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RESPONDING TO THE HIV/AIDS PANDEMIC: 'BEST PRACTICE' ISSUES FOR EDUCATORS

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Carol Morgan Coombe
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SECTION 1
INTRODUCTION

The world is facing one of the greatest crises of human history. Sub-Saharan Africa is already ravaged by HIV/AIDS. Countries in Eastern Europe and the Asia and Pacific regions will confront similar challenges as the pandemic spreads (MAP, 2001).

THE ROLE OF THE EDUCATION SECTOR IN FIGHTING AIDS

HIV/AIDS raises three principal questions for the education sector:

1. What is the role of the education sector in preventing the spread of HIV/AIDS?
2. How can the sector ensure that all young people achieve their full potential?
3. How can the sector protect the viability of the education service, and quality of education provision?

General agreement has emerged (USAID, 2001; Coombe and Kelly, 2001; Inter-Agency Working Group, 2001, for example) that there are three primary tasks for sector partners:

1. **Prevention**: helping prevent the spread of AIDS;
2. **Social Support**: working with others to provide basic care and support for learners and educators affected by HIV/AIDS; and
3. **Protection**: protecting the education sector's capacity to provide adequate levels of quality education, principally by stabilising the quality of education provision (Coombe and Kelly, 2001; Inter-Agency working Group, 2001).

CURRENT RESPONSES AND 'BEST PRACTICE'

Education ministries in the Southern African Development Community (SADC) region were surveyed early in 2001 about their action on HIV/AIDS.[1] Although HIV/AIDS has been present in the region for over twenty years, ministries of education reported little concerted action (Appendix 1). This and other evaluations of current responses to HIV/AIDS suggest that 'education is not living up to the demands that the HIV/AIDS crisis imposes' (Kelly, 2000a).

Is it possible to identify a suite of principles that constitute 'best practice'? A study of presumed HIV prevention success in Senegal, Thailand and Uganda (UNAIDS, 2001) suggests that successful national AIDS strategies share some common features:

- political commitment;
- early intervention;
- intensive multisectoral approaches at national, provincial ***and*** community levels;
- large-scale implementation;
- effective monitoring and dissemination of findings; and
- combined prevention and care.

[1] Southern African Development Community (2001). The thirteen countries that reported are Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, South Africa, Tanzania, Zambia and Zimbabwe.

Education sector HIV strategic plans must be based on sound policy and a realistic assessment of available capacity (Hunter and Williamson, 2000). Current understanding of the principles that should guide strategic planning and action in the sector might be summarised as follows.

1. Governments cannot by themselves protect education services, but must work with all other stakeholders in the education community as well as with other social sector departments at national, provincial and community levels.
2. Effective responses are those devised to meet local conditions.
3. Local responses must be complemented by vigorous, extensive and intensive national programmes relating to condom use and STD prevention, lifeskills curriculum in schools, orphan feeding and subsidy schemes for example, to reach as many vulnerable people as possible.
4. Interventions must be within the managerial competence of the system to deliver, and contribute to building capacity to manage more challenging interventions later (Marais, 2000).
5. Educators are often not the best people to deliver vital messages about death and sex, behaviour change and risk. Young people on the other hand have often been at the forefront of successful change (Devanney, 2001).

UNAIDS has recently suggested benchmarks for evaluating practical 'best practice' projects at district and community levels.[2] UNAIDS proposes that interventions must

1. Recognise the child/youth as a learner who already knows, feels and can act responsibly with regard to health and HIV/AIDS-appropriate behaviours;
2. Focus on risks that are most common to the learning group and responses that are appropriate and targeted to the age group;
3. Include not only knowledge but also attitudes and skills needed for prevention;
4. Take account of the impact of relationships on behaviour change and reinforce positive social values;
5. Rest on analysis of learners needs and assessment of the broader social, economic and values context;
6. Provide training and continuous support for teachers and other service providers;
7. Use multiple and participatory learning activities and strategies;
8. Involve the local community;
9. Ensure sequence, progression, accuracy and continuity of messages;
10. Where appropriate, be linked to school curriculum;
11. Be sustained for a sufficiently long period of time to meet programme goals and objectives;
12. Be coordinated with the wider school and community health promotion programmes;
13. Acquire political support through advocacy in anticipation of scaling up;
14. Portray human sexuality as a healthy and normal part of life, and avoid inhibitions or biases related to gender, race, ethnicity or sexual orientation; and
15. Provide for external monitoring and evaluation of content, implementation and outcomes.

Perhaps the most important strategic assumption is that the education sector has responsibilities for saving lives and protecting and socializing young children and adults, and that the time to act is now. South Africa's former President Nelson Mandela has urged that 'we have to rise above

[2] World Bank *Sourcebook* in draft, 2002.

our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now'.[3]

SECTION 2
EDUCATION RESPONSES TO HIV/AIDS

PREVENTION: CONTAINING THE SPREAD OF HIV/AIDS AMONG CHILDREN AND ADOLESCENTS

CURRENT PRACTICE

Governments in high prevalence countries have accepted responsibility for delivering mass prevention campaigns through learning institutions and nongovernment partners though their achievements are poorly described in the literature. Interventions have not generally been creative (Kruger, 2002) and have focussed primarily on *developing lifeskills curriculum and learning and teaching materials* from a central command unit. HIV/AIDS education is supposed to communicate relevant knowledge, engender appropriate values, and encourage learners to adopt behaviour that will minimise risk of infection. Curriculum programmes are often supplemented by mass media campaigns aimed at *disseminating information,* including *Love Life* and *Soul City* (www.comminit.com) in Botswana, Namibia and South Africa, the media campaign of the Johns Hopkins University unit in Rwanda, the *Sara* programme in Tanzania, and the Red Cross AIDS Network for Youth (West Africa) (Adu-Aryee, 2001).

The issue of *providing guidance on the distribution and use of condoms* for youth is a persistent cause of conflict between ministers and their constituencies, between parents and teachers, and between teachers and students. There is no evidence that guidance on condom availability, accessibility and use has been issued to teachers or school heads in any country from which information has been obtained.

An analysis of case studies from Ethiopia, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda and Zimbabwe for the United Nations Economic Commission for Africa highlights the shortcomings of current prevention programmes (Kelly, 2000a):

- Most programmes start too late, for children age nine and up;
- They are developed with little consultation with parents, teachers and young people, and are more concerned with the biology of human reproduction;
- Delivery is almost exclusively in the hands of teachers who are poorly prepared;
- The discredited cascade model used to train them (if they receive training at all) often dilutes or even misrepresents content;
- Many teachers are poor role models and feel uncomfortable talking about sexuality;
- Cultural beliefs, expectations, traditions and taboos related to behaviour receive little attention, and materials generally portray sexuality as heterosexual and consensual thus ignoring problematic issues of rape and harassment and rising levels of incest, homosexuality and child abuse;
- Programmes are driven by ministries of education, with little except ad hoc unofficial support from partners in the sector or other social sectors; and

[3] 13th International Conference on HIV and AIDS, Durban, South Africa, December 2000.

- There has been no effective evaluation of lifeskills programme content, implementation and outcomes so that the extent to which such programmes reduce HIV transmission, STDs, rape or coerced sex is not known.

'BEST PRACTICE' ON PREVENTION

Retaining Learners: Education as Vaccine. School is like a vaccine for children at risk: children who drop out of school are more vulnerable to HIV infection, are more likely to engage in early sexual activity with larger numbers of partners, and to use alcohol earlier than children in school.[4] Simply put, the more education, the less HIV. This is the single most certain step that any government can take to counteract HIV/AIDS among the young (Coombe and Kelly, 2001; Vandemoortele, 2001).

Subbarao et al (2001) make a strong argument for education subsidies for orphans not in school on a number of grounds. Malawai, Tanzania and Uganda waive fees at primary level. In countries that have 'implemented fee waivers, primary gross enrolment ratios have dramatically increased'.

Teaching Safe Sex: The Lifeskills Approach. Education's responsibility is to educate learners on lifeskills ***before*** they become sexually active (Larson and Narain, 2001, p 32). Mainstreaming lifeskills programmes effectively is everywhere essential (Carr-Hill et al, 2001). Where it is taboo to teach life orientation programmes because of cultural, religious or customary perceptions, alternatives to conventional lifeskills curricula can include value-based based approaches being used in Pakistan's *Aware for Life* curriculum (Save the Children UK, 2001b).

Ultimately, the life orientation approach can only take root where (1) it is implemented rigorously, intensively and extensively, and (2) where there is a climate in learning institutions that affirms the principles of respect, responsibility, rights and transparency, and which projects an image of good sanitation, safe water, and good health.

Educator Awareness: Educating the Teachers. It is assumed that teachers will be at the HIV/AIDS battlefront, but they are generally unarmed. Inservice and preservice programmes must take account of classroom trauma. Inservice structures are not robust in the developing world, and they are currently able to do little to support educators, despite reported successes in Karnataka State in India, and the Western Cape Province in South Africa for example[5].

Teaching and learning materials are needed to guide teachers, heads of institutions, and parents on dealing with HIV/AIDS issues with children in their care. In South Africa, the Department of Education's *HIV and AIDS Emergency Guidelines for Educators* sets out HIV/AIDS facts and eight key messages for all educators (South Africa Department of Education, 2001b). *HIV and AIDS: Care and Support of Affected and Infected Learners: A Guide for Educators* is a resource for those in South Africa working with children in trauma (Unicef East Asia, 2001; South Africa Department of Health, 2001; see also Rwanda Christian Counselling and Training Centre, 2001). UNESCO Harare has created a collection of teaching and learning materials, and a website (http://www.unesco.co.zw/webpages/html/programmes/education/edupreventive.htm#HIV/AIDS).

[4] Information from Uganda, Delhi and Rajasthan in Save the Children UK, 2001a, p 25; Coombe and Kelly, 2001.
[5] Personal communication from Karnataka State Minister of Health; South Africa Western Cape Department of Education, 2001.

Finally, educator upgrading must take place within the context of suitably sensitive workplace policies, workplace prevention programmes, and impact management programmes. ILO's *Code of Practice on HIV/AIDS and the World of Work* (2001) has been tabled and is suitable for adaptation to local circumstances (International Labour Organisation, 2001).

Youth Awareness: Using the Energy of Young People. Children and adolescents are part of the solution to HIV/AIDS. They need to be involved in the design and delivery of prevention programmes through peer school health teams, local and international NGO programmes, and anti-AIDS clubs. UNAIDS reports that where HIV prevention has been successful, young people have been at the forefront of change. Peer educators from Samoa, Tonga, Kiribati, Marshall Islands, Solomon Islands and Nauru have been trained in outreach work, interpersonal skills, and AIDS issues and help to train other peer educators. They are known for their commitment and dedication.

Women and Girls: Putting Them First. Girls who are learners and women who are educators are at greater risk of infection than their male counterparts, both inside and outside the classroom or lecture theatre. The United Nations General Assembly Special Session on HIV/AIDS made special reference to their vulnerability. Women must be empowered to make decisions and take control over their lives and sexuality and measures put in place to protect them from and eliminate further sexual violence and abuse (United Nations, 2001).

Tackling Communities: Creating a Safe Social Environment. Young people move between the competing value contexts of school, home, and the streets. New ways are being sought to bring the three into greater accord by developing programmes to address anomie and amorality, driven by poverty and deculturation, which undermine school-based behaviour change programmes. In Myanmar for example, risk behaviours among adolescents are being addressed by involving young people in cultural analysis, helping them to understand why they might be at increasing risk of contracting HIV/AIDS, but also making it easier to identify ways in which they can achieve positive behaviour change (Save the Children UK, 2001b).

Communities must be aware of, condone and actively promote lifeskills messages. They can do this only if local and religious leaders, teachers and parents, CBOs, NGOs, PLWHAs and young people are linked creatively. The Ministry of Education in Botswana is looking for ways to work at local level, through the District Multisectoral AIDS Committees (DMSAC), with communities and other social sectors. The recent draft assessment of the impact of HIV/AIDS on education in Botswana sets out graphically the kinds of relationships envisaged (Abt Associates, 2001):

Learning What Works: Monitoring and Evaluation. Little evaluation of lifeskills content, implementation and outcomes has been carried out thus far. Evidence from many sources makes it clear that unless life orientation curricula are being taught in all schools, to all learners, before children become sexually active, by teachers who have been adequately prepared, with suitable resource materials, and within the context of the local culture and community, a great deal of money will be wasted on half-baked prevention interventions.

SOCIAL SUPPORT: CARE AND COUNSELLING FOR LEARNERS AND EDUCATORS AFFECTED BY HIV/AIDS

CURRENT PRACTICE

There is significant literature on orphan care[6] but little is known in practice about how children and their families are coping with HIV/AIDS-related trauma, and the impact it has in the classroom (Ebersohn and Eloff, 2001). Most countries are at an early stage in their orphan epidemics, and it appears difficult for them to anticipate how educators will cope with very large numbers of distressed children (Abt Associates, 2001). There is substantial evidence from principals and teachers that nongovernment agencies are providing support to schools through peer group programmes, teacher advice and counselling, and training. Such programmes are generally ad hoc, underfunded, and officially unrecognized although they carry out work which governments might have been expected to undertake.[7]

'BEST PRACTICE' ON SOCIAL SUPPORT

Children in Trauma: Meeting their Needs. Schools cannot meet all the material, intellectual, emotional and social needs of children who are distressed. But governments can concentrate on keeping disadvantaged and challenged children in school or other suitable learning programmes, and creating acceptably healthy, secure and compassionate learning environments for them (Morrell et al, 2001; Hepburn, 2001; Williamson, 2000a). Schools are already overloaded but there are things that should be fundamental to every learning environment.

- They must provide a healthy environment for learners and educators including latrines, potable water and school feeding where necessary (Coombe, 2001c);
- They must be safe places, where there is zero tolerance for sexual abuse, harassment or abrogation of civil rights of any kind;
- They must be places where the human rights of all are guaranteed;
- They must be able to move beyond conventional teaching programmes and provide life and survival skills to children at relatively early ages;
- Educators must be able to identify children in trauma, handle them sensitively, provide basic counselling, and then know when to hand over to health, social services, homebased care or the police;
- They must have a youth peer health team professionally trained by local health and social workers; they must have ways of referring learners in confidence to accessible voluntary testing and counselling sites, and must make informed decisions about condom provision, accessibility and guidance on use;
- They must work vigorously with community authorities, parents, NGOs and FBOs (South Africa Department of Health, 2001); and
- They must have a rolling AIDS-response plan, with resources to implement it linked with the plans of health and community workers, and the homebased care system.

A common reason that HIV/AIDS-affected children drop out of school, or perform poorly, is lack of material resources to meet basic needs. If short-term crises can be avoided or managed, many orphans and other vulnerable children would be able to continue successfully with their schooling (South Africa Department of Health, 2001). In Botswana, teachers and schools have developed a

[6] Subbarao et al (2001); Hunter and Williamson (2000); Williamson (2000a and 2000b) for example.

range of responses to vulnerable children's needs, including recognition and referral of such children for grants and other support, providing supplies, monitoring orphan well-being, interacting with households and homebased care teams to reduce stress on children, helping with psychological needs and behaviour disturbance, and developing school HIV/AIDS plans. Government may have reduced the potential adverse affects of orphaning on learners by creating three complementary support programmes which together seem to keep many children in school, and help them perform adequately. The package is not a technically difficult one and includes (1) school feeding, (2) home based care, and (3) orphan registration and subsidy (Abt Associates, 2001).

Teachers Without Support: Meeting Their Needs. Many teachers work in dire conditions with little or no support. Teachers in high prevalence settings are caught between a rock and a hard place. They may be HIV positive themselves, and they may be ignorant about HIV/AIDS. Yet they are required to reach out to learners with compassion, advise and counselling.

Given this situation, it is essential that

- Every teacher understands the aetiology of HIV/AIDS, starting with a book in accessible language, graphically illustrated;
- Each teacher has upgrading in lifeskills curricula, and access to teaching materials;
- Selected serving teachers are trained in support techniques, and all teacher trainees are introduced to supportive skills in preservice programmes;
- Teachers have access to testing and counselling with regard to their own health, and to help them cope with the trauma of working those in difficulty;
- Heads of schools and teaching service managers are prepared to manage HIV/AIDS-related crises; and
- Educators in high prevalence areas have access to anti-retroviral therapy.

PROTECTING QUALITY: SUSTAINING EDUCATION PROVISION

CURRENT PRACTICE

Here is the core issue: the need to stabilise education provision and maintain quality. Education is big business. Government managers have nevertheless been slow to take action to maintain efficiency, sustain output, and reduce cost in the face of this pandemic.

Education sector 'strategic plans' vary in the way they recognise (if at all) the turbulence caused by HIV/AIDS. Botswana, Namibia and Zimbabwe are assessing the impact of HIV/AIDS on education, and Zambia has prepared its strategy as part of its SWAp. In Kenya, projections used for education planning take account of likely HIV/AIDS impact scenarios but are not factored into planning. In Uganda, though official projections incorporate assumptions about HIV/AIDS, planning projections in the ministry are based more on assumed intake and repetition rates than on projections of the size of the school age population and assumed enrolment ratios during a period when Uganda is moving strongly toward UPE goals (Abt Associates, 2001; World Bank, 2000a).

Evidence from both SADC and ECOWAS (Baku, 2001; Casley-Hayford, 2001) regions shows that current HIV and education strategic plans are characterised by concentration on curriculum interventions aimed at behaviour change. There is no evidence in the Sub-Saharan Africa region

of workplace policies in schools and offices,[8] codes of conduct, HIV monitoring protocols for the service, guidance on the rights and responsibilities of teachers, or management guidelines for senior managers. Current teaching service regulations need major review, as well as human resource management policies.

Finally and fatally, there is no observable attention being given to the managerial capacity, funding, human resources and infrastructural requirements that need to be in place to support practical strategic action in the sector (Association for the Development of Education in Africa, 2001). Ministries in high prevalence countries are failing consistently, in their planning and in their practice, to seek to sustain education quality and levels of provision.[9] Neither are they attempting to ensure that demand and supply are in qualitative and quantitative balance so that the level and quality of education provision is sustained through the future period of extreme dislocation. There is little research or expert analysis of complex cost factors, and no evidence of teacher training colleges or universities adjusting preservice and inservice models and curricula to meet teacher losses which can clearly be anticipated.

'BEST PRACTICE' ON PROTECTING QUALITY BY SUSTAINING PROVISION

Taking Advice from the Private Sector. Businesses that want to protect their profitability and viability recognise that HIV/AIDS is likely to claim some of the best leaders, managers and workers at all levels. The pandemic will create high levels of absenteeism, loss of productivity and high cost of training replacement workers thereby threatening survival and quality of businesses. They estimate indirect costs to business to include increased costs of recruiting and training staff given extra deaths and disabilities, costs of additional sick and compassionate leave, poor staff morale, extra costs to ensure occupational health and safety standards are adequate, prejudice among staff where some employees are HIV-positive, the need to maintain confidentiality for HIV-affected employees, management and labour meetings to discuss the AIDS crisis as it unfolds, the loss of profits due to the impact of the pandemic on clients/service users, and the diversion of management attention from strategic and operational issues.

Managers of large businesses assume that it is essential to invest in on-going damage-limitation programmes immediately, to save on both direct and indirect costs. 'The danger is that a company waits until the impact of AIDS becomes noticeable in their financial statements, then implements an AIDS intervention programme' (Moore and Kramer, 1999). And so, for big business, a holistic approach to AIDS would cover the following:

- projections of the impact of AIDS on the company (demographic profile and risk profile) by an experienced expert
- an actuarial analysis to quantify the direct costs of AIDS on current employee benefits, and to suggest more cost-effective benefit structures that meet the real needs of members
- customised managed care products for medical schemes which offer affordable treatment and access to medical practitioners, discounted suppliers and sound protocols
- effective AIDS intervention programmes that meet legal and confidentiality requirements, from experts in epidemiology, clinical medicine and human resources
- AIDS education programmes specifically tailored to convey the message about AIDS in a medium and using language that is culturally acceptable to the target audience

[8] The South African Department of Education has included workplace policy as one of the eight pillars of its HIV plan 2001-2002 (South Africa Department of Education, 2001c).
[9] Evidence from fieldwork in SADC and ECOWAS regions, in Asia and Pacific region.

- effective treatment of sexually transmitted diseases; human resource planning to manage the impact of HIV/AIDS on productivity, skills training and disability
- an effective communication strategy to gain the commitment of all significant role players
- understanding of how HIV/AIDS will impact on consumer markets, and the need to respond to meet the needs of people who are affected by HIV/AIDS
- counselling for employees who are HIV positive
- outreach programmes to assist in education communities in which the company works.

So far, these fundamentals have proved to be beyond the capacity of teaching service management in most countries – as well as many businesses. In order to stabilise education systems, it is essential now to ensure at the very least that the potential consequences of HIV and AIDS are factored into every education plan by national ministries and their partners as accurately and with as much integrity and attention to detail as possible.

Ultimately, by combining analysis with action it should be possible to provide for

- enough teachers to replace those leaving the service, especially those with scarce skills in university departments, teacher education, maths, science and technology,
- supply teachers to cover for those regularly ill and absent
- enough new teachers to keep expansion and quality up
- INSET support for those coping with trauma in the classroom
- replacement management skills lost to the system.

Assessing the Impact of HIV on the Education Sector. Impact assessments are necessary to identify the ramifications of HIV/AIDS for the service. Botswana, Namibia, South Africa, and Zimbabwe are assessing the impact of HIV/AIDS on education in order to understand the impact of HIV/AIDS on society and human resource development, as well as its internal impact on employees (education supply), and external impacts, focusing on learners and demographic shifts (education demand). Impact assessments provide the basis for understanding the social, economic, labour and planning implications of the pandemic for the sector, and to plan appropriate responses (South Africa Department of Education, 2000a).

Planning and Managing for Reality. It is no use undertaking impact assessments if there is no planning and management capacity to respond to and implement their recommendations. There must be a system for monitoring and reacting to skills shortages within the education service – from early childhood development programmes, through schools, up to universities and college, and through to the nonformal and private sectors. Policies and systems for reducing costs, improving efficiency and planning staff deployment and replacement must be in place. HIV/AIDS prevention training initiatives for professional and other staff are urgently required, as well as procedures to monitor HIV/AIDS rates and impacts on educators, in conjunction with government planning and manpower units (Coombe, 2001e).

Adjusting for Teacher Loss: Alternative Learning. The simple solution of expanding teacher training capacity will not solve the problem of teacher attrition, and institutions may well be left short of teachers, lecturers and trainers. Alternative measures include a more systematic and extensive use of multigrade teaching (provided this is backed up by the resources, training and supervision it requires); greater reliance on educational broadcasting; more use of community members for supervisory responsibilities and for actual teaching in areas where they have some expertise; greater use of untrained (or ‘para’-) teachers with a system in place for their ongoing

training on the job; transferring certain curriculum topics or areas to co-curricular activities that would be managed by senior students; and more extensive provision for peer education (with some teacher supervision and monitoring).

Community Backup: Harnessing and Supporting Local Resources. Community participation must be central to the response to HIV/AIDS. For education to combat HIV/AIDS and manage its impacts, it must also be proactive in establishing linkages with the communities being served. Education authorities and institutions must constantly explore with communities how best they can be of service to one another. In Zambia, one objective of the education sector HIV strategic plan is for all schools and colleges to participate in homebased care and other responses to AIDS-related community needs (Coombe and Kelly, 2001; Zambia Ministry of Education, 2001). Likewise in Botswana close links are emerging between learning institutions, local NGOs and faith-based organizations, and social and health workers (Abt Associates, 2001). In Thailand, the Sanga Metta project, with support from local and international agencies, supports a shift in the focus of work of some Buddhist monks and temples in the direction of social responsibility for those suffering from HIV and AIDS, including orphans who become novices, or are given education support. The programme is being extended in the region through Unicef's Buddhist Leadership Initiative (*Buddhist Approach*, 2001).

Women Power: Creating a Safe Environment. Possibilities for harnessing the energy of women in school, around the school, and on behalf of the school need to be elaborated, preferably within the context of existing government and agency gender programmes. Mothers in Uganda are known to have mobilised in informal ways to save their daughters from death by AIDS, and there is evidence that this is happening in South Africa. Mothers in Bangladesh teach their children in community schools; mothers in Ghana make sure their children have access to potable water and food at school; mothers in Dominica become community teachers for five years before they undertake 'initial' teacher training; mothers in the United Kingdom assist classroom teachers with special subjects or children with special learning needs. Mothers everywhere are the principal and most reliable guardians of their daughters' well-being.

SECTION 3
CONCLUSION

HIV/AIDS lurks in communities and families, in the most intimate, private moments of human relationships. It is a creature of culture and circumstances, local perceptions and behaviours, custom and religious belief. That means it is virtually impossible to generalise about good practice: what works to break the power of HIV/AIDS in one place may not work in another.

There are at least three ways to categorise good practice in the education sector, according to whether the intervention is aimed at

- containing the virus
- providing social support for affected educators and learners
- protecting education quality.

Radical, humanitarian interventions in these areas – tackling STDs, providing condoms, establishing home based care and school feeding schemes, and training peer health teams for all institutions for starters – can save lives in the short-term, while pilots are being tried,

governments are mobilising and allocating resources, the capacity of NGOs is strengthened, planning kicks in, and behaviour change programmes start up.

Global experience suggests there are a number of longer-term generic tools that can make a difference with regard to HIV and education, save lives, and protect education quality.

The first tool is *honesty*. It is essential to stop pretending progress is being made against AIDS. This is an overwhelming disaster and so far little has been done to confront it effectively. It is essential to analyse, diagnose, and then manage properly. It is absolutely essential to enhance crisis management capacity in and out of government, with appropriate senior executives, resources and mandates, and to design interventions appropriate to the management capacity of the sector. That probably means keeping them simple while strengthening the capacity of sector nongovernment partners.

Second, *working together*, making use of all available resources – and especially the skills of girls and women – is the best route to take. All poverty reduction plans must factor HIV/AIDS into their schema (it is not clear that this is being done) so that HIV/AIDS can be addressed within the context of poverty that drives it. Governments, though increasingly well-intentioned, are largely characterised by inertia. There are thousands of examples of good, very good and potentially good practice at community level, but these are generally on a small scale, ad hoc and underfunded. In theory governments are committed to cooperating with NGOs.

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

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

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

Third, it is only by *monitoring* the success of interventions, and evaluating whether they can be replicated or generalised that governments and agencies can be held accountable for taking effective action, against agreed performance benchmarks wherever possible. There is as yet no clear perception that the potential of HIV and AIDS to create havoc for education requires immediate intensive and extensive response throughout the education sector. But that is what is

required. The challenge of millions of AIDS orphans in several regions by 2010 may serve to concentrate a global sense of responsibility to learners and educators.

Finally, it is possible that HIV/AIDS is, for many countries, the most significant issue in education today, and probably the biggest challenge to development. The need to confront the pandemic responsibly will require a fundamental re-think of development principles and procedures, and the relationships between governments and their funding partners. HIV/AIDS is rooted in poverty, and until poverty is reduced, little progress will be made in limiting its transmission or coping with its consequences.

Carol Coombe
Pretoria
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APPENDIX 1 **SADC MINISTRY OF EDUCATIONS' RESPONSES TO HIV/AIDS 2001**	Y	S/P	N
CREATING A FOUNDATION FOR ACTION			
Combined approach: Is equal consideration given to (1) preventing spread of the disease and to (2) reducing the anticipated impact of the pandemic on education?	3	6	4
Leadership: Are political leaders, senior officials, unions, the teaching service, and school governing bodies knowledgeable and committed to action?	4	8	1
Collective dedication: Are partners outside government involved in the fight against HIV/AIDS? Do mechanisms exist for partnerships?	4	7	2
Research agenda: Is information about HIV/AIDS being collected, analysed, stored and spread? Is there an HIV/AIDS and education research agenda for the education sector?	2	3	8
Effective management: Has a full-time senior manager been appointed? Does a standing structure exist which includes partners in and out of government?	5	1	7
Policy and regulations: Are HIV/AIDS sector policies and regulations in place? Are there appropriate codes of conduct for teachers and learners, and are they applied rigorously?	1	4	8
Strategic plan: Is there an education sector HIV/AIDS strategic plan which covers all levels of the whole education sector, and is it funded?	2	5	6
Resource allocation: Are plans being funded adequately? Are funds being channelled to various levels of the system, and to partners outside government who can use them?	2	5	6
HELPING TO LIMIT THE SPREAD OF AIDS			
Appropriate curriculum in all learning institutions: Are learners being guided through the curriculum on safe sex and appropriate behaviours and attitudes?	2	5	6
Materials developed and distributed: Have materials suitable for learners in schools and post-school institutions been development and distributed to institutions? Are they up to date?	1	7	5
Serving educators prepared: Are school teachers adequately prepared through preservice and inservice to teach life skills curricula? Have they accepted this responsibility?	2	5	6
Teacher educators prepared: Have university, teacher training college and local teacher support staff been trained in HIV/AIDS issues and curriculum implementation?	0	3	10
Evaluation of curriculum and materials: Have materials and courses been evaluated in terms of content, implementation and outcomes?	1	1	11
Counselling for learners: Can pupils and students who are affected by AIDS find help from their teachers? Or from someone else?	0	2	11
Counselling for educators: Are teachers affected by AIDS, and those who are dealing with the trauma of children affected by AIDS getting help to cope?	0	1	12
Partnerships: Are other partners helping with prevention programmes?	0	9	4
MITIGATING THE IMPACT OF HIV AND AIDS ON THE EDUCATION SECTOR			
Assessment: Has an assessment been done of the likely impact of HIV/AIDS on the education sector in future?	4	2	7
Risk profile: Is there some understanding of the factors that make educators and learners vulnerable to infection?	0	5	8
Stabilising: Are steps being taken to sustain the quality of education provision and to replace teachers and managers lost to the system?	0	3	10
Projecting: Have relatively accurate projections been made of likely enrolments and teacher requirements at various levels of the system over the next five to ten years?	2	3	8
Social support: Are children affected and infected by the pandemic receiving counselling and care? Is there a culture of care in schools and institutions? Are human rights protected in learning institutions and education workplaces?	1	1	11
Responding creatively: Is the system trying to provide meaningful, relevant educational services to learners affected by HIV/AIDS, finding new times, places and techniques for learning and teaching?	0	0	13
Orphan needs: Is planning underway to understand and respond to the special needs of increasing numbers of orphaned and other vulnerable children?	1	5	7
All subsectors: Is attention being paid to the planning requirements of all education subsectors – from early childhood development through to university?	0	8	5

Y Yes, action in being taken
S/P Some action is being taken or is planned
N No action is being taken