AFRICAN VOICES ON HIV/AIDS AND EDUCATION: AN ELECTRONIC FORUM FOR 2000

by John E.S. Lawrence
December 2000

I. Summary Overview

This report describes a four month experiment to bring information technology to bear on the problem of HIV/AIDS in southern Africa. The mechanism was a United Nations-sponsored INTERNET discussion LIST, designed to open up an interactive virtual dialogue among African voices, around major issues currently facing educational policymakers. The focus was on the impact of HIV/AIDS on African education systems. The LIST offered a virtual electronic space for African input into a panel on HIV/AIDS in the Dakar World Education Forum in April 2000.

Postings to the LIST were organized around fourteen issues. Six were posed by the moderators: resistance to acknowledgement of HIV/AIDS; assisting those living with HIV/AIDS; best practices; cultural beliefs; next steps for IT and educational policy; and the LIST future. Eight issues were proposed by participants: importance of local values/customs; testing; gender and HIV; private sector initiatives; human resources approaches; role of international agencies; and orphans. LIST discussions around 53 topical `threads', weekly summaries, and references to other information sources, websites and knowledge bases are archived, accessible and searchable on the World Wide Web.

By networking interested African individuals and institutions, and providing a moderated LIST as a neutral, user-friendly medium, this project generated wide regional participation. More than 600 subscribers were identified from 54 countries, almost half of which were from SubSaharan Africa. Yet only a small number (14%) actually engaged in active discussion, and a few members contributed a relatively high number of postings. Yet while the discussion represented a very thin slice of southern African experience, the diversity and breadth of the contributions were striking.

Several postings illustrated how institutions were coping with the intricate personal and organizational problems of those living with HIV/AIDS. Open acknowledgement of the epidemic is still in its early stages in most countries, seriously limiting effective public response. The real fear of ostracism and discrimination inhibits access to services for people living with HIV/AIDS (PLWHAs) and affects both teachers and students adversely. Nevertheless in some cases, institutions (urban, academic) have done extraordinary work over many years in coping with these problems. A real value-added of the LIST was the opportunity it provided for sharing of these kinds of experiences, such as formation of associations of PLWHAs, and collective action to affect public policy. Some vivid personal experiences were courageously shared. Major `missing' issues needing policy attention were addressed, such as high levels of HIV infection among the more educated (e.g. teachers), and gender differences in approaches to the epidemic.

LIST participants clearly recognized that solutions to these problems must be cross-sectoral, and that HIV/AIDS is much more than just a public health issue. In addition, since many children are out-of-school, exclusive focus on formal education as a preventive strategy is inherently limited. Specific cultural contexts also must be respected, and approaches must take in to consideration local values and customs. Peer education has proven helpful in some cases, as has local arts and theatre. Engagement of local leaders, and traditional medicine and healers must be encouraged at grass-roots levels if real and lasting behaviour change is to take place.

Testing is a controversial, and complicated issue, and the discussions deplored the sporadic location and poor quality of facilities, and underscored the need for extensive ancillary services. Finally, the population is growing of orphans, and young street children made vulnerable by HIV/AIDS, and without either educational or employment opportunities. They require immediate and extended social services, and LIST respondents offer examples of pilot efforts throughout the region.

In conclusion, participants were supportive of LIST objectives, and many favoured continuation of the LIST. As a result, resources were found to take LIST administration/moderation into a second phase.

Furthermore, scholarships were provided to two LIST representatives to present discussion summaries at the Dakar World Education Forum. The LIST thus had direct impact on the Forum itself, and on the ensuing Framework for Action. Despite some initial misgivings regarding the suitability of an INTERNET-based virtual information-exchange in the Sub-Saharan African region, administrators and policymakers were appreciative of the LIST's contributions not only to the Dakar dialog, but also to the Durban 2000 meeting later in the year. These kinds of virtual networks can offset some of the negative effects of the African diaspora by providing a way for skilled professionals living/working outside Africa to have a voice in debate around policy issues in their native country.

The LIST exceeded the expectations of its designers, and showed great promise for this kind of networking for the future. Since its cessation in June, postings have continued to come into the Moderators. Four recommendations are thus offered for future consideration in the context of the fast-emerging INTERNET expansion throughout southern Africa: LIST continuation, but with moderation/administration sited at an institution within the subregion; explicit involvement of senior education policymakers in all aspects of the LIST; realtime knowledge-bases and clearinghouse capacities; and incorporation of an electronic helpdesk function.

II. Background

It is now almost 20 years since the HIV virus was identified. As of December 2000, according to UNAIDS (the UN agency consortium formally addressing this problem) almost 60 million people have been infected with HIV, of whom nearly half are in SubSaharan Africa. More than 11 million Africans have already died from AIDS- related diseases. Termed a `wildfire' racing through the region[1] this epidemic poses an unprecedented threat to development at all levels, and in every sector.

Impact of HIV/AIDS on the Education Sector …..

Nowhere is the impact more critical than in the education sector, for two reasons. First, education is a main line of defense against HIV/AIDS. While different age groups have different information requirements concerning the epidemic, everyone, regardless of HIV status, can benefit from outreach, advocacy, and improved knowledge on the epidemic's etiology, course and treatment protocols. In a rapidly shifting informational environment, access to updated information is

essential to any coping strategy. Education, at its interactive best, can provide a flexible two-way information conduit between national ministries and communities where it is most needed. Teachers, ministry staff, and teacher training institutions are central to this information exchange and rapid response capability. Yet, second, education systems are themselves acutely vulnerable. Morbidity and mortality among personnel is a huge and growing problem. Thus ironically, the role of education in combatting HIV/AIDS is seriously compromised at its roots.

…..needing innovative approaches…

Both of these types of impacts have been recognized, to different degrees, throughout the subregion. But there has been little opportunity to look across national borders, to open up discussion and share experiences in ways that could assist educational planners. HIV/AIDS is a *different* type of disease, requiring different kinds of approaches especially to behaviour change. So, in March 2000, in advance of the World Education Forum in Dakar, and in face of overwhelming evidence that Africa was in grave danger of incapacitation by a disease which struck at the heart of its human resources development systems, UNDP and partners set up an electronic forum for urgent communication and information-sharing around this problem. The focus was on African education systems, how they were reacting to HIV/AIDS, and identification of coping strategies that appeared to be working.

…especially of relevance to policy makers

According to UNAIDS the situation in southern Africa was `catastrophic'[2]. Demographic and epidemiological studies documented the HIV/AIDS effects[3], and macro-economic analyses had begun to demonstrate broad impacts on productivity[4]. Yet, as it turned out, surprisingly little research or inquiry was being conducted into the extent of teachers affected, the impacts on Ministries of Education, and perhaps most importantly, on the developmental aspects of the lives of families, schoolchildren and young people whose early years were being dramatically transformed. Despite alarms being sounded by international agencies[5][6], and by countries themselves[7], ministries were in many cases hamstrung by serious difficulties in resourcing and implementing essential studies on which to base their policies.

III. The HIV/IMPACT LIST

UN sponsorship of an electronic virtual space….

A major obstacle seemed to be the unwillingness of many governments to face the problem openly, and reluctance even to discuss the epidemic. So, as one way of quickly sharing ideas, and of informing policy, an open e-forum LIST was proposed, and endorsed by a coalition of UN and partner agencies[8]. In the context of `breaking the silence' (the theme of the AIDS 2000 Conference in Durban) the LIST was intended to be inclusive of all major constituencies, but phased, highly focused, and confined as far as possible to the African voice. While other regions were not actively discouraged from bringing experience to bear on Africa's needs, emphasis was placed on opening up the discussion specifically within the subregion itself. It was this aspect of African-ness which was intended to

distinguish this effort from others which had been active for a while, but largely filled with northern dialogue. It was also hoped that this introduction of e-dialogue explicitly into the ongoing African experience, building on earlier efforts by UNAIDS and bilaterals, would help boost INTERNET backbones and connectivity in the subregion.

The welcoming statement, rationale, archives of the discussion, and summary report are available on the Web at:

http://www.undp.org/poverty/forums/hiv-impact.htm

A LIST targeted towards the Dakar Forum….

Named the HIV-IMPACT LIST, the forum was designed to `provide anonymity to those who wish to learn more through serious discussion, and a global stage to those who wish to share effective adaptive, coping experiences, from teachers, students, school administrators, researchers and policymakers'[9]. The purpose was to provide input from the subregion to the Dakar World Education Forum on the crucial issues surrounding HIV/AIDS and education. In addition, a limited number of scholarships were offered to assist particularly active and articulate LIST members to attend the Dakar Conference.

Messages were posted in English and French. Explicit outreach efforts were made to contact known organizations/individuals, and to encourage extension. Although messages came from all over Africa, Western and Southern African responses dominated. Subscribers came from a wide range of organizations/positions, including members of NGOs, student organizations, teachers organizations, healthcare professionals, school administrators, government officials, the media, and various multilateral organizations, as well as ordinary people whose families and friends are facing the challenge and personal tragedies of HIV/AIDS.

…with broad regional participation

One rewarding aspect of this participation was the demolition of what could be called the negative e-connectivity myth of Africa. Initial resistance from some quarters to the idea of a LIST rested on assurances that e-infrastructures in Africa were minimal, and too embryonic, expensive, fractionated or unreliable to sustain serious LIST discussion within the subregion. This was clearly not so, as detailed later in this report.

Rather, the Forum provided an extraordinary window on the the depth of expertise, experience and commitment (in some cases over more than a decade) existing within African countries. It was as though `soulmates' were suddenly a possibility in a previously barren wilderness devoid of previous e-communication. The serious dedication of Africans to self-generated solutions was also eye-opening to some northern participants. A correspondent from the US magazine `The Nation' expressed this as follows, in a message to the LIST:

…and extensive African experience and expertise..

`I have been reading your posts and am filled with awe at your expertise and depth of thinking on the subject of AIDS. Very rarely do people in the USA

get the impression from the media that African doctors, scientists, social workers and educators play an active role in fighting the disease and its effects. Mostly, the US hears about Africans only as victims of AIDS.'

…and documented outcomes.

It was because the LIST contains such a rich (and hitherto unique) array of experience, expertise, thoughts, opinions, personal testimony that DFID saw a valuable opportunity to `mine' these archives, and try to draw policy-relevant conclusions from their messages. This report therefore contains suggestions and recommendations from African professionals, people working and living in Africa, and those with a direct personal stake in a timely resolution of this crisis.

Helped by the EDC final project report to UNDP[10], this analysis goes into greater depth by searching for and reporting, in respondents' own terms, what seems to be of most direct and immediate policy relevance for education sectors facing the HIV/AIDS crisis..

Findings are organized according to the broad chronological flow of major issues in the discussion. These are clustered where possible, to facilitate breadth of coverage without unduly lengthening the report.

Implications of two kinds are offered:

i) conclusions/suggestions and recommendations around the substance of the discussion, namely the ways that education systems are trying to respond more effectively to the various impacts of the pandemic on system functioning at all levels; and

ii) what has been learned about the relevance of IT to helping countries in Africa overcome this crisis, and specifically, the implications for policymakers of this kind of e-networking around issues such as HIV/AIDS.

IV. Method and process of this review of postings.

Web address for searchable archives.

All of the posted messages are contained in a keyword-searchable database at:

http://www.edc.org/GLG/hiv-impact/hypermail/

In addition, the database can be ordinally displayed by author, date, thread or subject, providing the essential classification scheme, as well as the `raw' text of each message for review in compiling this report.

Organization of the LIST…

Operationally, the LIST discussion was segmented into two sequential phases. Firstly, from March 20th until mid May, the LIST ran uninterrupted with input

into the April World Education Forum in Dakar as its major focus. Secondly, on May 16th, the decision was made to put additional resources into the LIST to permit it to consider followup to Dakar, as well as provide some guidance to LIST designers regarding future e-networking options, as well as to anticipate the Durban AIDS 2000 Conference. Messages from these two phases were merged, and the database treated as a single entity. esponse characteristics (numbers, regional representation) are summarized in the next section.

…and presentation of results.

The substantive structure of the LIST emerged around fourteen issues, some of which were suggested `externally' by the moderators, and others (the majority) of which emerged chronologically from suggestions by subscribers. The fourteen issues are tabulated in Section VI along with a synthesis of major recommendations (Table 1 below).

Although the LIST in general followed this broad sequential structure, nevertheless we need to look beyond mere chronological framing of these data. Sometimes, participants went outside the frame in interesting ways, with personal and anecdotal accounts that offered important insights. In addition, there was often a perceptible lag of a week or two as respondents either came `late' to an issue, or chose to express more thoughts/reactions regarding prior postings. Finally, the issue frame was essentially designed and managed by the moderators (EDC and UNDP). As such (and in spite of open invitations to LIST members to propose issues that might have been forgotten in this process) the frame represents the need of the LIST organizers to structure information. So Section VII discusses the key points and recommendations from the discussion while explicitly ncluding additional subjects raised by participants, as categorized in the 53 subjects/threads listed in the archives.

Finally, Section VIII examines the experience of this LIST with respect to utility of electronic discussion formats for networking/policy formulation around social policy issues in the future, relates the LIST to the explosive growth of the technology in Africa, and makes some suggestions.

V. LIST response:

Participation in the LIST was encouraging. 667 subscribers represented 54 countries, of which 25 were from the subregion[11]. More than 60% of subscribers (and of total messages posted) were identified by email addresses or email content as from sub-Saharan Africa. This is probably an underestimate, because others may have been Africans using northern servers to access the LIST[12].

Numbers and distribution of respondents

While 667 people/institutions *subscribed* to the LIST, the archives show that a total of 226 postings were received from 86 active participants who actually *sent*

messages to the LIST. About two thirds posted only one message. The highest number of postings from a single member was 14. Four other LIST members posted between 9 and 13 messages. So it is important to note that the voice are relatively few and that the discussion tends to reflect the perceptions/interests of a limited sample of subscribers.

Yet the high number of single postings mitigates this finding, and illustrates the breadth of substantive coverage, since many of these single postings raised additional issues. Also, analysis of the issues of most interest (defined as those eliciting the most postings) shows a broad participatory engagement, and not dominance by one or two members[13].

Weekly summaries of the discussion were posted to the LIST, and are available at the archive site. Complementing the substantive discussion around specific issues was a steady stream of inquiries and offers about related information needs, or relevant reports or documentation. Consequently, the archives also include compilations of **a)** information requests sent to the LIST (which were posted separately so as not to interfere with the flow of the discussions) and **b)** resources of potential interest to LIST members (such as references, websites, project announcements).

VI. LIST structure:

Substantive issue headings and source of origin

Table 1 provides an overview of the fourteen main issues in chronological order (for ease of reference back to archived source material) and recommendations stemming from them. The structure of the LIST is evident from the Table. The six moderators' issues (Column 1) acted as `bookends' reflecting at the outset, a need to get the LIST `going', and then at the end to help establish closure. In the middle are the eight issues emerging on the basis of participants' (respondents) advice in Column 2. The number of respondents' postings to each issue are in parentheses in each column. The asterisk against Issue # 13 means that no single response was identified solely (or mainly) with this subject, though many responses touched on it in part. Column 3 contains brief summaries of the policy recommendations regarding each issue.

TABLE 1. Issues in chronological order, and major recommendations

1. MODERATORS' ISSUES	2. RESPONDENTS' ISSUES	3. MAJOR POLICY RECOMMENDATIONS
1. Resistance to acknowledging HIV/AIDS (N=18)		don't focus on fear, but on encouragement; address/overcome inappropriate responses (e.g. stigma, shame, superstition), increase educational outreach in formal and non-formal settings; & link national to local strategies;
2. Assisting those living with HIV/AIDS (N=20)		recognize HIV/AIDS not just a health problem; identify/foster PLWHA's associations and local caregiving efforts; expand PLWHA's engagement in upstream as well as downstream programming; facilitate access to affordable treatment;
3. Best practices (N=5)		critical analysis/dissemination; review/disseminate institutional (e.g. university) policies;
	4. Local values, customs (N=13)	`bottom-up' planning; understand community interests; involve traditional healers; tailor national approaches; support local research to assist in evidence-based planning;
	5.Testing (N=9)	make voluntary; assure confidentiality; offer home-based testing; extend & cluster support services;
	6.Gender(n=3)	identify needs by gender; emphasize girl's education
	7. Private sector (N= 5)	facilitate/foster private/public coalitions;
	8. HRD approaches (N=2)	conduct impact studies; build on institutional experience on the

		ground; ensure inclusion of HIV/AIDS into all educational planning; integrate strategies into HRD management
	9. International agencies'role (N=5)	give HIV more prominence; help info-sharing across national boundaries; second staff; complement national efforts;
	10. Keeping families intact (N=2)	recognize family as key; support family caregivers; engage families participatorily in planning programs
	11. Orphans (N=8)	prioritize schooling; support community responses;
12. Cultural beliefs (N=13)		open discussion & strengthen schooling role; recognition of adverse aspects of local culture (e.g. gender discrimination & sexual violence or exploitation); engage parents; peer education and children as teachers; use of drama, roleplaying, street-theatre;
13. IT next steps (*)		inter-regional networking; expanding African connectivity
14. LIST future (N=7)		continue for networking with explicit focus on additional areas

In general, the LIST and its structure seemed to have met with members' approval. Several messages illustrate these reactions, expressing appreciation to:

` *the moderators for the job well done. Without their unfailing efforts to structure the debate we probably might have meandered for weeks on end'*[14].

and noting that:

`*this forum has been remarkable for the clarity and wealth of information………. and particularly for its implications pertaining to HIV and AIDS in sub-Saharan Africa. The Moderators are to be commended for providing this service and keeping it on target.*'[15]

Any attempt to summarize the thoughtful, constructive dialogue from the LIST is inevitably faced with what to leave out. Many constructive ideas were proposed, difficult to summarize in a short paper. Categorization by issue topic is an imperfect mechanism for sorting or classifying responses, because many issues might be covered in one posting. This is an inherent shortcoming of the archiving process. There is no substitute for searching/reading the actual postings to fully experience the LIST's diversity and depth of engagement. Yet it is important to try to capture some of the key findings and

recommendations, especially those of direct significance for immediate policy action. The following section brings together content from the LIST that most closely satisfies this criterion.

VII. Key points from the `voices':

One way of measuring importance of specific issues to to LIST participants is to see which gained the most airtime, i.e. the highest number of postings. The two subjects receiving the greatest attention, judged by this measure, were: **`Assisting those living with HIV/AIDS'** **and `Fostering Acceptance of HIV/AIDS'**. The first generated considerable personal and anecdotal information on individual cases. The second was consistent with `breaking the silence', the central theme of the Durban AIDS 2000 Conference. They are closely linked, and are addressed together below.

A striking finding was the demonstrated commitment, energy and experience garnered in the subregion, in spite of still limited diagnostic, treatment and communication facilities. A major value-added of the LIST therefore was to help link practitioners, professionals, and those concerned with HIV/AIDS, and to enable information-sharing around how various institutions were coping, with emphasis on critical analysis of best practices (which emerged as examples in many of the discussions). Most important however are recommendations as to how policy should be directed and services improved.

Facing up to issues of HIV/AIDS and PLWHAs… examples from Zambia….

The Copperbelt University in Zambia has openly faced HIV/AIDS, and the problems of people living with HIV/AIDS (PLWHAs) for many years, and has developed a careful and effective response over time. A medical officer with long experience put it this way:

`AIDS has greatly affected educational institutions in our part of the world. Teachers and students have died from AIDS, the former suffering more. Our first task as a health unit was therefore to get a recognition of the problem from our governing council at the University. This having been done, we then prepared a policy guideline for the institution on AIDS. Our policy on AIDS stresses that there shall be no discrimination .....and that those with AIDS shall be treated like all other individuals suffering from other illnesses. Secondly, there is no pre employment screening for AIDS….. The medical centre acts as a resource base. ….[and]...has a twelve bed admission facility and a well established laboratory and pharmacy. Unfortunately we cannot treat all patients with antiretrovirals because of the cost but on occasion those able to pay have managed to source the drugs.'.[16]

Another respondent endorsed this approach, suggesting collaboration with the private sector:

`I support the model proposed by Dr. Oscar Simooya not only for learning institutions but also for large corporations who have an HIV/AIDS workplace policy to also host a health centre which is made available to those infected and affected by the disease, including family members'.[17]

Other institutional efforts included the following:

….Zimbabwe..

`From 1995 to 1999 we in the Mutare City Health Department, Zimbabwe, have been working on the development of guidelines for nutritional support for people with HIV. As little useful information was available on the subject at that time, we discussed, tested and amended whatever was available in cooperation with members from the local AIDS support organisations during weekly nutrition courses. As we thought our experiences were extremely useful, we published a booklet, to be able to share our experiences with other people with HIV and their care givers.[18]

An academic physician in Ethiopia outlined collaborative efforts of PLWHAs to help each other:

…Ethiopia….

`Recently people living with HIV grouped themselves and established a society. In a short time, their members have increased significantly and they are in fact been teaching others on how to protect themselves from HIV and what does it mean to have HIV. It is indeed exemplary to notice such a progress in a country where sex is not discussed openly even among adults, for people living with HIV/AIDS to come forward and teach others openly about HIV prevention and even go further to discuss their illness. I think the same initiative can be tried elsewhere especially in places where anti-retroviral drugs are not available.'[19]

…and Kenya.

In Kenya also, local and professional collaboration averted a negative outcome, and resulted in adjustment in education sector policy:

`The Teachers Service Commission, the government department where all teachers fall (apart from university lecturers) on its hand has resolved to isolate those teachers living with HIV/AIDS. In a recent circular to all the districts, the commission directed all education officers to determine teachers living with HIV/AIDS and develop lists.

However, the intentions of this directive were not clear as the method of determining the health status of teachers was not specified. The teachers' union was quick to intervene to save the situation with a strike threat. The commission came to its senses in time and withdrew the circular'[20].

Resistance to open discussion of HIV/AIDS in Kenya…..

Taboos against talking about HIV/AIDS were discussed by several participants.

`Sadly, many developing societies are unwilling to accept that AIDS is wiping out their citizens. A doctoral student from Kenya told me that in a particular faculty

department of 25 professors (or faculty members) at Moi University in Kenya, only two or three of them are left, as the others have been wiped out by AIDS. Yet, when these people died, their families insisted that their death certificates should read otherwise, i.e. by heart attacks, ulcers, etc. Is this helpful, where true statistics are concerned? There are cases, whereby HIV/AIDS infected persons are deemed bewitched by "bad" or "powerful" family members! I remember giving boxes of condom to some friends somewhere in Africa, but many of them looked at me and said something like: "You really want to curtail my sexual enjoyment," or "You want to reduce my child-production abilities. These rubbers are for white people, not for black men..." Just, imagine! My wife and I have also heard some people saying: "Those who will get AIDS will get it, no matter what. It's a matter of destiny...!"[21]

And from another country,

…Mauritius…

`*AIDS is still known as a disease for others (tourists, sex workers, gays and drug addicts)…… Silence kills in Mauritius*.'[22]

A participant form the National University of Lesotho noted:

…Lesotho…

`*It is true that HIV/AIDS is a rampantly increasing disease in Southern Africa, however, capturing the statistics of the illness is still much of a problem in Lesotho. The problem emanates from the resistance of accepting that the disease really exists and that through proper prevention measures we can lower the spread. The way the awareness of the disease in our country has been introduced since the early 1980s has created a negative stigma to it so much that people do not want to open up and talk freely of the disease or rather even accept their condition when they are diagnosed HIV positive*[23].

A Ugandan national currently working at the University of Vienna said:

…..and Uganda.

`*Fear is the consequence of insecurity. How can a person be willing to know and publicly declare his [or her] sero-status in a society in which chronic diseases, and particularly STDs, are highly stigmatised and easily lead to isolation (loss of self-esteem, loss of a job, spouse, loved ones, etc), if one is not well prepared and supported to do this*?[24]'

Yet courageous individuals were still willing to share their own personal concerns:

Personal experiences with avoidance of HIV reality….

`*I am an African born and grew up in Tanzania. I have no medical background but have so much interest in HIV/AIDS because I have been touched by its vengeance and scars still remain. I would like to share my personal experience which might shed some light… and maybe help those who are trying to combat the disease in Africa. I have lost many relatives to AIDS but this is not discussed in the family. I would like to share with you one of the incidences...*'[25]

and another personal story from a senior UN adviser on the extraordinary risks to women:

`Nobody is safe, for the first time, rural and urban women are on the same side on this issue. I know a friend who in an effort to protect herself lied to the gang of robbers who came to her house to rob her that she was HIV positive and the robber replied that he was HIV positive as well so there was no problem and raped her, she is now HIV positive.'[26]

It is important to note that not everyone agreed to the characterization of African reluctance to acknowledge these problems. A native of Côte d'Ivoire, currently working at the FAO Regional Office for Africa in Accra said :

`No, there is no resistance in most African countries to acceptance of HIV/AIDS as a reality'[27].

……and implications for public policy

Nevertheless, where it exists, as a matter of public policy, stigmatization needs to be approached within the local context, and in relation to the the extent to which the pandemic has progressed:

`…the extent of stigmatization of individuals living with HIV/AIDS is closely related to the stage of epidemic. In areas where the epidemic is mature (Uganda, NW Tanzania) stigma no longer exist. In areas where the epidemic is young, stigmatisation is, to most people living with HIV/AIDS (hereafter PLWHA) and their families, quite common. This broad categorisation is also applicable in the education sector. I have no evidence of pupils shunning a teacher because he is suffering from AIDS or vice versa. At local level families and even non-relatives may provide help to a teacher who is sick from AIDS...in Bukoba district, NW Tanzania, this is not uncommon.'[28]

The same respondent felt that public sector policies often fall short:

`……..local and central governments in many African countries are not doing their job to help and support education employees affected by AIDS. While this is neither marginalisation or ostracism of PLWHA, it is a tactic, a sort of quiet abandonment of PLWHA by the same government they work for.'[29]

…and evidence of positive policy response.

Nevertheless, municipal efforts have been targeting PLWHAs effectively.

`From 1995 to 1999 we in the Mutare City Health Department, Zimbabwe, have been working on the development of guidelines for nutritional support for people with HIV. As little useful information was available on the subject at that time, we discussed, tested and amended whatever was available in cooperation with members from the local AIDS support organisations during weekly nutrition courses. As we thought our experiences were extremely useful, we published a

*booklet, to be able to share our experiences with other people with HIV and their care givers***.**[30]

Human resources policies in education ministries, especially to assist those living with HIV/AIDS, was singled out for special attention (Issue # 8, Table 1). But despite scattered references and suggestions throughout messages that tended to focus on other issues, this topic did not seem to arouse much interest.

`Missing' issues needing urgent policy attention…. especially with implications for education systems

Other questions perceived as having been generally avoided in policy debates however were raised, such as:

`*Why is it that some of the highest levels of HIV infection in sub-Saharan Africa are being seen in the teaching profession? Can it be attributed to their position of power over young people and ability to coerce them into sexual relationships, as some commentators have suggested? If so, wouldn't we see a significant difference between prevalence among male and female teachers*?'[31]

Again, gender differences in experience, and implications for setting policy, were separated out (Issue #6, Table 1), eliciting few specific responses, but several references in other messages. Answers to the above questions included the following:

`*The view that teachers are more affected than others is only partly correct...they are more likely to sleep with strangers because of high mobility. It is also partly incorrect because teachers are socially visible. They are few (not more that seven teachers at an average Tanzanian primary school), they earn money (a significant sum in impoverished villages), and are therefore in a socio-economic class of their own in rural areas. If one teacher dies at a school with seven or even ten teachers you are talking of a loss of more that ten percent. If three of them die, you are talking of around 50% loss! Mortality among teachers, especially if measured in percentages, is not a good indicator or rather wouldn't be a good indicator of differences in HIV positivity between teachers and the general population.*

That said, I tend to be cautious about the claim on power relations and forcing pupils into sex. If this was true we would be witnessing a high number of HIV+ girls (below 20). My long-term epidemiological data from Tanzania (1983-1998) shows that the HIV+ graph for girls begin to rise after age 19 and peaks between age 25-29 (these are obviously not school girls, are they?). I would be the last to disagree that some teachers have sex liaisons with their pupils/students. But….. these are very few, well known, and could be easily dealt with'[32]

Another perspective was expressed by a university professor in West Africa, who regretted

` how sex has come to school with the stink and stain of disaster, almost subverting the goal of schooling – ‘[33]

Among concrete solutions to the problems of receptivity and assistance are those offered by a research officer for an NGO in Sexual and Reproductive Health in Swaziland, who suggested that we need to :

**Carry out research that will assist in evidence based planning for IEC Strategies and messages;*

**Involve teachers in revamping the educational system. The educational programmes for HIV should not only be directed to the child but also to the teacher;*

**Community based initiatives need to be encouraged as these will incorporate all those that are in the community; teachers, pupils, parents, leaders and the general public.*

The media is a very important aspect of addressing the problem. Relevant and appropriate media should be used. Where computers are available, let them be used. In Swaziland, access to computers in very low but the potential to use them is there so long as these could be available’[34]

Clearly, major focus must be on the school and formal education for participatory intervention methods and information dissemination/sharing. But the reality is still that, in many southern African countries, significant numbers of children never enter the schoolhouse door.[35] Thus alternative, non-formal educational approaches, sensitive to the diversities of local contexts and schooling strategies, must also be central to national policies.

The social, economic and psychological aspects of HIV/AIDS necessitate going well beyond just a health sector approach.

`Any HIV prevention programme that does not deal with human beings in their social environment is likely to hit a wall.[36]

The importance of respecting specific cultural contexts…

LIST discussants recognized the importance of considering **local values and customs** and **cultural beliefs**, two issues also generating relatively high levels of messages. In Uganda (a country with some demonstrated success in coping with the epidemic) a recent study, available on the INTERNET, documents a culture of sexual risk-taking among the young, which rests on male irresponsibility and female disempowerment.[37]

And the scope of the problem for school-aged children is starkly presented in results of a new South African study:[38]

`Adolescents are sexually active when they are young: in rural KwaZulu-Natal, 76% of girls and 90% of boys are reported to be sexually experienced by the time they are 15-16.

*Boys start sexual intercourse earlier than girls (13.43 years versus 14.86 years), have more partners and nearly twice as often have an STD history. In Free State, teenagers reported they were sexually active at around 12 years old, due to experimentation or peer pressure, and relatively few practiced safe s*ex'

Thus it is critical that concrete suggestions be found for improving the context for socialization of school-age children in this currently threatening sexual environment.

and relevance of peer education

Examples were given of young people teaching young people in a co-educational secondary school in the city of Ibadan, Nigeria, among out-of-school settings in in Dakar, Senegal, and among young men in Botswana.

'*Supported by a local NGO with a particular focus on sexual health, each class in this large secondary school had appointed two peer educators - one boy and one girl. At the level of each class, these two young people became the knowledge base in relation to all aspects of sexual behaviour, STDs, HIV/AIDS, etc. They worked on a weekly basis with the whole class, and were engaged in individual discussions with class members about particular issues. In addition, and to our amazement, these young people took responsibility for presenting on some aspect of sexual health to the whole school during assemblies. This involved them speaking to around 2,000 students, in the open-air, using a public address system - something they seemed able to achieve with great skill and not a little confidence. We met with the whole group of peer educators and were moved by (a) their commitment, (b) their technical knowledge and (c) their confidence to speak about difficult issues*.'[39]

Measuring success in these programs is difficult. One short term indicator used in the Senegal case was `*whether the….participants ..are themselves more capable of communicating around issues of sexuality, relationships, AIDS/HIV - and whether they do communicate (with peers, sexual partners, family, etc.). The theory is that those who are empowered to discuss issues, to bring up questions and confront situations and to negotiate verbally, are less likely to be pressured into decisions they are not ready for or do not want to take. A lot of "unspoken" maneuvering goes on in relationships which allows power plays by those who have an edge in age, gender, status, and personal assertiveness (there can be implied violence, shaming, threats and so on, as well).*'[40]

..local arts and theatre….

Roleplaying, art and dance, using local languages can also be very persuasive. A South African faith-based organization describes the use of `*a truly African piece of drama which puts the messages across in a very powerful way*.'[41] Another example is the Theatre for Development (TFD) project in Nigeria.

`*As it has been observed in TFD communiques, theatre is a very vital means of social education in African communities, and has to be enlisted in tackling local African problems. The power of visuality that theatre commands is particularly appropriate in addressing school children on HIV. Such visual practice is even*

more realistic and effective when the actors are drawn from the age range of the target audience, and when it is constructed in non-sophisticated way.'[42]

..and engagement of traditional medicine/healers and local leaders…

Local cultural norms require that affordable and credible treatment includes traditional medicine, and faith healers. If as one participant noted, almost 70% of Ugandans depend on Herbal Cure for disease, these treatment dimensions are indispensable on social as well as economic grounds. Neither is their importance confined to the African region, as corroborated by accounts of use of six forms of medicine, including homeopathy, in India[43]. However, the issue is salient enough across national boundaries that a regional Task Force on traditional medicine and AIDS in East and Southern Africa was inaugurated in Kampala, Uganda, on 10 April 2000.[44]

`*In some countries (Zimbabwe, South Africa, Liberia, Mozambique - to name a few) traditional healers have served on the frontlines of HIV education and prevention. There have been several cases in these where HIV/AIDS prevention programs, local ministries of health, international health organizations, researchers, etc. have collaborated with the traditional health sector with a good degree of success. Here, healers were trained as HIV educators and served to educate not only their communities, but also other healers as well. The World Health Organization even released guidelines on training and utilizing traditional healers as HIV/AIDS educators*.'[45]

Uncertainties about efficacies of traditional healers, and consequences of this resistance regarding local responses should not be underestimated. In Tanzania, for example `*during ..fieldwork I initially encountered silence and resistance when I asked respondents about their use of traditional medicine. Why? Many people felt that use of traditional medicine is contrary to the teachings of the church……… The real problem facing the advance of this alternative branch of medicine is lack of recognition from governments and church groups*.'[46]

But among the most troubling aspects of local cultural settings are the (hypothesized) prevailing customs and social climate for abusive sexual behaviours. In a 1995 survey by the National Progressive Primary Health Care Network in South Africa,

`*semi-structured interviews with youth, mothers and policemen in one town found that gaining and keeping boyfriends and girlfriends were critical to status and position within peer groups. Even when aware of it, mothers did not interfere with violence committed within relationships by their sons; the police were reluctant to press charges in cases of gender violence; and authority figures such as teachers were often responsible for sexual exploitation of teenage girls*.'[47]

And further…

`*Without wanting to stereotype or simplify, there seems to be a strong connection between violent masculinities, forced (non-consensual) sex and the spread of HIV …*

High levels of sexual activity amongst adolescents (with multiple partners) is worrying, but when this is often conducted upon a foundation of uneven gender power, the problem assumes colossal proportions…..'[48]

Perhaps most disturbing of all is

`*child abuse which seems to be on the increase with the pandemic….. as men think that either they can avoid AIDS by having sex with a child, or they can be cured if they are already infected.*'[49]

…in real behaviour change.

While there are no easy or quick answers, the consensus of LIST participants seemed to be around opening up dialogue at local levels, and engagement of community leaders.

`*We are totally convinced that the community is the context for healthy sexuality - and that programmes need to address individual behavioural changes, the family, and also the community norms. But it isn't the PROGRAMME that does this - it is the participants themselves who do it.*[50]

A Malawian , who has also been a senior adviser in education, emphasizes that schools have both the opportunity, and the responsibility to address the epidemic at local levels, most especially with girls:

`*These issues need to be dealt with and discussed openly. Because of the stigma and taboo nature of the subject, girls feel guilty about coming forward when they are attacked. If the schools find this subject too impolite to tackle, more women and children will die, and girls will have no place to go. I think educators have a responsibility here to teach girls how to deal with these problems. And schools have a responsibility to establish trust and offer counseling to the girls who are brave enough to come forward.*'[51]

Testing was the other issue which attracted the most attention.

The elusive context for testing….

`*There is no doubt at all that there is widespread resistance to HIV testing in most African countries'* [52]

Reasons for this vary, and range from distrust or inability to access or afford reliable testing sources, to normal reluctance to determine undesirable outcomes.

`*There is only one HIV testing center in Mauritius , and an average of 150 voluntary tests per year. (HIV testing is illegal in private clinics or laboratories*)'.[53]

The process of testing, and its benefits, as currently gauged against its disadvantages, were questioned:

As an educator, a health worker and individual, I still have mixed feelings about the importance and advantages of HIV testing. My experience has shown me that, as health practitioners we often encourage our clients or patients to go through this traumatic test without considering the other implications of the test to clients. These implications are not totally medically dependant, rather, about 80% of them are socially and emotionally dependent. Thus, we often ignore the participation of other professionals who could indeed assist the individual before and after the test, e.g., Social Workers, Psychologists, etc. What most of us do, at least in Botswana, is to conduct pre-test counselling and post test counselling. No concrete follow-up is made to ensure that the individual's life goes back into track. In other words, we mess up his life and leave him like that or offer him antiretroviral therapy...like it is the only solution.'[54]

No mention is made of women in the previous posting. However, a female respondent pointed up the problems a man may have with adjusting to negative test results

`*I am reminded of how this subject is serious. One student had gone for HIV testing and he tested HIV positive. That same evening, he committed suicide. That was the end of him. Cases like these seem to be common and many go unreported*.'[55]

… and urgent need for ancillary services.

The complexity of the testing process, and its varying effects on behaviour, necessitate great care in carrying out the testing process as a matter of public policy:

`*In my professional life I have experienced homicidal and suicidal reactions related to positive test results. On the other hand, I have experienced rapid exposure and spread of HIV infection when individuals who were tested negative the first time, believed they were "untouchables" and celebrated sexually and unsafely. In the case of medical screening, unless a client has comprehensive and affordable access to all services from psychological support to medical care and treatment, family support, etc., it does not seem to make any difference in that person's life to be tested*.' [56]

Suggested solutions included making available home test kits where only the individual taking the test will know the result, or use privately based institutions to provide counselling and testing services, away from public institutions and hospitals. .Mandatory testing, especially as a precondition for employment was contested. A case of successful litigation against pre-employment testing in South Africa was cited [57] . But all agreed that a cluster of supportive services must be available surrounding any testing procedures.

` *In the past few years I have discussed these issues with the medical fraternity in Kenya and Tanzania ……pre-and post-test counselling is geared towards lessening pain around the disclosure of one's HIV status. Perhaps more could be done. I believe all of us, medical doctors, religious leaders, academics, researchers, policy-makers, NGOs, bilaterals and multilaterals, have a role to play in breaking the silence about AIDS. There must be a less painful way through which silence could be broken*.[58]

Finally, two **additional issues** were explored by participants, with valuable policy-relevant insights, although not with as much general interest or engagement of other LIST members. These addressed the startling growth in the number of HIV/AIDS orphans, and the role of international organizations.

Orphans as a major priority.

The special case of **orphans**, family structures and livelihoods, led to several ideas and case examples. It is important to remember that orphans are part of a broader population of children and families affectd by HIV and AIDS. Also the problem of their status is not confined to the effects of HIV and AIDS on children only at the point that they become orphans [they are severly affected in many ways - economic, social, cultural and pschy-socially before they are "orphaned"].[59]

Evidently, the problem is growing:

USAID, in Children on the Brink, estimates that in nine sub-Saharan Africa countries at least one of every five children will have lost one or both parents by the year 2000, with AIDS being the major cause of death. An increasing number of children are being pushed by poverty, parental illness, and death onto the street or are struggling on their own to scrape by in rural villages. Family and community safety nets are not sufficient for some children, and child protection and care interventions are needed if the most vulnerable children are to survive and have a chance for healthy development. But with the large and growing number of orphans, there will not be enough resources available to make direct service delivery the primary type of intervention for the majority of orphans and children made vulnerable by HIV/AIDS.[60]

Difficulties facing orphaned children are many and interactive, including psychosocial, economic, nutritional and health related factors.[61] Encouraging schooling, and continuation of schooling for those suddenly orphaned, is an important if partial solution. Bursaries such as those provided by the Zambia Education Capacity Building Programme (ZECAB) are targeted towards orphaned children, especially girls. ZECAB supported about 1,000 children from Lusaka, Kitwe, Samfya and Mpika in 1999.[62] The CINDI network brings institutional resources collectively to bear on the needs of affected children. [63]

Community response is again an essential element in coping strategies at local levels, as noted by a South African respondent:

`*One of our bishops went to Burundi a couple of years ago, and he saw that families had large numbers of same age children. He asked if there was a tendency to multiple births in that culture, and they said no, the Christian families had been challenged to take in orphans as part of their families. "Hello, South Africa?" he said after that.*'[64]

Sensitivity required of international agencies.

The **role of international organizations** is inherently a delicate one, as summarized in the few responses that dealt with this issue. Notwithstanding the

micro-macro gap, and the sensitive nature of intervening in national-to-local social policies, especially in areas of sexual behaviour, it is clear that

`..*it is time for agency personnel to recognise that HIV is not just a health issue; it is a social, economic and cultural issue which is battering the very foundations of our communities and governments. In this regard at least, agencies have a responsibility, because of their financial and professional resources, and because of the opportunities they have for regular and systematic interaction, to: (1) be much more proactive about the planning issues involved; (2) help move the discussion away from purely health issues; (3) create more arenas for advocacy, sensitisation and training vis a vis socio-economic planning; and (4) promote and sustain a practical research and development agenda in this regard. At the present time, it seems to me, it is only international agencies - or ministries through international agencies - which have the time, resources and clout to address HIV-impact issues at the level of magnitude now necessary. We may all accept that national ministries must initiate impact assessments in-country. But international agencies must surely feel themselves under an urgent moral obligation to go to scale at least regionally without further vacillation*. '[65]

International agencies can: initiate advocacy forums, and promote information sharing; help governments and NGOs see beyond HIV/AIDS as just a health problem; encourage and support sector impact studies; exchange or second staff; and assist MOEs construct education sector policies, and action programmes that address: (1) increasing numbers of orphans, traumatised teachers and parents, and (2) increasing randomness in education as communities and families fall apart.[66][67]

VIII. Conclusions: the future of e-networking as a policy tool.

Strong participant support for LIST objectives

The LIST provided a unique and timely resource to those trying to grapple with the HIV/AIDS problem in southern Africa. Accolades both on and off the LIST have testified to this, some of which were already documented above. It is important that many of these were appreciative African voices:

`*For the past week, I have been composing my thoughts to thank everyone who has participated in this forum and to thank the moderators for their splendid job………….This has been the most intelligent and informative discussion about HIV/AIDS that I have ever participated in*.'[68]

Positive impact on Dakar.

A panel was dedicated at the Dakar World Education Forum to the issues of HIV/AIDS and education. Two African professionals who had participated in LIST discussions (but had no other connections to, or even knowledge of the Dakar conference) attended the panel, supported by scholarships funded by CIDA. They each presented summaries of their perceptions of the LIST discussions, providing direct evidence of LIST utility in two ways. First, neither would have attended Dakar unless the LIST had offered the opportunity. Second, the panel (and audience) was able to hear from actual LIST participants as to the value-added to African professional discourse on HIV/AIDS and education.

Recommendations from the panel went forward to the drafting committees for the Dakar Framework for Action, and were reflected in the final document. The LIST is now part of UNESCO's official electronic documentation website for the Dakar Conference at

http://www2.unesco.org/wef/f_conf/00000050.htm

Utility of LIST to participants… sidebars and railhead strategies….

Examples of direct and practical utility to subscribers include the pre-publication of an education sector policy paper for South Africa on the LIST, which allowed for wide circulation, input and subsequent refinement of the ultimate draft[69], as well as the bibliography and web addresses contained in the LIST annexes. Discussions off-line, but stimulated by the LIST are referred to as `sidebars', after the US televised court proceedings showing impromptu conferences between participating lawyers and the judge, but out of hearing of the jury. Several examples were encountered, in addition to those around the South African education policy paper. Another `spinoff' advantage provided by the LIST was the spawning of local `railhead' strategies, whereby the e-information from the LIST, having reached the computer `terminus' (using a transportation analogy) could then be packaged or transformed in various ways, including into local languages, and disseminated through a variety of methods to additional (and e-unconnected) consumers. Examples include the sharing of LIST issues by a development agency (CIDA) with project leaders dealing specifically with peer (workplace) education efforts among commercial sex workers and other high risk groups such as truck drivers as well as with "single women's groups".

In the Ugandan mother tongue of a LIST participant, there is a proverb which says, "Lewic weko icamo awola", meaning "Those who are shy miss the opportunity to express their problems and learn from others". The HIV/IMPACT forum allowed such shyness to dissipate, and for ideas to be shared in a virtual space which preserved individuality, and respect.

The quick response capability of the LIST to provide almost instant answers to respondents' questions was also useful. For example, a simple two lines provided a web address responding to a request for published handbooks for schools:

`*Versions in English, Afrikaans, isiZulu, isiXhosa, Sepedi, Sesotho and Xisonga are available on the Internet at: http://education.pwv.gov.za*.'[70]

Explosion of African INTERNET connectivity….

The fact that this was in many ways a groundbreaking effort in electronic connectivity in the region did not seem particularly relevant. The speed at which access to INTERNET is expanding in southern Africa is difficult to document accurately, but it is proceeding unabated. One 1998 survey showed that at the end of 1996 only 16 countries had access, but in the following two years, over three-quarters of the 53 capital cities were online[71]. One currently functioning website has operating hyperlinks to all 53 countries. [72] Another site periodically updates the INTERNET status of each country.[73] As cellphones proliferate, and the technologies for linking handheld devices to the INTERNET become more widely

available and cheaper, the possibilities for applications, at least in large urban settings, become more realistic throughout Africa.

and demand for knowledge-based electronic interaction…

As responses to this LIST have shown, there is a hunger for information and networking among (often disparate) programmes, professionals, educators, and PLWHAs working in the area of HIV/AIDS. The LIST demonstrated that INTERNET-based communications can stimulate and implement multi-way information-sharing between various constituencies, within the region, and with the rest of the world. People can communicate interactively, and share concerns, experience and advice. Speed of information-processing is critical in a fast-changing world, and a well-managed email-based LIST is a practical means for coping with fast, easy, and relatively cheap knowledge exchange. In addition, these kinds of virtual networking offer one way in which the African diaspora can be ameliorated, and professionals working outside their home countries can contribute meaningfully to policy development in their countries of origin.

Despite its acknowledged disadvantages (widespread lack of access in poorer communities, and even `cheap' INTERNET pricing that nevertheless places the technology yet beyond the reach of the majority of even urban Africans) this method of opening up discussion has another great advantage. It permits, if not anonymity, at least a modicum of distance between the communicator and the immediacy of the message which may be a really useful factor in addressing sensitive issues around public sector strategies coping with HIV/AIDS. Participants who `lurk' and do not respond directly can still use the `sidebar' and `railhead' strategies to their advantage.

Four recommendations for future action: 1. LIST continuation…

But the LIST is only a first step. There are **four** ways in which the LIST could continue, or be expanded. Firstly, The LIST itself can continue, either informally as an already constituted network of people/institutions free to email each other as necessary, or formally as a moderated discussion forum focusing on issues of collective interest. This process could be enhanced by, for example, guest `experts' who could address the LIST, then be online to answer questions. But in whatever form this continuance evolved, it would be much preferable to have a regional institution (e.g. a southern African university with good web capabilities) as host.

2. engagement of policymakers

Secondly, it is most important that links be strengthened between this kind of electronic discussion process and policy decisionmaking at all levels. As long as the discussants are academics, scholars, technical staff, and practitioners, the connection to policy is serendipitous at best. The LIST was influential in bringing HIV/AIDS impacts on education sectors to the fore in two major international conferences, the World Education Forum in Dakar, and (to a lesser extent) AIDS 2000 in Durban

Involvement of policy bureau representatives in some UN agencies resulted in LIST discussions, case histories, studies and resource lists getting wider attention. But there is no direct evidence of the LIST having any direct effects on policy in these agencies.

Furthermore, policies at country level, which are ultimately where the focus must lie, stayed even more remote from the LIST process. Thus any next steps in electronic networking of this kind, if it is to have positive influence on policy, must find concrete ways to connect directly with senior policymakers in constituency governments, non governmental and civil society organizations, and institutions, as well as the international community. Links outside the region, eg. with other policy and programme initiatives in other parts of the world, must also be explicitly targeted and fostered.

3. realtime knowledge sharing…and

Thirdly, the references that the LIST gathered (and summarized in the archived resource summaries) constitute an important resource. Sharing of these kinds of information sources as they become available is a crucial element in a substantive network of this kind, particularly where information is so lacking. As new research (PhD theses as well as competitively funded professional studies) and new treatment modalities (e.g. vaccines recently approved for human testing) become available, speed in communicating the best of these to practitioners is essential. But so is quality, and there should be a clearinghouse function, with quality control built into the network. Unscreened information soon becomes a burden simply because of its volume. One of the reasons the LIST functioned as well as it did was due to careful, and skilled, round-the-clock moderation.

Finally, the capacity is today underutilized of electronic networks to provide just-in-time responses to questions about programme design, policy options, and determination of research priorities. As already outlined, this LIST provided a useful forum for `floating' a trial balloon in the form of a policy paper for the South African Education sector in addressing impacts of HIV/AIDS. Much of the ensuing discussion and exchange of reactions took place off-LIST, but would not have been possible without the LIST as catalyst. Moreover, questions about documents, handbooks, manuals, for training aids,as well as about prior experience in peer education programmes, were posed, and answered on the LIST. These are among the best examples of practical utility that came out of the whole LIST initiative.

4. electronic helpdesk functions.

It is possible to institutionalize this quick-response process into an electronic Help Desk, such as can be found now functioning well on several corporate and agency websites. The capacity exists in southern Africa to host all of the above elements in a strong HIV/AIDS electronic webcenter. Demand is demonstrable on the ground. Resource needs are relatively modest. There is serious interest in the international community. All that is needed is the will to pull it together and make it happen.

IX. ENDNOTES/REFERENCES

[1] Memo issued on June 2, 1999 to World Bank staff and supporters announcing the new AIDS in Africa initiative: full english text available at http://www.worldbank.org/aids-econ/africa/fire.htm
[2] UNAIDS website at http://www.unaids.org/africapartnership/index.html
[3] See UNAIDS/WHO Global Surveillance data at http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/index.html
[4] The Macroeconomic Impact of AIDS in Sub-Saharan Africa. M. Over. Population and Human Resources Department. The World Bank June, 1992 .
[5] S. Shaeffer. Impact of HIV/AIDS on Education. Background Paper to IIEP Seminar. IIEP UNESCO Paris. December 1993.
[6] UNDP HIV Programme. Issues Paper No. 32 The HIV Epidemic and the Education Sector in sub-Saharan Africa. Desmond Cohen, 1999.
[7] Kelly M.J. Impacts of HIV/AIDS on Schooling in Zambia. Paper prepared for ICASA X. 1999.
[8] Including, at various times, UNDP, UNESCO, UNICEF, UNAIDS, WHO, the World Bank, and bilaterals such as DFID, CIDA and USAID. The Education Development Center, Newton, Massachusetts managed and moderated the LIST.
[9] UNDP Welcoming Statement, HIV-IMPACT LIST.
[10] Final Report. Global Forum on the Impact of HIV/AIDS on Education Systems: Focus on Africa. Submitted by the Education Development Center Inc. July 2000. Full text available on: http://www.undp.org/poverty/forums/hiv-impact.htm
[11] Botswana, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Guinea , Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Niger, Nigeria , Rwanda, Senegal, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe
[12] See Footnote #6 in the EDC Report at http://www.undp.org/poverty/forums/hiv-impact.htm
[13] In the seven issues gaining the most postings, even in the one with the most postings (N=19) no more than 25% of postings were from the same respondent.
[14] Gabriel Rugalema. Re: Extending the HIV-Impact Discussion May 18, 2000
[15] Roulette Wm. Smith. Re: Cultural beliefs and customs. June 16 2000
[16] Oscar O Simooya. Re: Assisting those living with HIV/AIDS. March 29 2000.
[17] Veni Naidu. Re: Assisting those living with HIV/AIDS April 3 2000
[18] Marlou Bijlsma Re: Assisting those living with HIV/AIDS. April 7 2000.
[19] Lissane Seifu Assisting those living with HIV/AIDS March 30 2000
[20] Dismus Obuba Re: Assisting those living with HIV/AIDS April 3 2000
[21] Akwasi Assensoh. Fostering Acceptance of HIV/AIDS March 24, 2000
[22] D. Napaul. Re: Assisting those living with HIV/AIDS March 29th 2000
[23] Tsepiso Mohapi. Re: Fostering Acceptance of HIV/AIDS. March 22, 2000
[24] James Okee-Obong Re: Fostering Acceptance of HIV/AIDS March 27, 2000
[25] Vera Ngowi Re: Fostering Acceptance of HIV/AIDS March 30 2000
[26] A. Doka Re: Sexual Customs, HIV/AIDS, and education systems. May 31, 2000
[27] Atse M. Yapi Re: Fostering Acceptance of HIV/AIDS March 22, 2000
[28] G. Rugalema. Re: Assisting those living with HIV/AIDS. March 31st 2000
[29] ibid
[30] Marlou Bijlsma Re: Assisting those living with HIV/AIDS. April 7 2000.
[31] T. France. Re: Assisting those living with HIV/AIDS March 28th 2000.
[32] G. Rugalema Re: Assisting those living with HIV/AIDS March 30 2000
[33] Obododimma Oha Re: Fostering Acceptance of HIV/AIDS Mar 21 2000
[34] Marjorie Mavuso Re: Fostering Acceptance of HIV/AIDS March 23 2000
[35] Indicators II on Primary Educaation in Eastern & Southern Africa. UNICEF ESARO. 1998.
[36] G. Rugalema. Best practices addressing HIV/AIDS challenge. April 10, 2000
[37] Ugandan Adolescents and Safe Sex: Teens Have Trouble Avoiding Risks. Population Council. Washington DC March 9, 2000 http://www.popcouncil.org/news%5Fviews/ugandan%5Fadolescents.html

[38] C Coombe. Re: Cultural beliefs and customs. June 6, 2000
[39] T. Allsopp. Strategies in schools to discuss HIV/AIDS. March 23 2000
[4040] W. Hasselblad Strategies in schools to discuss HIV/AIDS. March 27, 2000
[41] Paddy Meskin Strategies in schools to discuss HIV/AIDS. May 15, 2000
[42] O. Oha Re: Lessons learned from local approaches. April 13 2000.
[43] L Rebello. Re: Lessons learned from local approaches. April 24 2000
[44]The Lancet, Vol 355, 1284, April 8, 2000
[45] Josh Gagne. : Lessons learned from local approaches. April 19 2000.
[46] G. Rugalema. : Lessons learned from local approaches. May 1 2000.
[47] C. Coombe: Re: Cultural beliefs and customs. June 6, 2000
[48] Robert Morrell Re: Sexual Customs, HIV/AIDS, and education systems June 1, 2000
[49] C.Coombe. Re: Sexual Customs, HIV/AIDS, and education systems May 31, 2000
[50] Wyva Hasselblad Re: Cultural beliefs and customs. June 14, 2000
[51] A. Doka Re: Sexual Customs, HIV/AIDS, and education systems. May 31, 2000
[52] O. Simooya HIV testing and women's risk of infection. April 10, 2000
[53] D. Napaul. Re: Assisting those living with HIV/AIDS March 29th 2000
[54] M. Mooko Re: HIV testing and women's risk of infection. April 14, 2000
[55] Dixie Maluwa-Banda Re: Strategies and programs of HIV testing April 19 2000
[56] Michele Rigaud Re: Strategies and programs of HIV testing April 24 2000
[57] Settlement in First Labour Court Case on Pre-employment HIV Testing
Against South African Airways (SAA) cited in James Okee-Obong. Re: Strategies and programs of HIV testing. May 12, 2000.
[58] G. Rugalema. Re: Strategies and programs of HIV testing. April 28, 2000
[59] Pers. Comm. Desmond Cohen. Email May 18, 2000.
[60] J Williamson. Re: Addressing the needs of orphans May 30, 2000
[61] G. Rugalema. Solutions in addressing AIDS orphans. April 18, 2000
[62] F. Elbers. Re: Addressing the needs of orphans. June 7, 2000
[63] Y Spain Re: Solutions in addressing AIDS orphans April 25, 2000
[64] Carol McDonald. Re: Solutions in addressing AIDS orphans. May 4, 2000
[65] C. Coombe Re: Role of international organisations. May 17, 2000
[66] ibid.
[67] G Rugalema. Re: Role of international organisations. May 19, 2000
[68] Wyva Hasselblad. Re: Extending the HIV-Impact Discussion May 17, 2000
[69] C. Coombe. Briefing paper on HIV Impact on Education in South
Africa. June 21, 2000
[70] C Coombe Strategies in schools to discuss HIV/AIDS. May 23 2000
[71] Where is Africa on the Information Highway? The Status of Internet Connectivity in Africa.
M. Jensen. RINAF Day / CARI 98 Dakar, Senegal October 16th, 1998. Full text at
http://www3.sn.apc.org/africa/cari98.htm
[72] http://www.woyaa.com/
[73] http://paradigm.wn.apc.org/africa/counsrch.cfm

ACKNOWLEDGEMENTS

The author expresses appreciation to colleagues in the UN agency and bilateral consortium which funded this experiment (most especially Mina Mauerstein-Bail and Pascale Engelmajer at UNDP, and Janice Brodman at the Education Development Center, Newton, Massachusetts), to CIDA for providing scholarships to LIST participants for Dakar, and to USAID for its continued affirmation of the importance of this endeavour, and help with its design and implementation. Finally, my thanks go to DFID, and David Clarke for encouragement and support for this paper.