# Deadly inertia

## A cross-country study of educational responses to HIV/AIDS

NOVEMBER 2005

GLOBAL CAMPAIGN FOR
EDUCATION

**Authors**

Tania Boler and Anne Jellema

Published in 2005 by The Global Campaign For Education, 5 Bld Du Roi Albert II. 1210 Brussels, Belgium



For citation purposes:

Boler, T. and A. Jellema (2005). Deadly inertia: A cross-country study of educational responses to HIV/AIDS. Brussels, Global Campaign for Education.

The Global Coalition on Women and AIDS

actionaid international

*FRONT COVER PHOTOGRAPH: ACTIONAID*

# Deadly inertia

## A cross-country study of educational responses to HIV/AIDS

CONTENTS

## ACRONYMS

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| ART | Anti-retroviral therapy |
| ARV | Anti-retroviral |
| CIDA | Canadian International Development Agency |
| CSO | Civil society organisations |
| EFA | Education for All |
| EI | Education International |
| EMIS | Education Management Information System |
| FBO | Faith-based organisation |
| GFATM | Global fund for AIDS, Tuberculosis, and Malaria |
| HBC | Home-based care |
| HEARD | Health Economics and AIDS Research |
| HIV | Human immunodeficiency virus |
| IATT | Inter-agency task team on HIV/AIDS and Education |
| IMF | International Monetary Fund |
| INGO | International NGO |
| MOEC | Ministry of Education and Culture (Tanzania) |
| NGO | Non-governmental organisation |
| OVC | Orphans and vulnerable children |
| SCF-US | Save the Children Fund – United States |
| SRH | Sexual reproductive health |
| STI | Sexually transmitted infection |
| UNESCO | United Nations Educational, Scientific and Cultural organisation |
| US | United States of America |
| VCT | Voluntary counselling and testing |
| WHO | World Health Organization |

## ACKNOWLEDGMENTS

GCE was funded by CIDA to carry out this work, in partnership with IIEP, UNESCO. Tania Boler (ActionAid) led the research project, with the assistance of Kate Carroll (ActionAid). Coordinating the national level work were Angelina Lunga, Jean Claude Fignole, Anne Marie Hadcroft, Branimir Torrico, Tito Lopez, Mr Brian Gilligan, Emmanuelle Abruix, Ramesh Joshi, Ms Suman, Justice Egware, Joe Makano, Sileye Gorbal Sy, Matarr Baldeh, Adelaide Sosseh Gaye, Assibi Napoe, Eulalie Nibizi, Mamadou Diallo, Lydia Aku Adajawah, Juliana Adu-Gyamfi, Kamilia Ibrahim Kuku, Nydeng Gordon, Mubark Ali Yagoub, Peter Modison Yugu, Elizabeth Baroudi, Bruna Siricio, Mahjoub M., Fred Mwesigye, Salome Anyoti, Blastus Mwizarubi, Njeri M. Kinyoho, Wambua Nzioka, Vincent Mwakima, Olad Farah, Otieno Aluoka, Emily Kioko-Echessa, Light Wilson Aganwo.

Thanks also to Wouter Van der Schaaf and Elie Jouen (Education International), Diego Postigo (Ayuda en Accion), Alexandra Draxler (UNESCO), Maysa Jalbout (CIDA), Dan Wilson (HEARD), Peter Badcock Walters (HEARD) Chris Desmond (HEARD) Otieno Aluoka, Emily Kioko-Echessa, Vincent Mwakima, Wambua Nzioka, Njeri M.

Comments were gratefully received from Sheila Aikman, David Archer, Elizabeth Baroudi, Don Bundy, Kate Carroll, Christopher Castle, David Clarke, Alexandra Draxler, Harinder Janjua and Jan Wijngaarden.

# Executive summary

The AIDS epidemic has become a global crisis – currently threatening the lives of around 38 million people and devastating entire societies. Education systems have a critical role to play in fighting this epidemic, because of their capacity to reach very large numbers of young people with life-saving information and skills. A complete primary education can halve the risk of HIV infection for young people; and in fact, basic education has such a powerful preventative effect, especially for young women, that it has been described as the 'social vaccine'. As the epidemic gathers pace, however, it poses increasing risks to education itself, threatening to stop children from enrolling, teachers from teaching and schools from functioning.

*PHOTOGRAPHS: LEFT: GIDEON MENDEL/CORBIS/ACTIONAID RIGHT: HOWARD LEWIS-BAKER ACTIONAID*

However, faced with these awesome challenges, the education sector appears to be paralysed. Few countries have mounted ambitious, nationwide efforts to mobilise all schools in the fight against AIDS. Our research, undertaken in 2004 in coordination with the first-ever UN Education Sector Global HIV/AIDS Readiness Survey, found that only two of the 18 countries reviewed had a coherent education-sector AIDS strategy that was actually being implemented. In other cases, strategic plans either did not yet exist, or they were largely ignored because they had been developed in isolation from other policy and budgetary processes.

Our research revealed that no action had been taken in 17 out of 18 countries to prevent the potential impact of teacher shortages, and governments were turning a blind eye to the educational needs of orphans and HIV positive children. In most cases, donor aid was not helping governments to address these problems more systematically. Rather, aid tended to be directed towards a series of stand-alone initiatives that enjoyed little ownership by government.

An effective educational vaccine demands, first, a fully funded plan to achieve universal primary education (UPE). A complete primary education is the threshold at which young people's risk of infection starts to fall significantly, and secondary education brings

GIDEON MENDEL/CORBIS/ACTIONAID

additional protective benefits. However, the protective benefits of education are being missed when one in two African children either fails to enrol in primary school at all, or drops out before finishing. In most of the countries studied, large numbers of the children most at risk of HIV infection – girls, working children, the very poor and children affected by conflict – are not in school at all, or drop out too early to benefit. These countries urgently need coordinated support from the international community, for example through an expanded Education for All Fast Track Initiative, to expand access to education and achieve UPE. Second, an effective AIDS response must include special measures to ensure that HIV/AIDS infected and affected learners are not left out. Unfortunately, although the plight of AIDS orphans has been highlighted internationally, the educational responses have been misguided, unsustainable and one-dimensional. The widespread practice of providing school bursaries is a temporary, quick-fix solution, which does not tackle the pressing need to remove user fees and reduce other costs of schooling. Furthermore, although school bursaries may reduce the financial barriers facing orphans and vulnerable children (OVCs), they do not address the pressing psycho-social needs of these highly vulnerable children.

Evidence shows that in many countries, children who are (or are suspected to be) HIV positive are being turned away at the school gate. Although civil society has a role to play in combating stigmatisation, only governments can guarantee and uphold the right of HIV positive children to attend school. In this responsibility – a responsibility to one of the most vulnerable and powerless groups in society – they are failing shamefully. Rather, efforts to keep HIV positive children in the classroom have been largely left up to individual teachers and school committees, who not only have to fund these efforts themselves but also have to battle the prejudices of the local community without any assistance or leadership from the Ministry of Education. Despite laudable initiatives by some schools, AIDS-related stigma and lack of resources more often than not mean that schools to give up on these children.

AIDS also poses a grave threat to the education workforce, yet policies to address workforce issues can only be described as abysmal. Teacher shortages, already severe in much of Africa and South Asia, are expected to worsen significantly in the wake of AIDS. However, most of the countries that we reviewed didn't have any plans in place for coping with AIDS-related staffing crises. The UN Global Readiness Survey found that only about 25% of high-prevalence countries have plans to train more teachers to cope with increased staff losses, and only about 10% have reviewed or amended their human resource policies in light of the AIDS challenge. Only one country of the 18 we reviewed was monitoring attrition rates and using this information to plan for the future.

Moreover, because teachers are perceived as children's guardians and role models, those with HIV have been particularly vilified; and with little prospect of confidential counselling and testing services or affordable access to treatment, they are afraid to disclose their status. Yet no country in our study had adequately put in place laws or procedures to protect teachers from AIDS-related discrimination.

Too much government and donor money is being spent on poorly designed interventions that go unimplemented because the most basic foundations – resources, ownership, training, even basic data – have

not been put in place first. In the absence of comprehensive, system-wide planning for HIV/AIDS, both donors and Ministries of Education have concentrated efforts on getting prevention messages and materials into the classroom. This is a highly visible intervention that can seemingly be implemented as a stand-alone project. In practice is impossible to teach children about HIV in classrooms that lack the essential ingredients for successful teaching and learning about any subject. In most of the 18 countries studied, classrooms were too overcrowded, management systems too under-resourced and teachers insufficiently trained to deliver HIV/AIDS messages effectively. Not surprisingly, implementation of HIV/AIDS education remains piecemeal. It fails in three key areas: materials, content and training. Insufficient quantities of materials are reaching schools, the realities of sexual transmission are not covered, and training to enable teachers to handle the new topics is woefully inadequate. In only three of the 18 countries had Ministries of Education made systematic attempts to train teachers about HIV and AIDS.

On all of these counts, the plans and policies of most of the 18 countries studied are shockingly inadequate. However, the blame cannot simply be passed onto national governments. The international donor community has also failed to deliver leadership and political commitment. Few donors are pledging the coordinated, large-scale assistance that would be needed to implement a programme of free and universal access to education in the face of HIV/AIDS – and few countries struggling with the economic and social impact of the epidemic can afford to finance such steps themselves. Finally, education non-governmental organisations (NGOs) are surprisingly under-informed about the epidemic. Their contributions have been patchy at best; at worst, some NGOs have used AIDS as a vehicle to promote ideological and religious messages of their own choosing.

But while the response to date is undoubtedly too little, it is not too late. By acting in concert now, donors, governments and civil society can give our young people a fighting chance to stay safe from AIDS. It is not too late to break the deadly inertia.

# Summary of key findings

## Responses by Ministries of Education

### Strategic responses

There was huge variation in the degree of strategic response to HIV/AIDS in education, although the type of response was remarkably similar across countries, perhaps revealing the donor-driven nature of the responses. In the Asian and Latin American countries, there was no policy response from Ministries of Education, firstly because HIV/AIDS was seen as the responsibility of Ministries of Health and secondly because HIV/AIDS was not deemed a serious problem. In Africa, Ministries of Education had made different levels of progress in developing and implementing an HIV/AIDS strategy.

Moreover, HIV/AIDS strategic plans, where they exist, are not being implemented because they have been developed in isolation from other policy and budgetary processes.

- HIV/AIDS units within Ministries of Education are not working. They tend to be isolated, under-resourced, and lacking in political power. Where this is the case they have not succeeded in getting Ministries of Education to take AIDS more seriously.
- Ministries of Education do not have access to the evidence base they need to formulate effective policies on HIV/AIDS.
- Ministries are not engaging systematically with civil society to design HIV/AIDS policies.

### Curricular responses

Ministries of Education have made most progress in the area of HIV/AIDS curriculum development, not, coincidentally an area that has also been popular with donors. Nearly all countries had developed an HIV/AIDS curriculum – often with the support of UNICEF or UNESCO. However, in almost all these cases, implementation was very limited. HIV/AIDS

material is not integrated into the general syllabus but is left on the margins, or is ignored all together. Implementation failure can be traced to the following problems:

- Civil society groups and teachers have not been involved in the design of HIV/AIDS curriculum, in most cases leading to a lack of ownership and a perception that the curriculum is 'donor-driven'.
- The majority of countries have not invested adequately in pre-service and in-service training to equip teachers to handle HIV/AIDS topics.
- Implementation of HIV/AIDS education, in most cases, has been slow and piecemeal, and insufficient quantities of HIV/AIDS learning materials are being distributed.
- Lessons tend to avoid open discussions around sexual health, and are further undermined by the failure to provide specific training and support to teachers so that they can handle the new subjects.
- HIV/AIDS education is often treated as a marginal and stand-alone topic instead of being reviewed and integrated through a general curriculum-development process. Since the general curriculum is already overloaded in most countries, this means that HIV/AIDS modules tend to be ignored or neglected.
- Many schools suffer from quality challenges and teacher shortages so severe that they make 'interactive' and 'participatory' approaches impossible.

### Responses to infected and affected learners and teachers

There was overriding consensus that Ministries of Education are not taking sufficient steps to ensure that HIV/AIDS infected and affected learners can stay in school.

- In the vast majority of countries, Ministries of Education had little understanding of the specific educational challenges facing OVCs.
- Although some OVCs have access to bursaries and/or free school meals, these tend to be localised interventions sponsored by NGOs, which can reach only a small proportion of OVCs.
- In the few countries where there was a national-level educational response, this was also restricted to providing bursaries to cover school fees. Existing bursary schemes were criticised for being piecemeal and under-resourced.
- None of the 18 countries studied had adequate laws, policies or procedures to prevent schools from discriminating against HIV positive children.
- Beyond financial needs, counselling to respond to the psycho-social needs of OVCs is rarely available.

It appears that the issue of HIV/AIDS-affected teachers has been ignored, partly because of the controversy it causes. In particular, because teachers have an important role in society as guardians and role models for children, the immorality associated with AIDS serves to vilify HIV positive teachers even more than other HIV positive people. The situation is further aggravated as the teachers are less likely to disclose their status because of the lack of confidential voluntary counselling and testing (VCT) services, and free or affordable access to anti-retrovirals (ARVs).

Ministries of Education are ill-prepared to deal with potential impact of HIV/AIDS on teachers.

- Ministries have failed to put laws, policies and procedures in place to prevent discrimination against HIV positive teachers.
- None of the countries in this study had adequate workplace polices on HIV/AIDS.
- Few governments are able to monitor teacher absenteeism and mortality, or have a plan to tackle AIDS-related teacher attrition.

## Responses by civil society

### Partnership

The relationship between civil society and Ministries of Education differs greatly across countries. In 17 of the 18 countries, there were some partnerships between NGOs and Ministries. However, there was concern that these partnerships were perceived as one-sided, in that the Ministries viewed NGOs with suspicion and only favoured partnerships with the larger and very much more powerful, international NGOs. In most cases, partnerships were informal and depended more upon individuals and 'personalities' rather than formal institutional cooperation.

Within the field of HIV/AIDS and education, some NGOs had been involved in designing the HIV/AIDS strategy paper, while others had been involved in curriculum design and data collection. Overall, civil society respondents complained at the lack of partnership and cooperation with HIV/AIDS and education, suggesting that they had a useful role to play in teacher training and curriculum design.

The study also found that there were very few partnerships between education and HIV/AIDS coalitions – in most cases, the GCE project offered the first opportunity for such collaboration. There is a need to strengthen the capacity of coalitions to develop their partnership work so that they can represent civil society organisations in linking to key policy-makers and also linking organisations together at the sub-regional level.

### Programmatic responses

NGOs have responded to HIV/AIDS in education in two key ways: providing HIV/AIDS education in schools, and giving direct and indirect support for children orphaned by AIDS. NGOs have been much slower to respond to the issue of teachers and HIV – and the little work that is being conducted is concentrating solely on HIV prevention.

Efforts are hindered by a number of issues.

- Many education-sector organisations still lack a rudimentary understanding of HIV/AIDS issues while many health-sector organisations pay little or no attention to the role of the education system in fighting the spread of AIDS.

- There is an overall lack of coordination, with little networking or partnership between teacher unions, education NGOs and HIV/AIDS networks. Few NGOs involved in running school-based programmes consult ministries when deciding which schools they should target, leading to extremely uneven coverage. Conflicting and multiple messages on HIV/AIDS are delivered when NGOs determine the contents of HIV/AIDS education according to their own ideology or religious beliefs.

- Finally, NGOs tend to tackle the immediate symptoms without considering the underlying causes, which means that some of their actions may be self-defeating in the long run. Many NGOs are involved in providing school bursaries, for example, but this could undermine wider popular demand for free and universal basic education. The creation of special schools for OVCs, another popular NGO response, may stigmatise children.

### Advocacy responses

GCE members have campaigned relentlessly to achieve Education For All. Three campaign areas in particular (abolition of user fees, girls' education and quality education) are strongly linked to the educational response to HIV/AIDS. Campaigning around HIV/AIDS should not create any contradiction to campaigning on Education for All, because the HIV/AIDS epidemic only serves to highlight the importance of free and quality education.

In terms of specific campaigns around HIV/AIDS, GCE members have been slow to respond. However, this project has already led to a number of important changes, including proposed campaign work on HIV/AIDS in eight of the participating countries. Obviously the areas of concern differ depending on the local context but there are common threads emerging around protecting the human rights of teachers and OVCs, as well as ensuring the right to information for all.

# Recommendations

It is clear that none of the initiatives summarised above is enough to deal with a deadly epidemic currently infecting more than 13,000 people each day. A larger, better-coordinated and more systematic response is urgently needed, and in order to achieve this, a number of key challenges must be addressed without delay:

**1** Ministries of Education should formulate a clear and costed strategic plan on HIV/AIDS, which is integrated into education-sector plans and national poverty-reduction strategies, and which is complemented by state and district level plans.

**2** Ministries of Education must clearly define the rights of HIV positive children in schools, as well as the rights of HIV positive education workers, and establish policies, regulations and procedures to prevent AIDS-related discrimination against learners and teachers. Workplace policies must be put in place to respond to the needs of HIV positive teachers. At the very least these should include access to confidential VCT services and affordable access to treatment.

**3** Greater effort must be made to understand the special educational needs of children affected by HIV/AIDS. The educational response must go beyond simply providing bursaries to include psycho-social support through existing counselling services in schools.

**4** Governments must put in place adequate monitoring systems for measuring the impact of the epidemic on education. In particular, education management information systems (EMIS) need to be strengthened in order to capture data on teacher absenteeism and mortality as a result of AIDS.

**5** High priority must be given to training teachers to teach about HIV/AIDS. Both in-service and pre-service teacher training should include compulsory HIV/AIDS components that are examinable or certifiable. Teachers and their unions must be involved in the design and roll-out of such programmes.

**6** HIV/AIDS should not be taught in isolation, but as part of a wider sexual and reproductive health framework. Curriculum development should be in partnership with civil society and, while being culturally appropriate, should be based on scientifically accurate information rather than being ideologically driven. Such curricula must be based in the reality of young people's lives and provide young people with realistic choices to protect themselves from HIV infection.

**7** Civil society organisations (CSOs) need to be more proactive and systematic in seeking to influence HIV/AIDS-related policies and plans of their government. Stronger linkages and alliances between teachers' unions, education groups and health groups (among others) would help to ensure a more effective and better-informed civil society input to policy discussions. CSOs can make important contributions to the design and implementation of school-based HIV education, but their efforts should be coordinated by the Ministry of Education to avoid duplication or contradiction. At the same time, however, CSOs have a responsibility to act as independent monitors of HIV/AIDS policies and spending at all levels, and to campaign for the educational rights of all vulnerable groups.

**8** In order for schools to play an effective role in fighting AIDS, all children, especially the poorest and most marginalised, must be able to go to school. Completion of primary education is the threshold level to unlock the preventative power of education, yet across Africa only 1 in 2 children ever finishes primary school, while large class sizes and under-trained teachers undermine learning. Basic education must be made free, universal and compulsory. Governments must abolish fees, build more schools and train more teachers, establish stipends and/or school meals to help keep children in school, and take additional necessary steps to ensure schools attract girls, orphans and other vulnerable children.

**9** Financing these measures will require immediate and major increases in aid and debt relief for affected countries. In the face of the wider economic and budgetary pressures, earlier donor estimates of countries' education-sector needs may need to be revised, and in particular, more money made available for recurrent costs such as payroll costs. While the potential to finance such measures through HIV/AIDS designated funding channels should be further explored (such as The Global Fund for AIDS, Tuberculosis and Malaria), it is urgent that the Fast Track Initiative (FTI) partnership expands to include more low-income countries and to offer coordinated and generous support for Ministries of Education to scale-up their response to AIDS.

# 1. Introduction and methodology

## 1.1 Background and rationale for the study

This report analyses responses to the HIV/AIDS crisis, both by Ministries of Education and civil society groups working on education, in 18 countries across Asia, Latin America and Africa.

As summarised in our 2004 report *Learning to Survive*, there is growing evidence that a general foundation in education promotes safe behaviour and is highly effective in protecting against HIV infection. *(see Box 1).* As AIDS continues its rapid spread across much of the developing world, it is imperative that education systems are ready to play their full role in fighting this devastating disease.

The action research underpinning this report was carried out in coordination with the first-ever UN Education Sector Global HIV/AIDS Readiness Report, a questionnaire-based exercise that collected information from 71 Ministries of Education. The UN survey's aims included:

- assessing each country's education system in terms of 'readiness' and response capacity
- analysing vulnerability and need in order to guide donor agency support
- establishing a benchmark for the annual updating of this information
- helping Education Ministries to assess their own preparedness and identify areas of concern or vulnerability.

Global Campaign for Education (GCE) discussions in late 2003 with the UN working group backing the survey revealed that no plans had been made to involve civil society in the exercise, either at national or at global levels. Although the time remaining to make an input to the Global Readiness Survey was by then extremely limited, we felt that our members at the national level could still provide valuable data to help triangulate and assess official responses from governments. We also hoped that through their involvement in the survey process, our members would gain knowledge and make links that would encourage them to increase their own advocacy efforts on AIDS and education in future.

With the backing of the UN Inter-Agency Task Team on HIV/AIDS and Education, and with funding from the Canadian International Development Agency (CIDA), we launched a rapid action research exercise in cooperation with our members – civil society education networks and teachers' unions – in the following 18 countries: Bolivia, Burundi, El Salvador, Gambia, Ghana, Haiti, India, Kenya, Mali, Nepal, Nigeria, Senegal, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

The objectives of the project included:

1. improving the accuracy and usefulness of the Global Readiness Survey by feeding civil society perspectives and experiences into the research process
2. enabling national civil society to engage government, media and others in serious dialogue on the policy issues raised in the report, in order to ensure that the findings of the Global Readiness Survey are not ignored by senior policy-makers in government
3. laying the foundations for ongoing civil society involvement in shaping AIDS and education policies by increasing AIDS awareness and concern among education NGOs and teachers' unions, and by linking these groups to civil society AIDS networks, Ministries of Education and donor agencies (specifically, members of the UN's Inter-Agency Task Team).

All 18 coalitions received a small amount of funding to hold a consultation, bringing together diverse civil society groups from the education and AIDS sectors to share and consolidate information and perspectives on existing educational responses to the AIDS crisis. All 18 were subsequently asked to complete a questionnaire developed by the GCE to parallel the UN questionnaire being distributed to ministries. Six of the participating coalitions received additional funding to carry out more detailed studies on particular issues highlighted in the Readiness Survey. The Appendix gives a more detailed description of the action research process.

This report attempts to synthesize learning from the 18 countries and in particular, to answer the following three questions:

1. What progress have Ministries of Education made in responding to the epidemic?
2. How have civil society organisations working on education responded to the epidemic?
3. How can the educational response to HIV/AIDS be strengthened and galvanised?

Although limited funding and time meant that we were not able to cover the role of donors as fully as we would have liked, the national reports did yield some useful insights on donor engagement and these have been mentioned where relevant.

It should be pointed out that both the UN survey and our research were carried out over a period of approximately three months in 2004, and therefore cannot capture how policies have changed over time. Some of the countries included in our study have taken significant steps forward since the research was completed. We hope, however, that the baseline assessment sketched in this report will be useful not only to policy-makers and civil society groups in the countries covered, but will also enable stakeholders in other countries to draw some useful lessons that might improve their own AIDS planning.

The report is split into four chapters. This first chapter describes why educators need to start taking HIV/AIDS seriously; the second gives an overview of national responses to HIV/AIDS; the third chapter discusses civil society responses to HIV and education, and the fourth covers partnerships between NGOs and Ministries of Education.

## 1.2 AIDS: Why it must be a priority for educators

The AIDS epidemic is fast becoming one of the most severe societal challenges facing education systems. The lives of millions of children and teachers have been permanently changed by the epidemic, in ways that constrain their ability to go to school, to stay in school and to learn or to teach (Ainsworth and Fimer 2002; Bennell, Hyde et al. 2002; Case, Paxman et al. 2003, Boler, 2004). Finding ways to meet these needs, to keep children in school and teachers teaching, is a pressing issue for the education community, as discussed in section 1.2.1 below. However, it is also a matter of urgent concern for society as a whole, even in countries where the prevalence rate is still low – because education is a necessary part of any HIV/AIDS-prevention campaign and pivotal in stemming the spread of the epidemic.

A sceptical civil servant in a developing country might point out that education systems are already struggling at the limits of their capacity, and hardly have the staff, the administrative capacity or the budgetary resources to take on yet another 'priority'. Why does HIV/AIDS deserve special attention?

There are three major reasons why educators must scale-up their collective response to the AIDS epidemic:

- First, without a medical vaccine, education is critically important as the most powerful 'social vaccine' against HIV infection.
- Second, without a systematic strategy for mitigating the impact of AIDS, the epidemic will undermine the provision of education, thereby denying children access to the quality learning they need to stay safe from HIV, and slowing or even reversing progress towards universal education.
- Third, the children who most need the protection and skills afforded by education – those affected or infected by the disease – will not be able to attend school unless their special needs are addressed.

GIDEON MENDEL/CORBIS/ACTIONAID

## 1.3 Education as the 'social vaccine'

Central to economic and social development for the nation as a whole, formal education is also often one of the only chances that individuals and families have of breaking the cycle of poverty. Recognising this, leaders of both developed and developing countries put universal basic education at the heart of the UN's Millennium Development Goals (MDGs) for halving world poverty. The MDGs call on rich and poor countries to cooperate to attain gender equality in primary and secondary school enrolments by 2005, and universal completion of primary education (usually abbreviated to 'Universal Primary Education' or UPE) by 2015. Within the MDG framework, education ministers and donor agencies have made further commitments to a more ambitious and holistic vision of 'Education for All' that includes not only UPE and gender equality, but also a 50% reduction in adult illiteracy by 2015, measurable quality improvements and an expansion in lifelong learning opportunities.

In the early years of the AIDS crisis there was a tendency to treat the epidemic as largely or entirely a medical problem. The debate on appropriate policy responses was dominated by scientists and doctors and focused mainly on issues surrounding treatment and palliative care. What prevention initiatives there were tended to be run by health departments.

However, as the epidemic continues its frighteningly rapid spread with no vaccine in sight, there has been growing recognition, first, that prevention is critical; and second, that prevention requires more than just transmitting accurate health information. The only effective way to prevent HIV is by helping people to change behaviours that put them at risk, such as age of sexual debut, number of sexual partners and use or non-use of condoms. These behaviours are usually embedded in deep social, economic and cultural patterns, so that billboard advertising or flyers distributed in health clinics may have little effect unless accompanied by other efforts.

The new emphasis on accompanying treatment with prevention has generated interest in the power of education as a complementary weapon against AIDS. School systems have a threefold role to play in fighting AIDS:

- Education protects individuals. Completion of at least a primary education is directly correlated with dramatic reductions in HIV infection rates, even if pupils are never exposed to any specific AIDS education or life skills programmes in the classroom. The reasons for this are not adequately researched, but a general foundation in education equips individuals with cognitive skills needed to understand, evaluate and apply health information. Education also boosts earning power, self-confidence and social status, giving young people and especially young women increased control over sexual choices. Girls who are in school are more likely to delay sex than their out-of-school peers. Finally, schooling is a sustained and powerful socialisation process, shaping values, identities and beliefs through daily exposure.

- Education informs individuals. Schools have the potential to be efficient and inexpensive vehicles for passing on HIV/AIDS information and promoting safe behaviour, because they reach the right target group (children and youth) at the right time (when their values, beliefs and sexual behaviours are still open to change), and reach them daily over a period of months and years (Kelly 2000).

Additionally, while young people do not necessarily learn about sex from their teachers, schools are viewed by young people as important and trusted places to learn about AIDS (Boler, Adoss et al. 2003).

- Education protects societies. Over the medium to long term, keeping education systems functioning is critically important to mitigate the loss of human capital as increasing numbers of adults die, taking their skills and knowledge with them. Many high-prevalence countries are already starting to experience shortages of nurses, teachers and other key workers.

There is therefore both a social and a moral imperative for schools to take some responsibility in teaching all children and young people about sexual reproductive health –both to encourage behaviour shifts that are in the interests of the whole society, and so that young people can have a chance to protect themselves from infection.

There is also a strong pedagogical rationale for including HIV/AIDS and sexual reproductive health in the curriculum. Educational theory dictates that education systems should be flexible enough to respond to the changing needs of their learners, including when necessary, a change in what is actually taught. Schools have a purpose and responsibility to prepare children and young people for adult life. Schools often teach technology, home economics, and sewing – the argument for teaching about HIV/AIDS surpasses them all.

## 1.4 Impact of HIV/AIDS on the supply of education

In order for schools to deliver the 'education vaccine' effectively and make the necessary impact on HIV's spread, governments first have to be able to get all children, girls as well as boys, into the classroom and keep them there long enough to acquire basic analytical and literacy skills – usually said to require five to six years of education, or a full cycle of primary schooling. This would be accomplished if all countries implemented the promise they made in 2000 to achieve universal completion of primary education (UPE) by 2015, which requires steps to expand supply (building more schools and training more teachers) as well as to unlock demand (abolishing school fees, enforcing laws against child labour, ending early marriage).

**Box 1 Learning to survive**

Recent studies indicate that young people with little or no education may be 2.2 times more likely to contract HIV as those who have completed primary education. This implies that, while those without a complete primary education represent around 36 per cent of young adults in low-income countries, they are likely to experience around 55 per cent of new HIV cases for that age group.

Without universal primary education (UPE), we can expect 1.3 million young adults who lack primary education to become infected every year – a substantial proportion of the predicted five million new infections annually. However, if everyone received a full primary education, we would expect over 700,000 of these cases (about 30 per cent of all new infections in this age group) to be prevented each year. Keeping these 700,000 young people safe from HIV would in turn prevent them from infecting others, and educated young people also play an important role in spreading safe sex messages and practices among their peers; so the ultimate effect on prevalence rates would be even greater than these estimates suggest.

*Source: GCE 2004*

*ICIAR DE LA PÈNA/AYUDA EN ACCIÓN*

Unfortunately, progress towards UPE – already too slow to achieve the 2015 goal – is further threatened by the spread of AIDS, and especially by its impact on the teaching force. Sub-Saharan Africa is already facing a serious teacher shortage and AIDS-related sickness and mortality is exacerbating this problem. In fact, early during the epidemic it was reported that teachers were actually more at risk of HIV than the

general population because of their relatively high socio-economic status and a general lack of understanding about how the virus was spreading. (Kelly 2000). This trend appears to have changed, especially where mature epidemics exist, with increasing evidence that the more educated people are, the better able they are to change their behaviour. Indeed, some evidence suggests that teachers may now be changing their behaviour faster than the general population making them relatively low risk to HIV (Bennell, Hyde et al. 2002; Boler 2004).

Nevertheless, even if teachers, administrators and other education workers face infection rates no greater than those affecting the rest of the population, in medium- and high-prevalence countries this is enough to cause serious problems in the supply and quality of education.

Long before an HIV positive teacher dies, she is likely to be ill, and therefore absent from school, for substantial periods, leading to teacher shortages or classes being taught jointly. A lack of HIV-related

**Box 2 Quantifying impact of AIDS on teachers** *(extract from Boler, 2004)*

A significant number of methodological limitations exist in current approaches to quantifying the impact of HIV/AIDS on teachers and teaching. Not only is the data, in most cases, unreliable, but it is also limited unless placed in context. It is clear that the impact will be felt differently in different contexts: depending on how mature the epidemic is and what wider educational reforms and policies exist to mediate impact.

The clearest quantifiable impact of HIV/AIDS on teachers is the level of in-service mortality. Actual and past impacts have been measured mostly through school-based surveys, and educational personnel records. The second key area of quantitative research has been around HIV prevalence for teachers; the data in this case relies mostly on projections and some limited population-based studies.

**Personnel systems and EMIS (Education Management Information Systems)**

Well-functioning personnel systems and EMIS offer consistent, sustainable and simple ways to examine teacher mortality. These systems need to be strengthened in a number of resource-poor countries – not merely to further our understanding of the impact of HIV/AIDS, but more crucially, to better the capacity to monitor and respond to changes in the education sector. From a wider management perspective, EMIS human-resource related data could be integrated with personnel, e.g. payroll systems, to allow for a more rigorous assessment of quality and completeness of data.

**Seroprevalence studies**

Large-scale and representative seroprevalence studies are an important way to quantify the actual and likely impact of HIV/AIDS on teachers. This type of study should be encouraged in the school-place and testing should ideally also include a CD4 count so that progression of the virus can be monitored. Although testing is anonymous, it is vital that VCT services are available for teachers and that testing should, more broadly, be part of an initiative to respond to the needs of infected staff.

**Modelling**

Projections are our main tool to understand, and plan for, the future impact of HIV/AIDS on teachers. However, given the paucity of robust input data, projections must be contextualised as much as possible and should offer scenarios which reflect the subtleties described earlier. This level of sophistication requires the work of experienced modellers.

Finally, projections must be frequently validated, and revisited with epidemiological, demographic and risk behaviour data.

In attempting to quantify the impact of HIV/AIDS on teacher mortality, it is paramount to bear in mind that impact will differ between districts, and even between schools and years. Teachers are not a homogenous group and data should therefore be disaggregated as much as possible. It follows that impact management must – at the very least – be country specific, and target different sub-groups of teachers in different ways.

workplace polices compounds the problem as there often is no sick pay, no access to treatment and inadequate teacher replacement policies (Coombe 2000; Badcock-Walters, Desmond et al. 2003). AIDS mortality also substantially increases the education wage bill, as attrition costs are high and death benefits soar.

## 1.5 Special educational needs of children infected or affected by AIDS

There are an estimated six million people in developing countries in urgent need of, but unable to access, anti-retroviral drugs (WHO 2004). Hence, for the majority of HIV positive people, the virus inevitably leads to death, preceded by chronic illness (Coombe 2000; Kelly 2000; Cohen 2002). In sub-Saharan Africa, the main mode of transmission of HIV is through sexual intercourse (UNAIDS 2002). Consequently, those who are dying are adults during the most productive part of the human life cycle (both in terms of procreation and economically).

'Impact of HIV/AIDS' refers to the consequences of this pattern of increased chronic illness and death (Barnett and Whiteside 2002). Each person – as an individual in society – is embedded in a network of family, peers, communities and society. As a person becomes ill and dies, there are important consequences (impact) for their family – particularly for any dependents such as children or grandparents. When enough individuals become infected with HIV, the consequences begin to affect whole communities.

Some researchers argue that the impact of HIV/AIDS is first felt as an immediate and severe shock (short-term impact); and later by more complex, gradual and long-term changes (long-term impact) (Whiteside 1998; Barnett and Whiteside 2002). For instance, when a parent dies, a child might have to move house – a sharp and perceptible consequence. A few years later, that child might drop out of school because of emotional stress and poverty – both of which were indirectly triggered by their parent dying.

In most cases, children are first affected directly by the consequences of HIV/AIDS when an adult member of their family becomes ill through a weakened immune system, yet very little is known about the impact of parental illness on the well-being of children. The limited research which does exist suggests that parental illness triggers a role reversal in which children – particularly girls – begin to care for sick adults and take on income-generating activities (Morgan 2000; Patel 2000; Ainsworth, Beegle *et al.* 2002).

Upon the death of a parent, the extended family traditionally takes responsibility for the welfare of the orphans (Foster 1997). Given the rise in the number of orphans, it appears that these coping systems are overstretched and are no longer coping (Nyambedha, Wandibba et al. 2003). In many cases, orphans are being cared for by grandparents (Foster 1997; Ntozi and Nakamany 1999; Bicego, Rutstein *et al.* 2003), or looking after themselves – evidenced by the increase in the number of child-headed households (Sengendo and Nambi 1997; Gregson, Waddell *et al.* 2001).

## 1.6 Mapping the impact of AIDS on children's education: challenges for policy-makers

When enough people have been affected by HIV/AIDS, whole societies begin to feel the consequences (Whiteside 2000). Governments are becoming increasingly aware that the very institutions holding society together, such as health and education systems and industry, are under threat.

However, it has been difficult for policy-makers to anticipate or head off these threats, as empirical understanding of the wider societal impacts of HIV/AIDS is still weak (Barnett and Whiteside 2002; Bennell, Hyde *et al.* 2002). This is as true in the education sector as anywhere else.

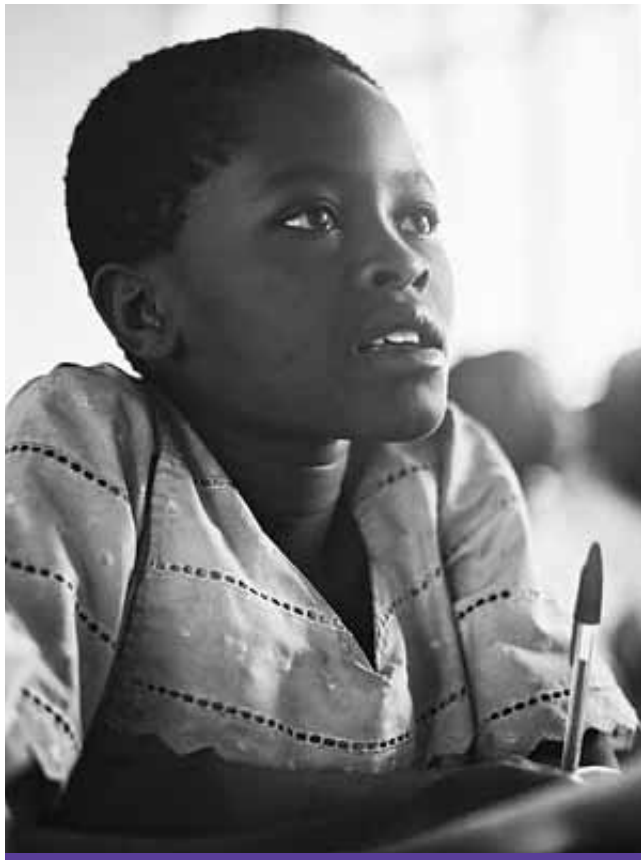
One possible reason is that in developing countries, many institutions are already under considerable stress, making it hard to disentangle the specific impacts of AIDS from other deep-seated structural problems (Badcock-Walters, Desmond *et al.* 2003). Moreover, as the chain of causation moves from the

individual and household to higher-level institutions, it becomes more complex – with many more intervening factors coming into play – and less well understood.

In the education sector, understanding has been further limited by the fact that most research on AIDS impacts has focussed on only one specific sub-group of affected children (orphans), and one specific sub-category of education indicators (enrolment) (Bank 2002). Unfortunately, this does not provide a very strong basis for policy formulation. It tends to encourage an overly simplistic approach that identifies drop out as the main impact and orphanhood (the death of one or both parents) as the main cause. In reality, AIDS-related educational disadvantage is far more complex.

While the evidence does confirm that educational disadvantage is faced by children whose parents have died, it is not known how much of this disadvantage took place before the parent died (Boler and Carroll 2004). Current knowledge certainly does suggest that when parents die, the amount of resources available for education decreases, and hence, orphans are more likely to drop out of school than non-orphans, as school fees and other education costs become unaffordable. There is a dearth of data, however, on the educational problems faced by children whose parents are ill with AIDS. It is also obvious that parental death is not the only factor affecting how well a child does at school. Anecdotal evidence also suggests that AIDS-affected households often have to call on children to work, and that AIDS-related stigma in the classroom also causes children to drop out of school.

Furthermore, research and monitoring of AIDS impacts is often restricted to enrolment indicators. Although enrolment is important, it is obvious that it does not capture all dimensions of educational disadvantage. A child may be enrolled at school but not learning because she is hungry; or else not able to concentrate because of anxiety at home, or missing classes to look after her family. Beyond increasing enrolments, policies should aim to improve retention and completion rates and learning achievement among orphans and vulnerable children (OVCs)[1]. Again, this requires tools to monitor, and measures to address, the ways in which the impact of HIV/AIDS on learning outcomes is mediated by factors such as gender, race, socio-economic status, physical ability or ethnicity.



*KATE HOLT/EYEVINE/ACTIONAID*

The educational needs of children born with HIV have also been widely ignored, possibly because they are seen as children without a future – and education is an investment for the future. This notion, always dubious from an ethical standpoint, also looks increasingly short-sighted with the increasing availability of ARVs and the consequently rising number of HIV positive children who are now reaching adulthood.

In short, current research is not providing policy-makers with enough data to identify with any degree of precision which children are at risk of becoming educationally disadvantaged, when, why and how to reach them. Policy-makers also need more information about how intervening factors (such as gender,

[1] *The term Orphans and Vulnerable Children, (OVC) has been coined in light of the high number of children affected by the AIDS epidemic, and refers to the wide spectrum of children and young people who are have been affected in one way or another by the AIDS epidemic.*

## Spectrum of educational needs faced by orphans and vulnerable children

| Consquences for Education | OVCs Issues | Education Response |
|---|---|---|
| • Low educational expectations of orphans<br>• Lower prioritisation of orphans' education over other children within the household<br>• Lack of homework support or household encouragement of education | LACK OF FAMILY SUPPORT | • Increase school-home liaison to work with families on increasing support to education<br>• Create after-school homework clubs to provide additional support to those without families<br>• Create mentor schemes in which vulnerable children have a mentor to provide emotional and intellectual support to their studies |
| • Low attention<br>• Absenteeism<br>• Difficulty in participating in certain school activities (e.g. sports) | CHRONIC ILLNESS | • Take special consideration with respect of each school activity to ensure that less physically able children are included<br>• Train all staff in first aid<br>• Resource person within the school with knowledge of local healthcare providers |
| • Drop out of education due to unaffordable schools fees<br>• Stigmatised because of inadequate uniform and learning materials<br>• Low attention span due to hunger | POVERTY | • Abolish school fees or provide bursaries for poor children<br>• School feeding schemes<br>• Change polices around uniforms and learning materials |
| • Social exclusion: marginalisation of children affected by HIV/AIDS<br>• Negative learning environment<br>• Barriers to participation | STIGMA | • Create inclusive school policies and practices<br>• Eliminate discrimination in education and care services<br>• Pressurise authorities to recognise rights and allocate funds<br>• Encourage all learners and educators to adopt inclusivity and zero tolerance towards discrimination<br>• Education of community and parents to combat AIDS-related stigma |
| • Low expectations of children<br>• Fear of infection by learners and educators<br>• Difficulties in adhering to ARV treatments due to lack of understanding | HIV POSITIVE | • Train teachers and learners around infection, to reduce stigmatisation and ensure that necessary safety precautions are available<br>• Foster policies, practices and cultures on inclusive education |

*Extract from 'Addressing the Educational needs of Orphans and Vulnerable Children', Boler and Carol, 2004)*

poverty, family size and family educational background) influence the ways in which AIDS affects children.

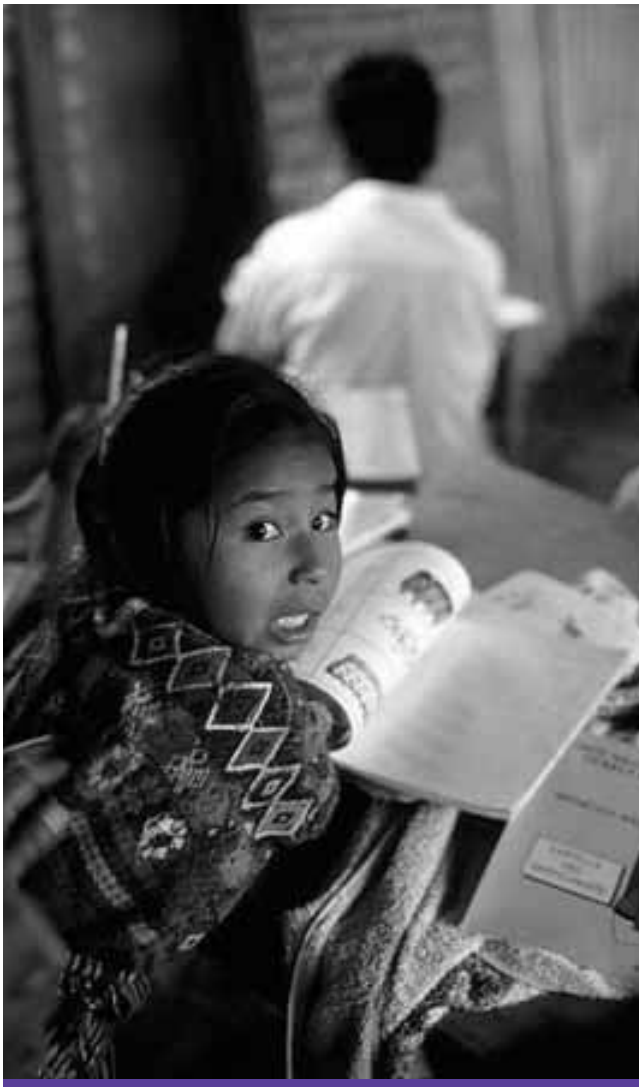
It is clear that OVCs face multiple disadvantages in their lives, which are reflected in their educational needs. One useful way to think about these needs has been developed by a group of academics and development workers in the UK, who identify the major problems facing OVCs and the corresponding policy measures that could be considered (Boler and Carroll 2004).

## Summary

This section argued the case for why formal education systems must start thinking and acting upon AIDS.

HIV/AIDS has changed the demands on all education systems. There is an urgent need for policy-makers, administrators and head teachers to identify and understand the needs of infected and affected learners and educators, and to meet as many of these needs as they can with the resources that they can mobilise. In addition, schools face an additional and vital responsibility to teach all pupils about HIV.

However, it is far from clear that education systems are taking the epidemic seriously. The next chapter assesses the formal education sector response in the 18 countries studied, and attempts to draw some lessons for future policy-making and planning.



*ACTIONAID*

# 2. National responses to HIV/AIDS and education

In only two of the 18 countries included in this action research did the Ministry of Education have a clearly formulated strategic plan on HIV/AIDS that was actually being implemented, either as part of a wider sector plan, or as an add-on to such a sector framework. In the remaining 16 countries, the MoE's policy response can be characterised as a) having no systematic planning at all, b) having plans that existed in draft form only, or c) plans that have been finalised but not yet translated into budgets and implementation. Section 2.1 of this chapter gives a more detailed assessment of country policies, and reviews some of the reasons for weak and ineffective MoE responses to the epidemic.

Programmatic responses by NGOs can broadly be split into two main categories. The first is providing HIV/AIDS education in schools and the second is providing ad hoc care (including bursaries) for OVCs. Both these approaches have been problematic and their limitations are discussed in this chapter.

## 2.1 Overall policy and planning

Ministries of Education are responsible for the formulation, implementation and monitoring of educational policies. Any systematic response to the AIDS epidemic should be manifested in policy changes, with such changes guided by an overarching strategy. This section gives an overview of policies and structures that have been created in response to HIV/AIDS.

Whether or not a Ministry of Education has an HIV/AIDS strategic plan is a clear indicator of the response to the epidemic, and is one of the key indicators used in the Global Readiness Report. Civil society perspectives suggest that in a number of Asian and Latin American countries, there has been no strategic response.

Of the African countries, many policies are still in draft form or have not resulted in significant policy change. However, in at least two African countries, strategic plans are clearly formulated and being implemented.

Generalising across regions, the policy response can be categorized as a) zero policy response or b) a plan but no policy.

### 2.1.1 Zero policy response

Of the participating countries, the four countries outside of sub-Saharan Africa (India, Nepal, Bolivia and El Salvador) show many commonalities in their lack of educational response, as demonstrated by the absence of a strategic plan.

In trying to understand why there has been no official strategic or policy response in these countries, civil society representatives pointed to two key factors. The first was that HIV/AIDS was perceived as the responsibility of the Ministry of Health, and not pertaining to educators:

> "Policies on HIV in mainstream education are still managed by the Ministry of Health from a specific health sector point of view."
>
> *Bolivian respondent*

The second common thread, in these Asian and Latin American countries, was the general perception that HIV/AIDS was not a problem:

"There is no policy or focal person for HIV/AIDS. This is because the government doesn't want to think about AIDS, claiming it is not a problem."

*Asian respondent*

"There are no policies on HIV in the education sector because the population at large still believes that the transmission of HIV is restricted to "high risk" groups"

*Bolivian respondent*

Although these countries are facing a much smaller HIV/AIDS problem than their African counterparts, this is also the time to act pre-emptively. Paramount to preventing an advanced AIDS epidemic is education – and thus, the lack of any guidance or polices on HIV/AIDS from the Ministries of Education is cause for concern.

### 2.1.2 A plan but no policy change

In four of the African countries[2], a strategic plan has been drafted but not yet finalised. The process of drafting and adopting a strategic plan is arduous – in Ghana the draft is still being revised after two years, and in Kenya the process has stalled while the Cabinet considers the plan. Of the participating countries, Tanzania was the only country to have finalised and started implementing its HIV/AIDS strategic plan.

However, having a strategic plan in place does not necessarily lead to policy changes:

"There is a strategy but in fact the government is lagging behind and the policies are not yet in place."

*Southern African respondent*

Indeed, one of the criticisms from the majority of countries was that HIV/AIDS is treated as a stand-alone issue within the Ministry of Education. Therefore, the existence of a strategic plan was limited because HIV/AIDS was not mainstreamed into the overarching educational plans, such as Education for All or the poverty reduction strategy processes. Without feeding into mainstream educational policy changes, an HIV/AIDS strategic plan becomes redundant, and impossible to implement.

This is not the case in all countries, for example, in Mali there are two national educational plans (PRODEC and EPT), and both of them address HIV/AIDS.

### 2.1.3 Data collection

It is almost impossible to design effective policies and plans without adequate data. However, Ministries of Education have struggled to collect good quality educational data (Carr-Hill, Hopkins et al. 1999). Often, there is close to no capacity or resources at the district or provincial level even to begin to collect the data needed for education indicators. Progress is worse with respect to HIV/AIDS indicators: very few countries reported any ministry-led research into HIV/AIDS and education. A couple of countries, Zimbabwe and Kenya, reported collection of some data for HIV/AIDS-sensitive indicators (e.g. number of orphaned learners or teacher mortality); but even in these cases, there was concern that data for many possible indicators was not being collected.

In some countries, HIV/AIDS-related research had been conducted by Ministries of Health, with little feedback to Ministries of Education (e.g. Mali and Bolivia). In other countries, research had been conducted by universities with little synthesis with – or impact on – Ministries of Education. At the worst end of the scale, some countries (particularly the non-African countries) reported absolutely no data on education and HIV/AIDS.

## 2.2 HIV/AIDS-related structures within the Ministry of Education

### 2.2.1 HIV/AIDS units

As a way to encourage Ministries of Education to take more responsibility for HIV/AIDS, the donor community has supported the creation of HIV/AIDS-related structures within the ministry, and the employment of a designated person to coordinate work on HIV/AIDS.

In most of the African countries, an HIV/AIDS coordinator is operating within the Ministry of Education. Their role is remarkably consistent across the countries – perhaps reflecting the influence of donor models.

[2] *Kenya, Zambia, Sudan and Ghana*

The role of the HIV/AIDS coordinator includes the following:

- coordinating HIV/AIDS work between Ministries of Education and Health
- policy formulation and implementation of school-based HIV/AIDS education
- coordinating district-level responses
- facilitating funding.

In some of the countries, there was concern that the HIV/AIDS unit (or coordinator) was initiated and wholly funded by donors, thus leading to sustainability problems. The following quotation clearly demonstrates this point:

"Funding of the focal person in many cases relies on donors and this means that when restructuring occurs again, the focal person is left out of the planning process and unsure of what role they should play."

*West African respondent*

Civil society organisations also felt one reason that HIV/AIDS units tended to be ineffective was that they were perceived as 'donor-driven, leading to a lack of ownership and political clout within the Ministry. However, the HIV/AIDS-unit model seems to suffer from other structural weaknesses as well *(see Box 3)*.
In several countries, there is more than one HIV/AIDS unit within the Ministry (e.g. Mali and Zambia). In El Salvador, HIV/AIDS has been subsumed by the 'Education for Life' unit. However, in the majority of cases, the HIV/AIDS unit consists of one individual, taking responsibility for all HIV/AIDS work. Having one designated individual taking responsibility for HIV/AIDS may hinder effective mainstreaming of HIV/AIDS by relieving other senior leaders and other departments of their responsibility to respond to the epidemic:

"The primary phase was not reviewed and no further action has evolved whilst the AIDS coordinating unit within the Ministry of Education tended to operate more and more in isolation and ended up becoming a stand-alone project within the Ministry".

*East African respondent*

### 2.2.2 Lack of effective decentralisation

Another problem faced by national HIV/AIDS coordinators is that, in most cases, the response has not been adequately decentralised. For instance in Kenya, civil society representatives were concerned that there was only one person working on HIV/AIDS at the national level, with no structures or support at provisional or district levels. In contrast, both Ghana and Zambia have made impressive progress in providing provincial, district and school level HIV/AIDS focal persons, although sustainability and resource

**Box 3 Common problems faced by HIV/AIDS unit/coordinater**

- Understaffed
- Not in control of their own budget
- No specific infrastructure
- No provincial, district or school structures
- Not integrated within the Ministry of Education
- HIV perceived as responsibility of coordinator, and not of all Ministry employees
- HIV strategic plans and activities are isolated activities rather than mainstreamed
- Difficulties in working with other Ministries (e.g. logistical or ownership)
- Dependent on personality and motivation of specific individuals

*LIBA TAYLOR/ACTIONAID*

problems in Zambia have led the government to consider HIV/AIDS committees rather than focal persons at the district level.

Decentralisation is not, however, a magic bullet solution, and can create structural problems of its own, as the India case illustrates. Responsibility for education is shared between India's many states and its central government, so it is essential to establish state and district level structures to implement HIV/AIDS programmes in schools. However, central government has limited power to ensure that its guidelines and programmes are actually implemented. The challenges are even greater when responsibility for implementation is shared between more than one ministry or department.

## 2.3 HIV/AIDS education in the classroom

Creating HIV/AIDS curriculum is the intervention that has received the most universal support from Ministries of Education and from donors. Of the 18 participating countries, 16 reported having developed an HIV/AIDS curriculum (Sudan and Zimbabwe being the exceptions). However, the level of implementation was far lower, with only two of the countries reporting that an AIDS curriculum was being fully implemented in the majority of schools country-wide.

In a further three countries, according to interviews with stakeholders, HIV/AIDS modules had been implemented into the curriculum in certain districts, with plans to scale-up to all districts in due course (e.g. Mali, Tanzania). The rationale for introducing the curriculum incrementally is to ensure that teachers are trained adequately before expecting them to teach new curriculum. By contrast, in Kenya the approach has been to get HIV/AIDS education out to as many schools as possible, with training to follow.

In countries such as Bolivia and El Salvador, where there is no nationally endorsed HIV/AIDS curriculum, some district education authorities and schools have taken the initiative to teach HIV/AIDS *(see section 3.1).*

**Box 4 India, decentralisation and HIV/AIDS education**

The National Coalition for Education (NCE) interviewed a number of national and state level education officials to find out how state and national level politics interact. NCE found that at the national level, a huge amount of effort has been invested in HIV/AIDS curriculum and training packages. Admirably, these efforts have involved close partnership between the health and education bodies.

While responsibility for implementing the HIV/AIDS curriculum rested with state level AIDS structures, situated within the health department, it was the state level education departments that ultimately decided whether or not to use the materials in their schools. The result was that only the minority of states that already have well-developed epidemics (Maharashtra, Tamil Nadu, Karnataka and Andhra Pradesh) decided to use the materials.

In the remaining states, officials did not cite any specific objections to the HIV/AIDS curriculum; rather, they evidently assumed that HIV/AIDS education is an unnecessary bother as long as the prevalence rate is low. In fact, of course, the opposite is true: prevention and education efforts are crucially important in the earliest stages of an AIDS epidemic, when it is still possible to "nip it in the bud". Lack of understanding of this vital fact suggests that state-level education officials have not received much information or training about HIV/AIDS.

A decentralised system also presents challenges for civil society advocacy. The NCE wants every child, regardless of where in India she or he lives, to have the right to learn about HIV/AIDS. One option that NCE has explored is to take the government to court in order to make HIV/AIDS legally required learning in all schools in India. However, the NCE hopes that by working more closely with state departments of education, sensitising them to the importance of early prevention, civil society will be able to increase the implementation rate more quickly and effectively than through a court case.

**Box 5 Tanzania's attempts to introduce school-based HIV/AIDS education**

In 2002, the Ministry of Education and Culture (MOEC) developed the school-based HIV/AIDS education programme. A holistic approach has been taken with four components:

1. life skills
2. school guardians – counselling to pupils on growing up, sexual reproductive health etc
3. peer education – peer educators trained in each class
4. school counselling and education committee – a sub-committee of school board

In terms of implementation, the MOEC is still trying to incorporate this program into carrier subjects. Some components are taken as curriculum subjects and others as extra-curricular.

Preliminary analysis suggests that in 2004, this programme was being implemented in 45 districts, reaching 7% of primary school pupils, 30% secondary and 50% of teacher training colleges. In addition, 12% of primary school teachers, 20% secondary school teachers and 25% of tutors in teachers colleges[3] had been trained.

Although many schools are still not implementing HIV/AIDS education, the government's attempts at providing HIV/AIDS education for all are commendable.

In exploring the reasons for this large-scale implementation failure, we found five common factors:

- poor design and failure to include key stakeholders (including teachers themselves) in the design process
- failure to integrate HIV/AIDS curriculum into the compulsory and examinable general curriculum
- inadequate training of teachers
- lack of appropriate, local-language learning materials, especially in rural areas.

### 2.3.1 HIV/AIDS curriculum design

HIV/AIDS curriculum can be categorised as taking either a scientific approach or a life-skills approach. Within the scientific approach (e.g. India), students are taught about HIV in science lessons such as biology, and are taught about the structure of the virus – usually without any discussion of sexual relations or sexual attitudes (Smith, Kippax et al. 2000; Bennell, Hyde et al. 2002; Boler, Adoss et al. 2003). On the one hand, this can be seen as an advantage, given that in many societies formidable cultural and religious barriers make it next to impossible for teachers to discuss sex in the classroom unless they receive extra training and support. However, since sexual transmission of HIV is the main cause of infection around the world, prevention education that ignores sex is certainly of limited use. Moreover, many experts feel that the scientific approach serves to 'dehumanise' HIV, making it difficult for students to connect with HIV as a real human issue that could affect them (Boler, Adoss *et al.* 2003).

The life-skills approach (typified by Kenya and Zambia, among the countries in our study) is based on the assumption that young people are somehow 'lacking' certain skills to prevent HIV, which they can be taught. However, such skills-based lessons are difficult to implement in the classroom because teachers are suddenly expected to teach in an "interactive" and "participatory" ways without adequate training and support (Boler and Aggleton, 2005).

In addition, if life-skills programmes are designed without first-hand involvement of teachers, children and community members, they tend to be heavily influenced by the middle-class and the somewhat 'westernised' values of NGO workers, education consultants and ministry bureaucrats. For example, the notion that individuals can take control and change their lives, often central to life-skills

[3] *These figures were given by government officials as part of the GCE project.*

programmes, may seem at best irrelevant to a young person growing up in an impoverished community where the ties of tradition, kinship and social interdependence are crucial to survival. At worst, the strong emphasis placed on individual responsibility and self-reliance may worsen children's feelings of failure and inadequacy.

With the exception of India, all countries with an HIV/AIDS curriculum had curriculum designed for both primary and secondary schools. In many cases, Ministries of Education appear to have received substantial technical support from UNICEF and UNESCO in developing such curriculum. Mali offers a good example of a multisectoral response: the HIV/AIDS curriculum was designed jointly by the Ministry of Education and Ministry of Health. In some countries, civil society input was also sought in curriculum design *(see 3.2).*

### 2.3.2 Integration of HIV/AIDS curriculum within the general curriculum

Only two of the countries with an HIV/AIDS curriculum had made these lessons a compulsory part of the general school syllabus. For example, the Kenyan Institute of Education had inserted a weekly compulsory HIV/AIDS lesson into all primary and secondary state curricula. In the two Latin American countries, curriculum was designed and piloted, but no further action has been taken by the Ministry of Education to integrate the HIV/AIDS curriculum into the general curriculum.

Some civil society representatives expressed concern that ministries had produced very comprehensive (and glossy) guidelines for HIV/AIDS curriculum, but no further progress was evident. In other words, the HIV/AIDS curriculum was not integrated into the compulsory general curriculum, either through carrier subjects or as an examinable subject in its own right. The result is that it was being left up to schools to decide whether or not follow the HIV/AIDS curriculum, leaving HIV/AIDS at the margins of the curriculum or

**Box 6 Building upon existing population education initiatives**

In reviewing Ministry of Education policies, the Indian National Coalition for Education found that there was most success in inserting HIV/AIDS into the curriculum when it was not viewed as a stand-alone issue, but complemented other issues. For instance, before the AIDS epidemic existed, there was already a push in India for stabilizing population growth, through the 'National Population Education Project'.

HIV and AIDS are linked to population control – both are the consequences of sexual and reproductive behaviour. Many of the messages used for family planning are also relevant for HIV/AIDS education. The complementarity of these two issues has often been under-utilised because they frequently are treated as separate spheres of responsibility.

In India, the body responsible for producing curriculum guidelines (NCERT) used the package they had devised for the population health project, and included HIV/AIDS components. In this way, HIV/AIDS was treated in a holistic manner, in the context of adolescence education. Because the HIV/AIDS curriculum built upon existing momentum for adolescence education, it facilitated the insertion of HIV/AIDS into curricula: about 10,000 schools are currently implementing the program in over 350 districts. In comparison, only 2,700 schools are implementing the stand-alone HIV/AIDS curriculum in four states.

Adapting existing curriculum and programmes to include HIV/AIDS also counteracts the criticism that most school curricula are already over-burdened. As one Indian government official poetically stated:

"If you have a full glass of water, you cannot add any more water to it. But you can add more salt, sugar and colour into the glass. In the same way, no more extra curriculum should be added to school education, but existing subjects can be modified to add in HIV/AIDS."

GIDEON MENDEL/CORBIS/ACTIONAID

restricted to extra-curricular subjects. One respondent suggested that the cause of the problem was that HIV/AIDS curriculum was not part of the general curriculum review processes.

School curricula are already over-burdened in most of the countries in this study (Smith, Kippax et al. 2000, Kinsman 1999). With increasing pressure on teachers to meet certain learning targets, it is understandable why a subject such as HIV/AIDS, when neither examinable nor compulsory, is left at the margins of curriculum.

One response to counteract this problem is to insert HIV/AIDS into carrier subjects such as economics or mathematics. In addition, there is great potential to build on existing and related initiatives such as population education initiatives – something which Ghana, Mali and India have attempted to do. The potential advantages of building upon existing population initiatives are detailed in the case study on page 23.

### 2.3.3 Teacher training

Teachers are the fulcrum upon which the success of school-based HIV/AIDS education depends. Their importance cannot be over-emphasised. Yet it is clear that not enough priority has been given to investing in teachers as AIDS educators. In only three of the 18 countries had Ministries of Education made systematic attempts to train teachers on HIV/AIDS. This figure is abysmal. Common sense suggests, and research confirms, that talking to young people about sensitive subjects such as sex, death and disease is very difficult, and teachers face myriad cultural and religious challenges (Kinsman 1999; Malambo 2000).

The WHO has stipulated that teachers *"should be willing and interested in teaching about HIV/AIDS/STIs; have sufficient and appropriate knowledge about HIV/AIDS/STIs; be accepted by the school staff, the community, and the pupils; be able to maintain confidentiality and objectivity; be familiar with and at ease when using sexual terminology and discussing sexual issues; be respectful of students' and family values; be an effective communicator and facilitator of classroom learning; and be accessible to pupils and parents for discussion."* To the Zambian National Education Campaign (ZANEC), these expectations are unrealistic: *"The desired characteristics of the educators are very challenging and demanding for any context or country, but especially for countries that are poor and struggling to survive – like Zambia."*

[4] *References 1 and 2, Siamwiza and Chiwela, 1999*
[5] *References 3 and 4, Ndutai (1997)*

## Box 7 Zambia: A paradigm shift in HIV/AIDS education needed

Concerned about the role of teachers and how ill-prepared they are to take on HIV/AIDS, ZANEC carried out a review to synthesise findings from available research on this topic. Some interesting insights included:

- 30% of Zambian teachers thought that teaching about HIV/AIDS would lead to promiscuity
- Zambian teachers who had received some training on HIV/AIDS education did not feel more confident to teach about this issue than those without any training[4]
- of 13 organisations working on HIV/AIDS prevention, only one explicitly aimed to influence sexual behaviour, highlighting the resistance to discussing the sexual transmission of HIV
- only about 30% of HIV/AIDS education programmes were regularly monitored.[5]

Following the literature review, ZANEC conducted focus group discussions with teachers and students in four schools and one teacher training college to find out their perspectives on the role of teachers in the epidemic.

The discussions suggested that the following problems exist:

- **HIV/AIDS is the individual teacher's responsibility** Although many schools have been teaching about HIV/AIDS since the early 1990s, there is not much of a formal structure, and it is often left up to the teachers to develop their own initiatives. Given that the literature suggests many teachers are uncomfortable with introducing discussion of HIV/AIDS in the classroom, leaving HIV/AIDS education to the responsibility of individual teachers cannot work.
- **HIV/AIDS is treated as a scientific issue** Teachers said they preferred to teach about HIV/AIDS during science lessons as it was easier to focus on the aspects of transmission of the virus rather than on the activities or context leading to that transmission. It is understandable why discussing HIV within a scientific framework is a less awkward option, but with evidence that over half of 15-19 year olds in Zambia are sexually active, avoiding discussion of sex, sexuality or emotions is seriously misguided.
- **Selective teaching about HIV/AIDS** Teachers said that with younger children they talked about infection in terms of razor blades and sharing needles: this is problematic as it disguises the reality of HIV – how many people actually get HIV from sharing razor blades? Why is this message the most relevant message to give to a seven-year-old? Rather than being helpful, messages such as these may confuse young children who think they can get HIV from sharing objects with other people – which in turn, is likely to increase stigmatisation of people living with the virus.
- **Content of the curriculum** The current, fashionable approach of training students in 'communication skills' and 'assertiveness' is overly general. Instead, specific skills to manage the situation of risk of HIV infection must be built. This will include frank discussion of issues such as condoms, oral sex, heterosexual and homosexual (i.e. vaginal, oral and anal) intercourse.

"Given the current reality for teachers, this is unrealistic – many teachers themselves do not possess these skills or knowledge," ZANEC acknowledged. "However, if sufficient resources were to be allocated towards educating our educators, it becomes a possibility."

As mentioned earlier, three of the participating countries, Zimbabwe, Ghana and Zambia, have made admirable attempts at nationwide teacher training. In Zimbabwe, HIV/AIDS education has been made compulsory in the Teacher Training Colleges. However, one respondent commented:

"The programme is not examined like other teaching courses so the students tend to take it causally. There also isn't any material for the trainee teachers to use."

*Zimbabwean respondent*

There were also complaints about the lack of training materials for teachers in Mali and Sudan.

In Ghana, the focus within HIV/AIDS education is very much on teacher training, with a large amount of funding secured through World Bank partnership. Unlike Zimbabwe, pre-service teacher training includes HIV/AIDS as a core and examinable course.

In Zambia, the focus has been more on in-service teacher training, although certain individual teaching colleges do offer HIV as part of pre-service training. The government has set aside $120, 000 towards teacher training and estimate that the following numbers of teachers have already been trained:

- 10,000 in HIV/AIDS
- 2,600 in interactive methodologies (for HIV prevention)
- 3,000 in life skills[6]

In-service training in Zambia has led to teachers being sent back to colleges during their holidays and term time – sometimes to their, and the children's resentment:

"Teachers are actively campaigning about training because there is so much of it and it is taking teachers away from schools."

*Zambian respondent*

[6] *these numbers were given by MoE representatives*

Apart from these three 'success stories', the other countries appear to have only taken on teacher training on HIV/AIDS in a piecemeal fashion. As one respondent commented:

"Teacher training has been minimal. Very few teachers have been trained in just a couple of districts, with limited funding from government."

*East African respondent*

Moreover, what little training does exist is sometimes perceived as being inadequate. For example, in Sudan there were complaints that the training did not include any discussion of the sexual transmission of HIV. If school-based HIV/AIDS education continues to be implemented in the same under-resourced, under-staffed and under-trained way, then not only will it not work, it may even serve to confuse young people about the reality of HIV and AIDS. Good quality HIV/AIDS education is intrinsically reliant on an education system which delivers good quality education. The linkages are apparent: the same challenges and recommendations apply to successful HIV/AIDS education as to quality education in general.

### 2.3.4 Learning materials

Across all countries there was consensus that there was an urgent need for more learning materials on HIV/AIDS. In Bolivia and El Salvador, there are no officially endorsed or distributed learning materials at all. On the positive side, learning materials do exist in the vast majority of countries. Perceptions of the quality of these materials vary: in Ghana and Zambia, these materials are viewed as being very good and country-specific. Whereas in Mali, there was concern that the materials had not been adapted sufficiently to local cultures.

Apart from the overriding conclusion that there were not enough learning materials, the following issues were also of concern:

- **language of instruction** – for example, in Zambia there are 72 local dialects but learning materials are exclusively in English
- **focus on urban areas** – it was noted that rural areas are particularly lacking in learning materials

- **materials are too 'glossy'** – because most HIV/AIDS learning materials have been funded by international donors, the resulting materials are often of a much higher standard of quality than normal learning materials. Some respondents suggested that schools were hiding the 'glossy' HIV/AIDS learning materials away because they did not want students to ruin them.

## 2.4 Response to orphans and vulnerable children

There was overwhelming consensus from civil society representatives that Ministries of Education were not doing enough to respond to the needs of orphans and vulnerable children (OVCs). In 17 of the study countries, there were no national policies or programmes aimed at this group of children.

In several of the participating countries, OVCs were seen as the responsibility of other government departments (such as social welfare) rather than Ministries of Education.

"The Ministry of Education should be taking more responsibility and not relying on the Ministry of Health to look after the orphans. A the moment, the Ministry of Education doesn't know anything about the children who are suffering and why they are suffering."

*West African respondent*

In the Latin American countries, there was the feeling that government believed the OVC issue had no relevance to their country, either now or in future. This was of concern to civil society representatives who urged the government to act more pre-emptively.

Obviously, the needs of OVCs go beyond formal schooling, and it is positive that other Ministries are responding. However, that does not relieve Ministries of Education of their responsibility to ensure that OVCs enrol in and complete at least a basic education. Ideally, Ministries of Education should be working with other Ministries to provide an integrated and holistic response to the OVC crisis. Unfortunately, there is no current evidence of such collaboration.

### 2.4.1 Bursaries and school fees

Poverty is the main reason that AIDS orphans are dropping out of school (Ainsworth and Fimer 2002; Badcock-Walters 2002; Bicego, Rutstein et al. 2003; Booysen Fle and Arntz 2003; Case, Paxman et al. 2003). School fees and associated school costs exacerbate the problem – not just for orphans but for millions of children. Some countries respond to this problem by setting up targeted waiver programmes such as school bursaries. However, where infrastructure is poor, setting up such schemes is often prohibitively expensive and most importantly, will never realise Education for All goals.

Two of the 18 countries – Zambia and Zimbabwe – have government programmes that allocate bursaries to cover the school fees of OVCs. Both Tanzania and Kenya have recently abolished tuition fees outright, although parents and carers are still expected to cover other costs such as uniforms, books and meals.

In Zimbabwe, the bursary programme is called the Basic education assistance module (BEAM) and the money is allocated directly to schools. However, BEAM is an initiative of the Ministry of Public Services, Labour and social Welfare. In the countries where the government is giving out bursaries for OVCs, respondents criticised the schemes for being under-resourced, and for excluding school uniforms – a cause for school exclusion in Zambia.

In the remaining countries there were no systematic attempts to make school more affordable for OVCs. In some countries, district level departments had taken the initiative to respond: for example, in the Far Western province of Nepal, where HIV prevalence is relatively high, local education offices are providing scholarships, food and uniforms to HIV-affected children. However, such approaches are piecemeal and measures need to be taken to scale-up the response.

### 2.4.2 Counselling services

If they are to complete an education, OVCs have psycho-social as well as financial needs that must be addressed. In Ghana and Sudan, schools already provide counselling services for vulnerable children. Respondents highlighted the untapped potential in adapting these existing counselling services to meet the needs of OVCs. For example, in Sudan each school has a parent teacher committee, whose role it is to identify poor children for counselling services – these committees could be trained or encouraged to identify the needs of OVCs.

Counsellors may need specialised training to deal with the AIDS crisis (e.g. bereavement/ stigma etc.). However, respondents also warned of the potentially stigmatising effect of having specific HIV/AIDS counsellors. Indeed, some questioned whether or not the needs of an OVC are any different to those of any poor and vulnerable child.

Piecemeal attempts have also been made by including counselling services to OVCs in anti-AIDS clubs (for example, in Mali). However, these clubs were criticised as being limited, unprofessional and under-funded.

### 2.4.3 HIV positive children

HIV/AIDS strategic plans in Ministries of Education do state the rights to education of HIV positive children, yet none of the Ministries of Education has progressed beyond writing strategies – as demonstrated by the lack of programmatic response for HIV positive children. Indeed, some Ministries of Education appear to shy away from the issue:

> "The Ministry of Education is doing nothing. OVCs are stigmatised and discriminated against. Early in 2004, HIV positive children from Nymbain home were denied access to primary school. The case was taken to court and the court ordered them to be enrolled. The Ministry of Education did little to intervene".
>
> *Kenyan respondent*

It is worrying that, in so many cases, Ministries of Education have remained silent on the issue of HIV positive students. Perhaps, these children were easy to ignore because they were seen as children without a future – and education is an investment in the future. But with the increasing availability of ARVs, this argument is redundant and governments must fulfil their obligations of Education for All.

As part of the GCE project, Bolivian civil society groups debated the issue of HIV positive children. Some respondents felt that children with HIV should be treated the same as other students, while other participants felt they deserved special attention – such as counselling services. In the end they agreed to campaign to "support children and adolescents living with HIV, not because they are sick but because their situation requires more attention". A second polemic rested around the conflicting rights of HIV positive children to confidentiality, and the right of parents and teachers to know.

Fundamentally, these issues are ethical ones, and need to be resolved by Ministries of Education, whose responsibility it is to offer guidance to schools on such matters. In addition to clearly defining the rights of HIV positive children, a holistic approach should also include education aimed at breaking stigma and discrimination.

## 2.5 Responses to HIV-infected and affected teachers

As discussed above, Ministries of Education should also be responding to the impact of the AIDS epidemic on their teaching staff. Possible interventions include workplace policies, voluntary counselling and testing services (VCT), access to treatment, and setting up early-warning signals for monitoring purposes (Badcock-Walters, Heard *et al.* 2002)

Of the 18 participating countries, only one – Zambia – has launched a significant response to a potential or actual problem. In low-prevalence countries – including African ones – the sentiment was that HIV/AIDS was not going to be a big enough problem to warrant action for teachers.

In Zambia, the Ministry of Education had identified the looming problem of AIDS-related teacher shortages, and had taken a number of steps. First, there is a policy of non-discrimination – the Ministry has just appointed an HIV/AIDS in the workplace technical adviser. In addition, the HIV component of in-service training includes VCT services, and teachers are encouraged to be tested and seek help. Unfortunately, not many teachers have disclosed their HIV status – partly through fear of a lack of confidentiality, and partly because a previous lack of treatment meant there were few benefits even if they did test or disclose. This situation is likely to change in the near future with a new government roll out of anti-retrovirals, which, while not targeting teachers specifically, should soon be available to an increasing number of HIV positive people.

DAVID SAN MILLÁN/ACTIONAID

Finally, in an attempt to train more teachers to replace those lost to AIDS, the MoE reduced the time it took to train teachers from three years to two years. Unfortunately, however, this step was based on a significant over-estimate of AIDS-related attrition. Together with IMF-advised limitations on teacher wage bills and donor reluctance to fund salary costs, this contributed to the creation in 2002-2004 a pool of several thousand training college graduates who could not be employed. This predicament highlights a) the importance of striving towards accurate data and b) some of the difficulties in making projections about the future. Nevertheless, the Zambian Ministry of Education should be congratulated for moving quickly to guarantee teacher supply.

# 3. Civil society responses to HIV/AIDS and education

## 3.1 Civil society responses to OVCs

Children who have been infected or affected by HIV/AIDS face a number of different problems (see section 1.3). A well-designed response should also be multi-faceted and not just be educationally driven. NGOs focusing on OVCs often work in both the community and in the school. Linking the two is positive as it recognises that a student is, first and foremost, a person in a family and community. However, it makes defining the 'educational response' problematic because many NGO programmatic responses to OVCs may not be educational yet may indirectly affect education.

For example, one of the most common responses to families affected by AIDS is for NGOs to provide home-based care (HBC). Although it hasn't been shown empirically, it seems a logical conclusion that effective HBC will relieve the burden of care on the household, and children who were out of school caring for their parents should be able to return to formal education.

Similarly HIV/AIDS awareness raising efforts in the community could (if they were effective in reducing stigma and discrimination) improve the psychological wellbeing of OVCs, which in turn, should improve their educational outcomes.

There are many other community-based HIV/AIDS interventions that will indirectly benefit the education of OVCs. For example, provision of ARVs should, theoretically, improve the health of parents, allowing them to return to work and relieve the economic and caring burden on children, thus improving their educational outcomes.

Similarly, education interventions that are not specifically aimed at OVCs are also likely to benefit OVCs. It becomes an issue of targeting – for example, many NGOs target 'poor' children for educational support. As orphans are, on the whole, poorer than non-orphans, socio-economic targeting will also encompass the majority of OVCs (Ainsworth and Filmer 2002). Indeed, some researchers argue that targeting for OVCs should not be based on orphan status but simply on poverty, to avoid unintended stigmatisation of beneficiaries.

### 3.1.1 School bursaries

In the GCE project, we asked respondents to limit themselves to discussing educational responses rather than the broader spectrum of HIV/AIDS interventions. Across the 18 countries many NGOs seemed to be involved in providing material support intended to help OVCs stay in school, in the form of school bursaries and occasionally food aid.

These programmes were started in response to concern that orphans were dropping out of school. However, although this type of relief does help students in the short term, there are a number of shortfalls that inherently limit its scope. First and foremost, it is not an approach that can ever reach all the children in need, and therefore, large groups of children will continue to be denied their right to education. So how do – or should – NGOs choose which orphans to help?

Second, it is worth remembering that free and universal primary education in Tanzania, Kenya and other countries was introduced in response to overwhelming popular demand and systematic advocacy by civil society, the combination of which made abolition of fees a political issue. When NGOs pay school fees for individual children, they may inadvertently attenuate such popular pressure. They may even undermine wider civil society efforts to lobby and campaign for the abolition of fees. Although the motivations underlying bursary programmes are benevolent, bursaries should only be seen as an emergency temporary response, as they cannot address the root of the problem: unaffordable school fees and the lack of a firmly entrenched legal right to free education.

Nevertheless, the paying of school fees remains NGOs' main educational response to OVCs. Apart from the problems of coverage and sustainability, respondents also complained that paying school fees perhaps alleviated the material needs of OVCs but failed to respond to their psycho-social needs.

### 3.1.2 Specialist schools

Apart from bursaries, respondents reported a number of other interventions aimed specifically at OVCs. In some African countries, NGOs had set up special community schools for OVCs. Some of the best of these programmes offered a holistic response to the educational needs of OVCs by providing counselling, ARVs, food schemes, vocational training, parental liaison, accelerated programmes and most importantly, eventual entry back into the mainstream education system. It is difficult to imagine a government response which is so multifaceted because it would involve the coordination of many different ministries. This is clearly one comparative advantage of civil society participation as it is better situated to respond multisectorally.

The three key criticisms leveraged at this response are that first, NGOs are relieving government of their responsibility to deliver free, basic education, and setting up parallel systems. Second, removing OVCs – and as a result, isolating them – from mainstream education can, in itself, be stigmatising and their education could be seen as inferior to mainstream education. Third, specialist schools will never accommodate all children and are unsustainable in the long term. The advantage of such approaches is that they can respond to specific needs of OVCs, which most mainstream schools do not. However, rather than the creation of more specialist schools, Ministries of Education should instead replicate and scale-up innovative approaches to OVCs from specialist schools, feeding them into mainstream education.

### 3.1.3 Other educational responses

Across countries, NGOs had responded to the educational needs of OVCs in a variety of other innovative ways. Some of these included:

- mobilising teachers – in Sudan, teacher unions have set up a 'therapeutic solidarity fund', into which union members donate money to support the orphans. In addition, they are encouraged to identify affected children, and offer additional psychological support. Similar programmes are also in place in El Salvador.
- educational rights of HIV positive children – in India and Kenya, NGOs have been involved in fighting for the rights of HIV positive students who have been denied access to schools.
- treatment for HIV positive children – in Mali, NGOs have started 'listening centres' outside schools, where they offer counselling and treatment to HIV positive children. Similarly, in Sudan and El Salvador, NGOs are offering treatment to infected students.
- institutional homes for orphans – in many of the African countries, NGOs had set up orphanages to look after abandoned orphans. As well as offering a home to the children, these institutions often include a school. However, the specialist schools suffer from the same problems mentioned above.

## 3.2 The role of NGOs in HIVAIDS education

"Teachers do not have the necessary basic knowledge to conduct HIV/AIDS education. Consequently, civil society organisations are called upon to teach HIV/AIDS classes."

*El Salvadorian respondent*

Without a doubt, civil society organisations were the first to respond to the AIDS epidemic. Much effort has gone into prevention campaigns – with schools viewed as being at the forefront of any intervention. Frustrated at the slowness in the government response, thousands of NGOs have persuaded schools in their communities to introduce HIV/AIDS education.

*JENNY MATTHEWS/ACTIONAID*

**Box 8 Obstacles to school-based HIV/AIDS education**

There are a number of factors which need to be taken into consideration when introducing school-based HIV/AIDS education. The following list demonstrates a range of issues. Certain issues are only relevant to particular countries.

- Parental resistance (Sudan)
- Taboos, lack of interest, embarrassment, and lack of funds (India, El Salvador)
- School policies on pregnancy (Mali)
- **Religion –** "the Catholic and Evangelical churches strongly oppose any discussion on HIV/AIDS and have a strong influence over the Ministry of Education".
  *Latin American respondent*
- **Lack of options for young people –** "the Ministry's policy is abstinence and teachers are not allowed to talk about condoms to students".
  *Southern African respondent*
- myths, prejudices, opposition from conservative groups, abstinence and fidelity-only programmes (El Salvador)
  - in Nepal, the following perceptions were seen as hindering efforts in the classroom:
  - young people should not be taught about sex
  - girls who know about HIV/AIDS are 'fast'
  - girls should not know about sex
  - nepal is so different to other countries that AIDS will not be a problem
  - our culture will protect us from HIV.

The motivations behind such interventions are certainly benevolent. However, such a programmatic response has inadvertently created unfortunate consequences. Respondents across the countries bemoaned the lack of coordination – with the result that some schools received no HIV/AIDS education, while others were the target of too many interventions. In the latter case, multiple messages from different NGOs can only serve to confuse young people (Boler, Adoss *et al.* 2003).

In addition to the lack of coordination, two other major criticisms were directed at such responses. The first was that even in the schools that are reached, not all students will be reached. In many of the countries, it was reported that NGOs mostly visit schools about once a month, reaching only a minority of students. Although these organisations are well placed to provide alternative and creative forms of HIV/AIDS education (drama groups and debates were very popular), the approach is undermined by the sheer lack of sustainability.

The second area of criticism was that many of the NGOs working in the community were faith-based, and hence, the discourse around HIV/AIDS became a religious one. The result is that many programmes are abstinence-only, either ignoring the issue of condoms or condemning them.

"AIDS is a religious problem. We need to preach the message of abstinence as widely as possible."

*West African respondent*

"Civil society, particularly faith-based organisations, has been opposed to the HIV/AIDS curriculum. They fear that the curriculum is yet another sex education programme and they associate it with increasing immorality."

*East African respondent*

There is increasing scientific evidence that abstinence-only programmes do not work, and that giving young people choices, does not increase sexual activity (Waxman, 2004, Human RIghts Watch, 2005). Coupled with the evidence that many young people are sexually active, precluding discussion about condoms is inherently limited. In fact, abstinence-only programmes only serve to make those young people already sexually active feel ashamed about their 'immorality' and less likely to seek advice and help when needed, whereas its effect on not-yet sexually active young people remains doubtful.

In addition to directly providing school-based HIV/AIDS education, respondents reported key programmes in the following areas:

- production of learning materials especially for private and community schools (e.g. Zambia, Bolivia and Mali)
- HIV/AIDS training for teachers (Bolivia)
- HIV/AIDS training in Teacher Training Colleges (Ghana)
- training of peer educators (El Salvador)
- education campaigns (not school-based)
- work with teachers as positive role models (Mali)

This list offers a glimpse of the type of interventions being conducted, but it is far from exhaustive.

These programmes are mostly based at the community level – more systematic and nationwide responses are mostly carried out in partnership with the Ministry of Education and are described in 4.2

## 3.3 Civil society responses to the impact of AIDS on teachers

Compared to the abundance of projects focussing on OVCs or school-based HIV/AIDS education, NGOs have been much slower to target infected and affected teachers. Of course, as with OVCs, there are many HIV/AIDS interventions that benefit teachers but do not target teachers specifically. This paper will only focus on those interventions targeting teachers directly.

**Box 9 The role of Teacher Unions** (extract from EI document "Partnership in Health Education")

In 1989 Jonathan Mann, the first head of WHO's Global Programme on AIDS, addressed the World Congress of the IFFTU, one of the predecessors of Education International (EI). Before hundreds of teacher leaders from all over the world, Mr Mann spoke on the impact of HIV/AIDS and mapped out what was to be expected in the coming decade. Despite their interest, many teacher trade unionists wondered whether the words of warning spoken by Mr Mann really should be directed to them. Should he not be giving his presentation at a congress of medical doctors?

Fifteen years later, not one EI-affiliated teachers' organisation doubts that teachers should be involved in the fight against the HIV/AIDS pandemic. All are fully aware that teachers can and must play a crucial role in the prevention of HIV. This can be accomplished by sharing information with colleagues and students, by raising awareness in the community, and by making skills-based health education an integral part of the curriculum.

Teachers unions around the globe have adopted resolutions and policies on HIV. Unions have started disseminating information and have made training programs on HIV part and parcel of their day-to-day work. In Tanzania, the Teachers Union (TTU) decided that in all its meetings, specific attention would be given to HIV and AIDS. Every issue of the monthly magazine of the South African Democratic Teachers Union (SADTU) features articles on HIV/AIDS and contributes to raise the awareness of SADTU's 210,000 members about the disease.

With the important exception of the teachers' unions, NGOs are doing very little to respond to the impact of AIDS on teachers. The programmes which are running suffer from being small and piecemeal. Moreover, in low-prevalence countries, there was the overriding sentiment that this issue was only relevant to high-prevalence countries.

Of the work that NGOs are conducting with teachers, the majority appears to be in HIV prevention for teachers. Groups in some of the countries (Sudan, Mali, and Burundi) were holding workshops for teachers in order to raise awareness about their own HIV risk. In Tanzania, GCE member coalition TENMET, has been involved in a novel project which has taken a two-pronged approach by raising awareness that teachers, like anybody else, are infected and affected by HIV. Second, they have been working with HIV/AIDS organisations to persuade them to take responsibility for teachers as a vulnerable group within society.

### 3.3.1 Teachers' Unions

The teachers' unions are the obvious example of a sector that should be, and is, responding to the AIDS crisis. Education International – the international body representing 315 national affiliates and some 26 million workers from the education sector – has been increasingly active in galvanising teachers around the epidemic. Their work is based on the underlying principle that teachers can significantly reduce HIV infection by avoiding infection themselves, and by helping young people to prevent infection. Box 4 highlights some examples of the work that national teacher unions are carrying out.

#### Education International's approach to teacher training

In partnership with the World Health Organization, Education International (EI) has developed a training programme, currently being used in 17 countries, that covers three related dimensions of AIDS education.

- A first set of activities is designed to help teachers examine their own vulnerability to infection, their own knowledge of the disease and its spread, and their own attitudes toward helping others, especially students, avoid infection.
- A second set of activities gives teachers tools for convincing administrators, teachers, parents and members of their community that HIV prevention through schools is appropriate and essential to the welfare of their children, their families and their nations.
- A third set of activities helps teachers gain confidence and experience in using participatory learning methods to enable their students to acquire prevention skills.

At a global level, Education International's work in strengthening teachers' responses to HIV/AIDS includes:

- holding regional seminars to support union leaders to gain knowledge and understanding in how to implement HIV-related policies for their unions, and how to work with their respective governments in developing workplace policies, curriculum and training
- working in partnerships with World Health Organization, Centre for Disease Prevention and Education Development Centre, in creating a 'school health/HIV prevention training and resource manual' to be used by national teacher unions in training teachers
- working with governments in advocating for teachers to be actively involved in HIV/AIDS curriculum design and training.

### 3.3.2 Treatment and care for HIV positive teachers

In none of the participating countries had NGOs made any attempts to target treatment and care at teachers. In fact, in Zambia, respondents were loath to target teachers for treatment because it served to stigmatise teachers. They felt that HIV positive teachers had received a disproportionate amount of bad media coverage, partly because of their role within the community. In order to mitigate the negative stereotyping that ensued, the decision was made to aim to treat HIV positive teachers no differently to any other people living with HIV.

# 4. Partnerships for change

This chapter describes existing partnerships in the 18 countries studied between civil society groups working in education, HIV/AIDS networks and Ministries of Education. In each of the participating countries, there are many – often hundreds – of civil society organisations (CSOs) working on one or more of the interfaces between HIV/AIDS and education. It is far beyond the scope of this paper to detail those responses – instead, this chapter will highlight the strengths and weaknesses of existing partnerships between MoEs and CSOs to tackle HIV/AIDS and present recommendations on how to build more effective collaboration.

One of the fundamental principles underlying GCE's mission is the belief that civil society has a responsibility to develop a coherent and unified voice in dialogue with education ministries, donors and other EFA stakeholders. Hence, the GCE has supported the creation of national coalitions or networks that bring together local NGOs, international NGOs, child rights groups, women's groups, faith-based organisations and teachers' unions. These national level coalitions are linked internationally through GCE and through regional networks belonging to the GCE such as ANCEFA and ASPBAE. Most are in regular contact with Ministries of Education, although their level of access and influence varies according to the government's attitudes towards civil society and the strength and maturity of the coalition itself. Prior to their participation in this action research project, only one of the education coalitions had links to HIV/AIDS coalitions.

## 4.1 Overall relationships between civil society and Ministries of Education

Relationships between civil society and Ministries of Education differ greatly depending on the country and the specific civil society organisation. In two exceptional cases, there appeared to be either no relationship, or a bad relationship, between the two; but in the others, the MoE did acknowledge the legitimacy of the coalition and made some effort to consult its members on policy matters.

In some countries, this relationship was viewed as one-sided:

> "There is some collaboration – it is more of a one-sided relationship with the government getting involved when it wants to."
>
> *West African respondent*

In other countries, MoEs were initially resistant to the idea of involving civil society in policy matters, but their suspicions had been overcome with time and, in some cases, the influence of donor agencies which stipulated the need to involve civil society.

> "Civil society presence was initially seen as a threat, and the process took time to get started, but after a while the government admitted, 'We cannot do this alone'."
>
> *Southern African respondent*

Relationships between civil society and Ministries of Education were, in most cases, quite informal, often depending on relationships between individuals rather than between institutions:

> "There are so many people in the Ministry of Education that there are not so many official relationships, but more unofficial relationships between individuals that work well [together]."
>
> *Southern African respondent*

**Box 10 Strengthening partnerships with Ministries of Education through the GCE project**

Part of the GCE project involved civil society representatives from each country to be present at a meeting at the Ministry of Education (see part 1.5.3). This meeting provided an opportunity for GCE members to share information with Ministries of Education about work on HIV/AIDS and Education, to network and discuss areas of possible collaboration. The following extracts highlight some of the positive consequences of the meetings.

"It was an opportunity to build up meetings and a relationship with the Ministry of Education. It was an eye-opener – the Permanent Secretary was there."

"The presence of UNESCO was useful because it meant that there was a greater likelihood of the government sticking to the promises of involvement."

"The meeting was useful because it sparked the realisation that there were no data on infected and affected, and that the policies had inadequate support structures. It was good to get the UN person involved as they are not very motivated."

"The meeting was really good and now the Ministry of Education wants to learn and gain help from the coalition. They want another meeting and have asked us to be in continuous contact – they have work which they cannot do alone."

CSOs identified excessive reliance on informal relationships as a weakness, as it meant they had to start from scratch every time a key individual left the ministry. In Zambia, the Ministry of Education has attempted to systematise its relationship with CSOs through organisational Memorandum of Understandings. However, the extent to which CSOs can hold ministries accountable to such memoranda is uncertain.

Collaboration was also undermined when the ministry and/or certain individuals within the ministry formed relationships only with certain CSOs. Coalitions complained that Ministries of Education favoured the larger international NGOs. Their privileged access to the MoE helped, in turn, to reinforce their control over the information, contacts and experience needed to influence policy.

In some countries, civil society had stronger relationships with state or district level education departments than national level officials.

"Within the Ministry of Education, it is only at the regional level, is the department open to non-governmental cooperation, and in turn, they receive economic and technical support."

*Bolivian respondent*

Although it is difficult to generalise about the relationship between Ministries of Education and civil society, there was – in all cases – the potential to strengthen partnership (see recommendations). The following issues were seen as obstacles to forming partnerships:

- lack of consultation
- no coordination between Ministries of Education and civil society
- HIV/AIDS unit within the Ministry lacks autonomy

- funding expectations – "NGOs think Ministries should give them money but often they are under-resourced. Instead, in Ghana, GCE gave the Ministry money to publish HIV/AIDS materials."
- only health-related NGOs are consulted on HIV/AIDS
- inability of Ministry of Education to recognise the role of civil society
- risks of duplication, confusion over responsibilities, and 'ownership' issues
- negative perception of government by donors (Zimbabwe)
- different international funders fund different things – leading to a lack of coordination
- within the Ministry:
  - limited capacity and structures
  - lack of transparency
  - slow to change
  - lack of will

## 4.2 Types of collaboration between Ministries of Education and civil society

Civil society respondents were asked to describe the ways in which they had worked with Ministries of Education around HIV/AIDS. Again, there were great differences between countries, making it hard to generalise. In most, involvement was limited, with respondents desiring more collaboration on policy and curriculum design.

In three of the countries – Mali, Zimbabwe, and Zambia – civil society had been a key partner in formulating the HIV/AIDS strategy paper.

"Civil society has been involved to a large extent. There was consultation at each and every stage of the development of the strategic plan."

*Zimbabwean respondent*

In another African country, civil society was not involved in the initial stages of formulating the HIV/AIDS strategy, but was invited to comment on a draft. In the remaining countries (where strategy plans had been formulated) civil society was not a collaborator.

In Zambia and Mali, the MoE also invited civil society to make an input to the design of the HIV/AIDS curriculum. In Mali, this was partly due to pressure from the World Bank, which was funding the curriculum development. The role of civil society in HIV/AIDS curriculum development was one which many respondents saw as relevant and important *(see box 10).*

In many countries, teacher unions are working with government to roll out HIV training to teachers, and representatives of the ministries of health and education are part of the unions' HIV Steering Committee. They provide their input, share information and seek ways and means to strengthen their working relationship at national and local levels. In Rwanda, the Ministry of Education provided study leave for all teachers to attend HIV-training seminars organised by the unions. In Senegal, the Ministry of Education decided to finance the printing of a large number of training manuals to be used by the union. In Zambia, the Ministry of Health provided the medical experts to the union-led training programme on HIV/AIDS.

Other forms of collaboration between ministries and civil society, in some cases, revolved around data collection (Sudan); pre-testing learning materials (Ghana, Sudan). NGOs are also implementers of policy (Ghana, Sudan, and Zambia); and fundraising (Zambia).

For example:

- **El Salvador:** NGOs were involved in revising materials produced by the Ministry of Education, and in holding information and sensitisation workshops with Ministry officials.
- **Bolivia:** at the district level, NGOs have partnered one Department of Education to jointly produce local intervention strategies, prepare education materials and train teachers and students.
- **Ghana:** the Ministry of Education has registered 122 NGOs to work on HIV/AIDS education in schools. NGOs were also involved in pre-testing the curriculum.


GIDEON MENDEL/CORBIS/ACTIONAID

- **Mali:** there is strong partnership between the Ministry of Education, UNICEF, Plan International and SCF-US around a number of projects. In 2002-2003 these included
  - developing school health policy
  - appointing technical advisers
  - analysing basic education curriculum for HIV/AIDS mainstreaming
  - structured partnership agreements between Ministries and NGOs on health education
  - design of new data collection and analysis tools on HIV.

## 4.3 Partnerships between Education coalitions and HIV/AIDS coalitions

With so many interfaces between HIV/AIDS and education it is surprising that only one of the education coalitions (GCE South Africa) had ongoing links with the HIV/AIDS coalitions. Part of the problem was that the two were seen as having separate spheres of responsibility, with HIV networks working with Ministries of Health, and education coalitions with Ministries of Education.

Moreover, people within each type of coalition tend to come from very different professional backgrounds and disciplines – making partnership challenging. The situation is lamentable, especially given the increasing recognition of the need for a multisectoral response to the epidemic.

Much could be gained through strengthening partnerships between the two types of coalitions, mainly through sharing knowledge – it cannot be assumed that education coalitions have the expertise to deal with HIV, and conversely, it cannot be assumed that HIV/AIDS coalitions have the pedagogic expertise to design educational interventions.

The GCE project created an opportunity for the two types of coalitions to come together. In about seven of the countries, this was actually the first time the two coalitions had met. The results were positive, with many coalitions making promises of future collaboration. However, coalitions were also quick to point out that the capacity of education coalitions was already stretched and thus, sustaining alliances with HIV/AIDS coalitions would be difficult.

## 4.4 Advocacy responses to HIV/AIDS and education

Alongside its ability to deliver services at a local level, civil society can also make an important contribution by holding governments publicly accountable for fulfilling their responsibilities, using the media and other channels to create debate over policies and spending priorities, and developing alternative policy proposals. Although the advocacy dimension of 'partnership' is usually much less popular with governments, it can be a key ingredient in moving issues up the political agenda, and framing new policies.

To date, neither GCE members nor HIV/AIDS groups in the 18 countries studied have done systematic advocacy work on the issues raised in this report. GCE members have been very involved in advocating for Education for All, with many of these campaigns certainly benefiting children and teachers infected and affected by HIV/AIDS. Although the positive effects of campaigning for EFA should not be under-estimated, this report has also argued that the AIDS epidemic has created new and specific challenges to educators – which should also be specifically addressed through advocacy.

## Box 11 Bolivia: Building partnerships

The AIDS epidemic in Bolivia is relatively nascent and confined. In an ideal world, a low prevalence setting should be the perfect situation to focus on prevention.

Unfortunately, HIV/AIDS education has not been given its due attention. As national coordinator of the GCE initiative, Ayuda en Accion had the opportunity to bring together the different agencies working in HIV/AIDS and education during three regional workshops in Cruz de la sierra, Cochabamba and La Paz. This was the first time that such a diverse group of agencies had come together, including representatives from

- 10 government departments
- 22 international and national NGOS working in HIV/AIDS and education
- 10 networks of people living with HIV
- 8 Universities and international donors.

The aim of these workshops was to discuss, and build upon, Ayuda en Accion's research, which had highlighted the low level of HIV awareness among teenagers, and their demand for schools to teach about HIV/AIDS.[7]

The workshops consisted of two parts – the first was an information-sharing stage in which participating organisations presented their work in HIV/AIDS and education. The second stage involved each workshop splitting into three working groups, each tackling an issue of concern with regard to the educational response to HIV/AIDS. Although most the issues in the readiness survey were covered, it became clear early on that there was one issue which was of utmost concern to all the participants: the lack of an HIV/AIDS curriculum.

HIV is taught in a couple of subjects – but these decisions were made by the specific curricular departments, not through any coordinated effort from the National Ministry of Education. The lack of a comprehensive strategy to deal with HIV/AIDS education is puzzling. The Ministry of Health clearly endorsed the inclusion of HIV/AIDS into the curriculum[8]. And discussions at the workshops suggest that the Ministry of Education did actually prepare a new health component to the curricula, with a strong focus on HIV/AIDS. However, this module never materialised into policy or official state policy.

One of the strengths of the workshops was that it showed the importance of the regional context in Bolivia. Without national support for HIV/AIDS education, some of the regional education departments have partnered NGOs to start producing their own curriculum and training. These departments (SEDUCA) encourage NGOs to access schools in their area and undertake HIV/AIDS education. In exchange, the NGOs also provide technical support to the department. This allows NGOs such as CEMSE to coordinate their effort through the regional education department, and shows the strong potential of NGOs to become involved in school-based HIV/AIDS education in a systematic way.

The NGOs hope that the national government takes the lead from some of its regional departments. Lessons can be learnt and fed into the national level – both in terms of training and learning materials.

Impatient with waiting, the agencies gathered at the GCE workshops and decided to take decisive action. The first was an inter-agency commitment to work towards the immediate inclusion of HIV/AIDS education into the general state curriculum.

This commitment involves:

- creation of working groups to prepare for meeting with Ministry of Education
- systematising experiences from civil society to feed best practices into the HIV/AIDS curriculum
- immediate inter-agency cooperation and coordination around HIV/AIDS education
- submitting a proposal for the immediate inclusion of HIV/AIDS education into the curriculum.

On the positive side, the Global Readiness Report process and civil society meetings provided CSOs with opportunities to discuss policy-influencing priorities and opportunities. Moreover, the research helped to provide a stronger evidence base from which to plan future advocacy. At the end of the action research project underpinning this report, each national education coalition reported back plans and ideas for future advocacy around HIV/AIDS and education, some of which are summarised below. GCE hopes to take these ideas further in a proposed second phase of the action research project.

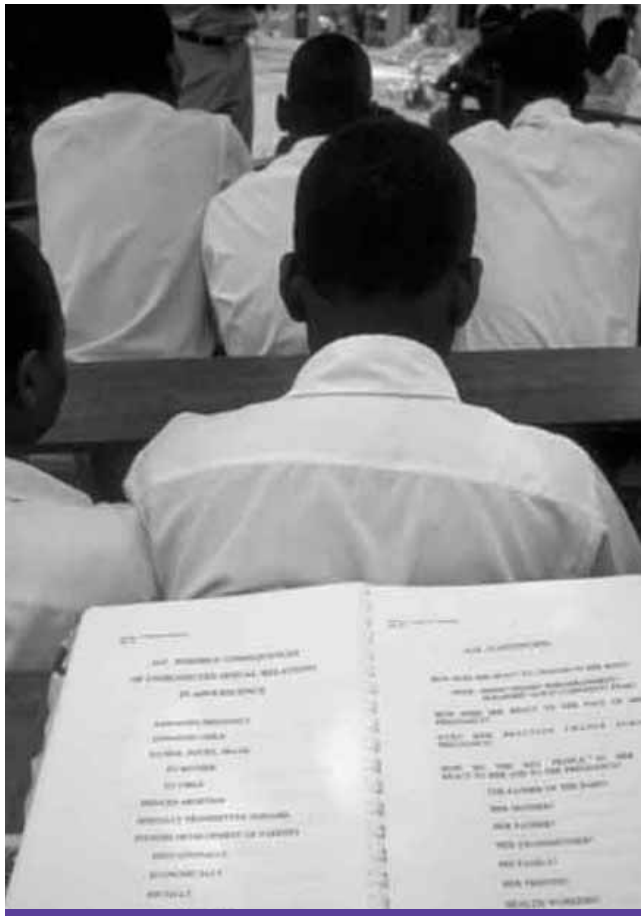
In Bolivia, impressive civil society momentum has been generated through the project, resulting in a multi-organisation campaign to include HIV/AIDS education in the general curriculum *(see box opposite).*

Following the regional workshops and inter-agency commitment, the group put together a proposal to be submitted to the Ministry of Education. The proposal includes the following items:

- insertion of an integrated HIV/AIDS curriculum
- the provision of HIV/AIDS training in both pre-service and in-service training
- the involvement of the Communication Unit of the Ministry of Education in work on HIV/AIDS
- creating a coordinating mechanism between the Ministry of Education and the Ministry of Health to work jointly on HIV/AIDS
- inclusion of an article on the law on children and teenagers living with HIVAIDS.

This proposal is to be submitted to the Ministry of Education in 2005. The inter-agency group, which was formed through the GCE initiative, is currently petitioning the government to include HIV/AIDS education into the national curriculum, as laid out their proposal.

The other participating countries are also making progress in developing advocacy strategies around HIV/AIDS and education. The table opposite summarises proposed activities:



*GIDEON MENDEL/CORBIS/ACTIONAID*

[7] *392 interviews were conducted in 10 schools in Santa Cruz de la Sierra. 16% of the teenagers had never heard of AIDS. 19% of teenagers thought there was a cure for AIDS. 98% of the teenagers thought that HIV/AIDS education and sexual reproductive health topics should be taught in schools.*

[8] *The Key Ministry of Health AIDS documents, "Bases for 2000-2004 strategic planning on the prevention and control of sexually transmitted infections/ HIV/AIDS", clearly describes the need for the Ministry of Education to include HIV/AIDS into its wider educational reform*

| Box 12 plans for future campaigning work on education and HIV/AIDS | |
|---|---|
| **Bolivia** | • Education and HIV/AIDS NGOs are petitioning the Ministry of Education to include HIV/AIDS in the general curriculum. Future activities include:<br>• encouraging the setting up of a communications unit within MoE to work on HIV and sex/health as cross-cutting themes<br>• HIV/AIDS sensitisation in all spheres of community life<br>• pushing for mass media to discuss HIV<br>• encouraging the creation of structures for coordinated work between MoH and MoE<br>• inserting HIV/AIDS subjects into the curriculum as an integrated and crosscutting theme<br>• strengthening training on HIV in TTC, and developing a strategy for on-going in-service training on HIV<br>• inclusion of an article in the law on children and adolescents living with HIV |
| **Tanzania** | • Plans to hold a roundtable meeting at MOEC to share campaign issues<br>• Proposed conference on HIV/AIDS and education |
| **Sudan** | • Lobbying religious leaders who are a standing block to effective HIV prevention<br>• Lobbying to support comprehensive sex education in schools<br>• Pushing for more funding from the Ministry of Finance for the MoE to deal with HIV<br>• Advocating HIV/AIDS education at all levels and in vocational training centres |
| **Zimbabwe** | • Offering psycho-social support to teachers<br>• Lobbying government to provide ARVs to teachers<br>• Lobbying government/ Ministry of Education to provide syllabuses and training materials to train teachers |
| **Kenya** | • Participating in forthcoming legislation on HIV/AIDS<br>• Working to reduce HIV related discrimination in education |
| **Mali** | • Informing people that HIV and malaria are avoidable and to prioritise preventive education |
| **Burundi** | • Raising awareness to promote VCT |
| **Zambia** | • Pressing for schools to recognise their responsibility to teachHIV<br>• Creating efficient and reliable relationships to fight HIV |

# 5. Conclusions and recommendations

The classroom represents a vital opportunity to reach youth with life-saving information and skills, but this opportunity is being squandered by the deadly inertia surrounding AIDS policy in the education sector.

*HOWARD LEWIS-BAKER/ACTIONAID*

Few effective steps have been taken to mitigate the epidemic's growing impact on pupils, teachers and schools. Orphans and HIV positive children are being forced out of school because governments are doing little or nothing to support and protect them. Stigmatisation and discrimination against both children and teachers with HIV have been allowed to flourish. Dangerously little is being done to avert looming teacher shortages due to AIDS-related attrition. Although much donor money and government effort has gone into producing lesson plans and learning materials on HIV/AIDS, few schools are actually delivering quality AIDS education to pupils.

AIDS has drastically changed the demands on educators, schools and students, posing formidable challenges to education systems that are already over-stretched and under-resourced. These new challenges – like the epidemic – are complex and require new ways of thinking and responding within the education sector. Successful responses to the crisis require a coherent system-wide strategy and plan, exactly what most of the countries reviewed in this study were lacking. Stand-alone projects targeting a single dimension of the AIDS challenge (such as developing an HIV/AIDS curriculum without addressing teacher training needs, or offering bursaries to orphans without a sustainable long-term plan to make basic education free for all) have failed miserably.

The stark reality is that these failures of policy and leadership have already condemned millions of young people to needless infection and even death. However, it is not too late to overcome the policy inertia on AIDS in education if government, donors and civil society work together more systematically and transparently.

Educators have a powerful role in forming society's values and attitudes. They have a unique platform that can be used to combat stigma, fear and apathy, and in particular to break moral taboos on open discussion of sex and the realities of sexual transmission. At all levels from the Minister of Education down to the village headmaster or NGO fieldworker, therefore, they have a responsibility to demonstrate leadership and courage in the fight against the epidemic. By changing the way that the education system deals with AIDS – replacing inertia with vigorous action, silence with frank discussion, and discrimination with a strong affirmation of the rights of the infected and affected – we can begin to change the way that individuals and communities respond to the epidemic.

**The following recommendations should be on the to-do list of all ministries:**

# Recommendations

**1** Ministries of Education should formulate a clear and costed strategic plan on HIV/AIDS, which is integrated into education sector plans and national poverty reduction strategies and which is complemented by state and district level plans.

- More effort needs to be made to translate strategic plans into policy and practice.
- National level responses must be complemented by state, provincial and district level responses.
- More resources need to be allocated to HIV/AIDS within Ministries of Education. In particular, the potential to gain funding from HIV/AIDS designated funding sources should be further explored (e.g. GFATM).

**2** Ministries of Education must clearly define the rights of HIV positive children in schools, as well as the rights of HIV positive education workers, and establish policies, regulations and procedures to prevent AIDS-related discrimination against learners and teachers. Workplace policies must be put in place to respond to the needs of HIV positive teachers. At the very least these should include access to confidential VCT services and affordable access to treatment.

- Ministries of Education must create workplace policies around HIV infected teachers, showing zero tolerance to HIV-related discrimination.
- Confidential VCT services should be offered to teachers and school counselling programmes must be expanded.
- Ministries of Health must strive towards providing affordable treatment for AIDS.
- The underlying problem of unaffordable school fees must be addressed and governments must provide free basic education to all children, not just orphans.
- It is important to study existing 'social and cultural safety nets' that could be mobilised or strengthened to ensure access to education for OVCs.

**3** Greater effort must be made to understand the special educational needs of children affected by the HIV/AIDS. The educational response must go beyond simply providing bursaries to include psycho-social support through existing counselling services in schools.

**4** Governments must put in place adequate monitoring systems for measuring the impact of the epidemic on education. In particular, education management information systems (EMIS) need to be strengthened in order to capture data on teacher absenteeism and mortality due to AIDS.

**5** High priority must be given to training teachers to teach about HIV/AIDS. Both in-service and pre-service teacher training should include compulsory HIV/AIDS components that are examinable or certifiable. Teachers and their unions must be involved in the design and roll-out of such programmes.

**6** HIV/AIDS should not be taught in isolation, but as part of a wider sexual and reproductive health framework. Curriculum development should be in partnership with civil society and while being culturally appropriate, should be based on scientifically accurate information rather than being ideologically driven. Such curricula must be based in the reality of young people's lives and provide young people with realistic choices to protect themselves from HIV infection.

**7** Civil society organisations (CSOs) need to be more proactive and systematic in seeking to influence HIV/AIDS related policies and plans of their government. Stronger linkages and alliances between teachers' unions, education groups and health groups (among others) would help to ensure a more effective and better-informed civil society input to policy discussions. CSOs can make important contributions to the design and

implementation of school-based HIV education, but their efforts should be coordinated by the Ministry of Education to avoid duplication or contradiction. At the same time, however, CSOs have a responsibility to act as independent monitors of HIV/AIDS policies and spending at all levels, and to campaign for the educational rights of all vulnerable groups.

- Ministries of Education and CSOs should draw up Memorandums of Understanding to clarify and systematise the nature and limits of their collaboration on specific activities.
- Individual CSOs should form a common platform, such as the national education coalitions involved in this study, in order to take a coherent and consistent set of policy messages to government. Education coalitions should partner HIV/AIDS networks for combined advocacy efforts.
- Future advocacy should build upon existing EFA campaigns and education groups must include campaigning on HIV/AIDS as an important part of their campaigns on quality and free education.

**8** In order for schools to play an effective role in fighting AIDS, all children, especially the poorest and most marginalised, must be able to go to school. Completion of primary education is the threshold level to unlock the preventative power of education, yet across Africa only one in two children ever finishes primary school, while large class sizes and under-trained teachers undermine learning. Basic education must be made free, universal and compulsory. Governments must abolish fees, build more schools and train more teachers, establish stipends and/or school meals to help keep children in school, and take additional necessary steps to ensure schools attract girls, orphans and other vulnerable children.

**9** Financing these measures will require immediate and major increases in aid and debt relief for affected countries. In the face of the wider economic and budgetary pressures, earlier donor estimates of countries' education-sector needs may need to be revised, and in particular, more money made available for recurrent costs such as payroll costs. While the potential to finance such measures through HIV/AIDS-designated funding channels should be further explored (such as The Global Fund for AIDS, Tuberculosis and Malaria), it is urgent for the Fast Track Initiative (FTI) partnership to expand to more low-income countries and to offer coordinated and generous support for Ministries of Education to scale-up their response to AIDS.

*DAVID SAN MILLÁN/ACTIONAID*

# Appendix

### The Global Readiness Report

In 2000, a number of the UN agencies were concerned about the lack of coordination within the UN around HIV/AIDS and education, and consequently set up the UN Inter-agency task team on HIV/AIDS and Education (IATT).

As part of its remit, the IATT recognised the need to assess how ready Ministries of Educations were to respond to the AIDS epidemic. Partnering with researchers at HEARD (University of KwaZulu-Natal), they designed a survey to be conducted by Ministries of Education.

The survey consisted of a series of questions regarding the absence/presence of key indicators. Most of these questions elicited a yes/no or true/false response but some required priorities to be ranked

### GCE partnership with the Canadian International Development Agency (CIDA)

In the original proposal for the Global Readiness Report, there was no mention of civil society involvement. However, it was soon recognised that civil society could have an important role in contributing to the survey, and ensuring that the survey was used as benchmark for advocacy. CIDA and IATT therefore partnered with GCE as a way to systematically mobilise national education coalitions around HIV/AIDS. Moreover, the Readiness survey was seen an important opportunity for GCE members to start engaging around HIV/AIDS – both with Ministries of Education and with HIV networks.

With CIDA's support, GCE embarked on an ambitious HIV/AIDS project that included capacity building, research and advocacy. The complex process follows:

**Pre-meeting:** Each of the 18 participating countries was encouraged to hold an initial meeting to bring together civil society perspectives and build partnerships between HIV and education coalitions. This informal forum – known as a pre-meeting – allowed GCE members to discuss their key concerns regarding the Ministry of Education, and to debate the role of civil society.

Although guidelines were provided, it was up to individual countries to decide how best to hold the meetings. A wide cross-section of stakeholders was invited, including students, teacher unions, government officials, parents, church and youth groups, and UN agencies. There were country variations in the strategy. For example, in Bolivia, a series of meetings was held across the country, leading to the formation of an inter-agency proposal which the group presented to the Ministry of Education (see 3.3). For many countries, the meeting provided a seminal opportunity for education coalitions to meet HIV coalitions and plan joint work together. For some countries, the level of awareness of HIV among GCE members was very low, and the forum was used for increasing knowledge. For example in Nepal an extra day was added to the pre-meeting, where education coalitions were briefed on critical aspects in HIV/AIDS.

**Meeting at Ministry of Education:** In each participating country, a meeting was set up at the Ministry of Education in order to complete the Global Readiness Report. This meeting was coordinated by one GCE representative and one IATT representative, although others were often present at the meetings, and offered the opportunity to strengthen partnerships between civil society and UN agencies.

Although the Global Readiness Report was completed by three or four key ministry officials, the GCE representative took the meeting as an opportunity to share information and learn more about the national educational response to the epidemic.

**Feedback to wider civil society:** An important part of the process was to feed information from the Ministry of Education meeting back to national and international GCE partners, in order to frame any future campaigning work on HIV/AIDS.

This was done in three ways. First, the 19 GCE representatives completed GCE questionnaires that were designed to elicit civil society perspectives on the key issues raised during the ministry meeting. Second, a workshop was held in Ottawa for the six countries involved in the research stage. The aim of this workshop was to pull together conclusions from the project, which could in turn, feed into advocacy strategies. Finally, each of the participating countries held dissemination workshops in which the findings of the project (both at national and international levels) were discussed.

# Bibliography


Ainsworth, M., K. Beegle, et al. (2002). The Impact of Adult Mortality on Primary School Enrollment in Northwestern Tanzania. Washington DC, The World Bank: 23.

Ainsworth, M. and D. Fimer (2002). Poverty, AIDS, and Children's Schooling. Washington DC, World Bank: 41.

Badcock-Walters, P. (2002). The impact of HIV/AIDS on education in Kwazulu- Natal, Pedu.

Badcock-Walters, P., C. Desmond, et al. (2003). Educator mortality in-service in KwaZulu-Natal. Durban, University of Natal.

Badcock-Walters, P., W. Heard, et al. (2002). Developing district-level early warning support systems to assist in managing and mitigating the impact of HIV/AIDS on education. Demsa 2002 Proceedings, University of Western Cape, Demographic Association of Southern Africa.

Bank, W. (2002). Education and HIV/AIDS: A Window of Hope. Washington DC, the World Bank.

Barnett, T. and A. Whiteside (2002). AIDS in the Twenty-First Century. New York, Palgrave Macmillan.

Barnett, T. and A. Whiteside (2002). Poverty and HIV/AIDS: impact, coping and mitigation policy. Florence, UNICEF.

Bennell, P., K. Hyde, et al. (2002). The Impact of the HIV/AIDS epidemic on the Education Sector in Sub-Saharan Africa. Sussex, Centre for International Education, University of Sussex.

Bicego, G., S. Rutstein, et al. (2003). "Dimensions of the emerging orphan crisis in sub-Saharan Africa." Soc Sci Med 56(6): 1235-47.

Boler, T. (2004). Approaches to estimating the impact of HIV/AIDS on teachers. London, Save the Children and ActionAid.

Boler, T., R. Adoss, et al. (2003). The sound of silence: difficulties in communicating on HIV/AIDS in schools. London, ActionAid International.

Boler, T. and P. Aggleton (forthcoming). Life skills education for HIV prevention: a critical analysis. London, Save the Children, Thomas Coram Research Centre and ActionAid International.

Boler, T. and K. Carroll (2004). Addressing the Educational Needs of Orphans and Vulnerable Children. London, Save the Children and ActionAid International.

Booysen Fle, R. and T. Arntz (2003). "The methodology of HIV/AIDS impact studies: a review of current practices." Soc Sci Med 56(12): 2391-405.

Carr-Hill, R., M. Hopkins, et al. (1999). Monitoring the performance of educational programmes in developing countries. London, DFID Education Papers.

Case, A., C. Paxman, et al. (2003). Orphans in Africa. Princeton, Centre for Health and Wellbeing, Princeton University.

Cohen, D. (2002). Human Capital and the HIV epidemic in Sub-Saharan Africa. Geneva, ILO.

Coombe, C. (2000). Managing the Impact of HIV/AIDS on the Education Sector. Pretoria, South Africa, University of Pretoria.

Foster, G. (1997). "Africa's children and AIDS – a continent in crisis. The devastation of the HIV / AIDS pandemic." AIDSlink(45): 4-5.

GCE (2004). Learning to survive.

Gregson, S., H. Waddell, et al. (2001). "School Education and HIV Control in Sub-Saharan Africa: From Discord to Harmony?" Journal of International Development 13: 467-485.

Human RIghts Watch (2005) "The less they know the better." Abstinence-only programmes in Uganda. Vol 17 no. 4

Kelly, M. (2000). Planning for Education in the context of HIV/AIDS. Paris, IIEP, UNESCO.

Kinsman, J. (1999). "Implementation of a comprehensive AIDS education programme for schools in Masaka District, Uganda." AIDS CARE 11(5): 591-601.

Malambo, R. (2000). "Teach them while they are young, they will live to remember: the views of teachers and pupils on the teaching of HIV/AIDS in basic education: A case study of Zambia's Lusaka and Southern Provinces." Current Issues in Comparative Education 3(1).

Morgan, S. (2000). "Response for all AIDS affected children, not AIDS orphans alone." AIDS Anal Afr 10(6): 3.

Ntozi, J. and S. Nakamany (1999). AIDS in Uganda: how has the household coped with the epidemic? The continuing HIV/AIDS epidemic in Africa. I. Orubuloye, J. Caldwell and J. Ntozi. Canberra.

Nyambedha, E. O., S. Wandibba, et al. (2003). "Changing patterns of orphan care due to the HIV epidemic in western Kenya." Soc Sci Med 57(2): 301-11.

Patel, D. (2000). "A national disaster: a social analysis of AIDS in Zimbabwe." Development Bulletin 52: 71-74.

Sengendo, J. and J. Nambi (1997). "The psychological effect of orphanhood: a study of orphans in Rakai district." Health Transit Rev 7 Suppl: 105-24.

Smith, G., S. Kippax, et al. (2000). HIV and Sexual Health Education in Primary and Secondary Schools. Findings from selected Asia-Pacific Countries, University of New South Wales.

UNAIDS (2002). AIDS Epidemic Update. Geneva, UNAIDS.

Waxman, H. (2004). " The content of federally funded abstinence-only education programmes". United States House of Representatives.

Whiteside, A. (1998). "Monitoring the AIDS pandemic." AIDS Anal Afr 8(5): 4-5.

Whiteside, A. (2000). "The real challenges: the orphan generation and employment creation." AIDS Anal Afr 10(4): 14-5.

WHO (2004). 3 by 5 Progress Report 2004. Geneva, WHO.

Designed by JF Design

P2189/10/05

The Global Coalition on Women and AIDS

actionaid international

The Global Campaign For Education
5 Bld Du Roi Albert II
1210 Brussels
Belgium

**www.campaignforeducation.org**

GLOBAL CAMPAIGN FOR EDUCATION