient and well-maintained latrines, separate for boys and girls.

Water and latrines are basics, and should have been guaranteed by governments years ago. They have not. Their presence will create an orderly and hygienic environment in which nutrition is guaranteed, and health messages can prevail. School becomes a normal place for children who would otherwise drop out of school.

MANAGING THE IMPACT OF HIV ON THE SECTOR

(a) **Executive management team**: Offer to provide high profile, full-time, senior executives to support the ministry of education, to drive the education sector's HIV campaign.

(b) **Volunteers and technical assistance**: Offer to provide contract and volunteer staff (national or international) as required. Technical assistance will be required from both the global and national pools of expertise.

(c) **Impact assessment**: Offer to get the impact assessment underway, and to provide staff to set up TORs, supervise it, analyse it, and see that it is factored into planning and action.

We must be thinking of hiring on managers from the private sector, from the military, from international bodies, and from other countries. There are not enough people with the right skills in government, and they have to be commandeered from wherever, on contract. It is time to offer to do this as a matter of urgency.

NOTES:

Management issues lie at the heart of whether we can make a difference or not to limit the progress of this pandemic, and stabilise our already derelict education systems. We have some idea of what needs to be done over the long term, BUT how will long-term development-oriented behaviour change be made to happen? If little of real merit has not happened yet, there are perhaps reasons for this – that is, a lack of capacity to make things happen.

It will take at least 30-50 years to get the ideal framework (like that proposed by the Inter-Agency Working Group on AIDS) into place so that lives can be saved. Development plans aimed at behaviour change are good in theory and concept, but cannot, for many reasons which can be elaborated, work in order to meet the immediate crisis.

So what will work?

Education System Resources: First of all, what educational resources do we have? I think that the only resource many *schools* can offer at the moment is that they host large numbers of children and young people in various places for several hours every day. This means that messages and help can reach them there. I don't think that schools can offer much more - if we are brutally frank.

I think that there are some wonderful *teachers* and principals around, but there are not enough of them, and those there are cannot be relied on systematically because they are either redeployed or overloaded. Teachers are not going to make good *mediators* in part because, like parents and other adults, they are culture-bound not to talk about death or sex with children. They don't talk to children about these matters; children don't talk to them. So will they really carry the message of safe sex and behaviour change to children in their charge?

We don't have *books and teaching materials* distributed to schools. NGOs and FBOs have developed materials but they are used locally rather than nationally.

Our *universities and colleges* are not even starting to think about training teachers of the kind we need, or in the numbers we will require. They are not working on curriculum for sexuality education or HIV planning; they are not setting a research agenda on HIV; and they are not doing

research in support of government or even their own institutions. Turning these institutions around is going to take decades unless there is a miracle: I know because I am trying to get one to turn.

These are the facts, and they will not be changed because we wish they would, much as we might wish things to be otherwise.

Other Resources: What we do have is (1) governments getting more worried because they are starting to think they should do something; (2) international agencies hoping that something will happen, and starting - not fast - to find ways to make funds flow; (3) communities of mothers, social workers, officials, and teachers, homebased care volunteers, ordinary people who are seeing people dying, who are losing people in their own families, and who are caring for orphans, and (4) NGOs, CBOs, and FBOs, mothers and young people's groups developing (often ad hoc and underfunded) programmes of merit.

So I thought about Helen Schneider's principle of simplicity and viability (from Marais: *To the Edge*, University of Pretoria, 2000).

> *'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". 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.'*

Principle 1: To me this means keep it simple, stick to things that we know can work. STD prevention is demonstrated to cut incidence of HIV infection drastically (Brundtland Commission report, forthcoming, December 2001).

Principle 2: We must look to cooperative community processes that harness the compassion of a lot of people, including young people, PLWAs, churches, NGOs and development agencies and ensure that they participate in one way or another without big administrative hassles and new mechanisms. I have seen this at work, and I know it is possible.

Principle 3: These proposals must be applied universally, in every school, and they must be mandatory. It will be up to parents, teachers, elders or other adults to make final decisions about condoms, for example – and they will be accountable for the outcome.

Principle 4: They will be applied collaboratively, with cooperation from MOH, NGOs, FBOs and agencies, etc, because that is the only way they can work in practice.

Principle 5: There can be no application of the affordability and sustainability criteria for development agency assistance in these areas, because they have no place in these circumstances of life and death.

Principle 6: We must be thinking of hiring on managers from the private sector, from the military, from international bodies, and from other countries. Affected governments can no longer excuse themselves by saying they do not have established public service posts for HIV staff. TAs,

volunteers etc, have to be assigned to contract posts. Many African governments don't have, will not have, or have already lost, enough people with the right skills to make things happen.

Principle 7: Many education management systems are in such difficulty that there is no way they can sustain an HIV programme on top of the responsibilities with which they are already struggling. I am talking black and white here - no more pretending. *Plagues and Peoples* (McNeil, 1979) demonstrates that where plagues have struck in the past, it was often strong (sometimes military) administration which tackled a disease among soldiers and civilian populations. We don't require military administration, but it does say to me that we need absolutely rigorous management appropriate to the level of infection. The historical messages are clear: this is not the first time that humankind has been hit by a plague. (See also Barbara Tuchman *A Distant Mirror*, on the 14th century plagues.)

Principle 8: I keep thinking that South Africa's apartheid regime was overthrown by a coalition of people and the international community. And I wonder if, where governments are unable, unwilling or too corrupt to act swiftly to save lives (passive genocide?), this 'parallel government' model for action cannot be mobilised once again to overthrow the evil that is HIV and AIDS?

Carol Coombe
Research Associate: HIV and Education
Research Programme Leader
University of Pretoria Faculty of Education
184 Lisdogan Avenue
Pretoria 0083
South Africa
Phone (27) (12) 342 2857
Fax (27) (12) 342 6320
Email coombe@mweb.co.za
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