LIMITED CIRCULATION ONLY

CONSULTATION ON HIV/ AIDS AND TEACHER EDUCATION IN EAST AND SOUTHERN AFRICA

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HIV/AIDS AND TEACHER EDUCATION: SYNOPSIS OF OBSERVATIONS AND PRINCIPAL CONCLUSIONS

InWEnt – Capacity Building International
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InWEnt (Capacity Building International), Germany convened a regional meeting of 60 senior officials and representatives of governments, universities and other tertiary institutions, nongovernment organisations, and unions. Professionals from Kenya, Malawi, Mozambique, Rwanda, Tanzania, South Africa and Uganda met to determine what support teachers and teacher educators require to respond to the complex needs of learners *and* educators affected by HIV/AIDS.

The consultation focused initially on teacher education (PRESET and INSET) and how best to upgrade the capacities not only of school teachers, but of teacher educators in colleges and universities, to deliver lifeskills curriculum. In general, lifeskills education for educator and learner populations has been inadequate, many educators have been reluctant to teach sexuality curriculum, and there are too few teaching and learning materials *in the system*. INSET programmes are rarely comprehensive or systematic enough to deliver adequate skills and materials to serving teachers. Not all teacher trainees are getting HIV-awareness training in PRESET programmes. Finally, little or no provision has been made by education systems to address the condition of orphans, care and counselling for affected learners and educators, or for the protection of children at risk especially in deep rural, impoverished urban, or war-torn areas of Africa.

There are complementary alternatives to the conventional – and thus far unworkable – lifeskills/ sexuality curriculum that may have potential to achieve quicker success in containing the spread of HIV, providing a modicum of comfort and stability to those infected and affected by the pandemic, and sustaining the quality of the education service: provision of condoms in adequate numbers, treatment of sexually transmitted infections (STIs) among students, peer health educator teams, school feeding, improved school management and planning, improved safety and hygiene in the learning environment and a greater focus on discipline and ethical conduct.

Ultimately two routes were identified for further strategic planning:

1. a slower, long-term *development approach* to prevention, care and counselling in which the aim is to change the behaviour of learners – as well as educators, parents, elders and others – so as to save lives and mitigate the consequences of HIV and AIDS; and
2. a quicker, short-term direct intervention *humanitarian approach* to prevention, care and counselling in which the aim is to save lives now, keep learners safe and in school, and at the same time support the build-up of capacity to deliver on behaviour change.

Capable Professional Educators

There are three primary tasks for educators:

- **Prevention**: helping prevent the spread of AIDS among learners and educators;
- **Social Support**: working with others to provide basic care and support for learners and educators affected by HIV/AIDS, including orphans; and
- **Protection**: protecting the education sector's capacity to provide adequate levels of quality education, principally by stabilising the quality of education provision

What kind of educators can save lives?

Multiskilled: Very generally all educators need to be HIV-aware, HIV-competent, HIV-safe. That means being multiskilled and capable of multitasking to respond to increasingly complex needs of the community. Not all teachers are able to do the specialist tasks of care and counselling for

learners and for colleagues: some teachers will **teach** and counsel; others will **counsel** and teach. For some teachers this will require a lower teaching load.

Realistic curriculum: AIDS-competent teachers need to work with a curriculum that reflects the new vision of what education is in the day of AIDS. A greater degree of realism must influence curriculum selection, curriculum delivery, and teacher education.

If teachers are unable or unwilling to take on this additional HIV-related burden give their current professional and personal circumstances:

- Then make informed choices now about what should and should not be in an already over-loaded curriculum, aimed at community as well as learner needs.
- Make arrangements now to appoint trained counsellors in senior learning institutions to take some load off teachers and teacher educators, so as to avoid having to train so many teachers.
- Make HIV-related subjects a stand-alone (examinable) subject: then all learners get all the information they require.

This is the minimum. BUT is the school curriculum the best tool for responding to HIV *as an emergency*? Can educators do what needs to be done? If it is not possible to create the 'new teacher' with a realistically adjusted curriculum, then what are the alternatives for saving lives?

Effective INSET and PRESET HIV-Competence Programmes

Teacher education is not keeping up with teacher needs. INSET and PRESET programmes must be able to train and support educators in their broader capacities as agents of behaviour change and front-line carers. Teachers in training, and teacher educators, also need help in internalising and changing their own behaviour vis a vis both AIDS and the way they teach lifeskills.

There have been no known evaluations of content, implementation and outcomes of HIV INSET programmes in any participating country. For the most part INSET provision from the centre has been superficial, ad hoc, unsystematic, and poorly funded and managed.

It would help to have a standard HIV emergency INSET curriculum capable of reaching hundreds of thousands of serving teachers. Even then, regular and systematic upgrading of teachers will require upgrading the HIV-competence of INSET tutors, serving heads, deputy heads, and senior teachers, and teachers who have been out of work for some years, but are coming back into the system. Appropriate sensitisation courses are also required for district education officers, district inspectors and finance administrators, with appropriate materials.

Such courses must be comprehensive and intensive, capable of reaching all educators regularly and systematically, and subject to regular evaluation. So far, the management foundation for undertaking such a huge task is not in place in education sectors in the region. The consultation did not comment on how systematic INSET could be implemented: this is a persistent problem throughout education sectors. Currently, it is not realistic to assume that HIV-competence upgrading can be piggy-backed on INSET provision that barely exists.

To deliver HIV-competence effectively to teacher educators and teachers in training, the whole institution must be HIV-competent, -aware, and -safe. The HIV ethos must pervade and permeate each institution. Lifeskills must be mainstreamed in teacher training institutions: preferably it should be offered as a mandatory core course, and be examinable.

HIV-competent Teacher Educators

Tertiary institutions must play a prominent role in maintaining education quality as it is attacked by HIV/AIDS, improving the content, implementation and evaluation of lifeskills programmes, and teaching sexuality in a sensitive and effective way. To do this, they need to broaden their responsibilities beyond simply preventing HIV infection among learners, to prevention, care and counselling for students *and* staff, researching and analysing HIV and education issues, and providing information and data to help in planning responses to the pandemic.

However, virtually all tertiary institutions, with their teacher inservice and preservice programmes, depend on external aid; recently the latter has focused almost exclusively on basic education. Inadequate attention has been paid to quality upgrading for senior teacher trainers, and resources have been scarce for upgrading secondary schools and teacher training institutions. Thus far it is not apparent that any higher education staff have been sensitised to HIV concerns, or that there are any HIV curriculum courses in faculties of education in the region, with the exception of two or three universities in South Africa.

All teacher training staff in colleges and universities must be HIV/AIDS-aware, HIV-competent, and HIV-safe. It is not clear who can do this training of teacher educators, although mobile teams of specialists, and the provision of virtual or hardcopy HIV and education libraries in each teacher training institution would be a good start. Existing teacher training institute curricula require review and adjustment so that HIV can be mainstreamed there as well as in schools. So far the cart has been before the horse: schools are required to do HIV tasks that teacher training colleges do not, and perhaps cannot, do.

Alternatives to Life Skills: Complementary Actions

Given the fragility of current inservice and preservice upgrading for teachers, teacher educators and other education personnel, it seems advisable to initiate complementary actions to save lives and keep learners and educators healthy and in school at least in the short-term, while longer-term behaviour change interventions take hold.

Creating an HIV-aware teaching service, with appropriate INSET structures, is a very long-term development process. Further, evidence worldwide indicates that lifeskills curriculum is a *necessary but not sufficient* response to the pandemic.

Therefore, we might assume that we cannot rely on curriculum alone to respond to the challenge of HIV/AIDS: we can complement the lifeskills curriculum with other methods, alternative interventions including zero budget or low budget options including:

Support and Development

- Make sure a policy framework is in place, and that ***monitored and costed plans of action*** are complete and ready for implementation – and implement if possible - for
  - creating partnerships for action among social sector ministries of education, among education ministries and (I)NGOs, CBOs and FBOs, and among schools, communities and district offices, and with clearly identified roles for partners.
  - strengthening INSET through self-study, peer-group study in school clusters, local peer support groups, peer counselling, using the services of local NGOs, FBOs and CBOs as well as volunteers – whatever works systematically, intensively and extensively.

  - making teacher educators HIV-competent through similar methods plus provision of (virtual) libraries and resource materials which are easily produced locally.
  - mainstreaming an HIV-awareness curriculum (core, mandatory, and examinable) in college and faculty of education programmes.
- Improve the *HIV-**management skills*** of heads, deputy heads, senior teachers, and other district officials for implementing school and community HIV programmes.
- Ensure educators are role models for learners, and that schools are safe places, by applying and adhering to a ***strict code of conduct*** for all learning institutions.
- Create an ***ethical and value-laden environment*** in learning institutions with regard to discipline, gender safety, non-toleration of violence, abuse, stigma or discrimination.
- Flood the sector with ***teaching and learning materials*** to ensure that communities, schools and colleges have access to basic knowledge about HIV and have the chance to become HIV-safe, HIV-aware, and HIV-competent, even when there is no one to teach them
- ***Be realistic*** about resource and capacity issues by designing interventions that take account of workloads at schools, the need to 'zero budget', the mental and social strains that HIV puts on individual educators and the school as a whole, and the value of peer education.

Health

- Establish anti-AIDS clubs or, preferably, para-professional youth peer health educator teams for awareness, prevention, care and support for pupils and students; establish similar peer counselling teams for educators.
- Reinstitute school health programmes, or start them where they have not existed before, and guarantee drugs and qualified personnel through the international community if necessary.
- Work with partners in health and social services to create a circle of care for those infected and affected by HIV/AIDS.
- Work to create safe and hygienic conditions in schools: provide potable water and latrines that are clean, gender-separate, and as safe for girls as for boys.
- Identify and guarantee treatment of sexually transmitted infections (STIs) and other HIV-related infections through health care programmes for learners: send a health worker to the school each term and guarantee drugs as required or refer to nearest clinic or hospital.

Condoms, provided in sufficient numbers, *do* make a substantial impact on levels of infection and should be distributed freely. School feeding programmes, especially in hot-spot areas, can keep disadvantaged and HIV-affected children in school.

At times, especially in a crisis, it is possible and perhaps advisable to move forward quickly without an articulated policy, but to wait for policy to evolve from experience on the ground. Nevertheless, an organised conceptual framework that sets out what needs to be done, and how it can be done, is essential in order to use available resources effectively.

Where there is a plan – whether by government or by government and partners within the sector – funding will almost certainly be found for it, from government's budget, from the SWAp budget, from international agency programmes, or through stand-alone negotiations on the basis of costed plans of action. Without costed plans for selected priorities – a package that includes improving INSET, training teacher educators, and treating STIs among students, for example - it is unlikely that urgently required action will find the resources needed to save lives, and keep children and young people alive and in school.

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