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**The Impact of HIV/AIDS on the
Education Sector in Africa**

**Sub-Regional Outlook and Best
Practices
(Eastern and Southern Africa)**

Synthesis Paper

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Foreword

A young person at the age of eighteen or nineteen is a person filled with vitality, life and dreams for the future. The difficult growing up years of childhood and adolescence have passed. Those years may have seen some turmoil and even physical setbacks, but these are now a thing of the past. The world is at the young person's feet, waiting to be conquered, waiting to be made one's own.

If HIV/AIDS were articulate, would it express similar sentiments? In the eighteen to nineteen years of its devastation among humans, it still appears to be full of lethal vitality. It has experienced its setbacks—the success of the antiretrovirals, better knowledge about its dynamics, the possibility of controlling mother-to-child transmission, some slowing down of transmission in Thailand, Senegal and Uganda, more intravenous drug-users using clean needles—but it still rolls on, taxing humanity's knowledge and understanding, reversing development, absorbing resources, weakening social systems, causing untold suffering and grief to millions of children, women and men.

This paper examines one aspect of the seemingly inexorable advance of HIV/AIDS: the way it has impacted on the education sector in Eastern and Southern Africa. The paper also examines the adjustments the sector has made to the epidemic and the steps it has taken to slow down its transmission. The overall impression is one of disarray, inadequate understanding, and piecemeal response—several projects, but few programmes. The great tragedy of the almost random way education is adjusting to the demands of the HIV/AIDS crisis is that in the present state of human knowledge and science every prevention effort and many impact-management approaches depend on education.

There can be no prevention of HIV transmission without the maintenance of behaviour that will protect oneself and others, or the change of existing behaviour so that it becomes protective of self and others. The only way of ensuring this is through education, regardless of the circumstances, of the age of the individual, of the nature of the intervention. To maintain existing 'safe' behaviour or to adopt safe behavioural practices, some form of education is necessary. Given this education, the other supports provided by society can be brought into play. In its absence, they remain useless. For instance,

- at the level of practice, messages about the risks of unprotected sex are essentially educational, as are messages about abstinence or about condom use;
- this also holds for messages about fidelity and about reducing the number of sexual partners;
- the same is true for messages about needle exchange;
- the ensemble of information, appropriate practice and drug treatment for the prevention of mother-to-child transmission implies considerable behavioural changes in the context of a minimal education package.

In this sense, education is a crucial, and currently essential, element in society's armoury against HIV transmission. It is a necessary, though not sufficient, component in all prevention activities.

But as this paper brings out, education is not living up to the demands that the HIV/AIDS crisis imposes. The paper will bring forward a number of reasons why this is so. Cardinal will be the need for leadership. Ironically, HIV/AIDS poses a twofold challenge for educational leadership. It undermines the very systems that should produce

the needed leaders and all the support personnel and human capacity on which their effectiveness must rely. But at the same time, it calls for creative, dynamic, visionary leadership that will inspire action which will place education systems squarely in the forefront of the combat against HIV/AIDS.

In considering "AIDS: the greatest leadership challenge", the African Development Forum 2000 will advance understanding of how education systems can be protected so that they play their crucial role in preventing HIV transmission. It will also show how leadership can be mobilised in this, and in all other areas, for halting the advance of HIV, reducing its incidence, and managing its impact.

This paper was prepared on the basis of the following country case studies:

1. The Impact of HIV/AIDS on the Education Sector in Kenya, prepared by James M. Mbwika
2. Impact of HIV/AIDS on the Education Sector in Malawi, prepared by Anne Domatob and Henry Tabifor
3. Managing the Impact of HIV/AIDS on the Education Sector (in South Africa), prepared by Carol Coombe
4. The Impact of HIV/AIDS on the Education Sector in Tanzania, prepared by Cosmas A. Kamugisha
5. Impact of HIV/AIDS on the Education Sector in Uganda, prepared by Henry Tabifor and Anne Domatob
6. The Impact of HIV/AIDS on the Education Sector in Zimbabwe, prepared by Williet N. Mabeza.

Material was also drawn from

1. JTK Associates (1999) Impact Assessment of HIV/AIDS on the Education Sector (in Swaziland). Mbabane: Ministry of Education
2. M. J. Kelly (2000) The Encounter between HIV/AIDS and Education. Harare: UNESCO

Chapter 1

HIV/AIDS in Eastern and Southern Africa

The AIDS burden falls more heavily on Africa than on any other part of the world. Within Africa, it falls more heavily on countries in Eastern and Southern Africa than on those in any other part.

In fifteen countries of the sub-region, the average prevalence rate for those aged 15–49 is estimated to be 13.95 percent; for Sub-Saharan Africa as a whole it is 8.57 percent; for the world it is 1.07 percent (Table 1). Infected adults in the fifteen countries appearing in Annex Table 1 account for 71 percent of those infected in Sub-Saharan Africa, while more than half of the global total of infected adults live in these countries. These countries are home to more than 69 percent of the African children aged 0–14 who are HIV infected, or more than 53 percent of the children infected world-wide. Almost 70 percent of the AIDS deaths in Africa, and 57 percent of those in the world, have occurred in these countries. Cumulatively, 8.08 million children have been orphaned by AIDS in these fifteen countries of the sub-region, compared with 12.1 million in all of Sub-Saharan Africa, and 13.2 million globally.

	People living with HIV/AIDS, end 1999			Deaths	Orphans
	Adult Rate (%)	Adults (15–49)	Children (0–14)	AIDS Deaths (Adults & Children)	Orphans, cumulative
Total for 15 Countries	13.95	16,560,000	692,600	1,531,100	8,080,000
Sub-Saharan Africa	8.57	23,400,000	1,000,000	2,200,000	12,100,000
Global Total	1.07	33,000,000	1,300,000	2,800,000	13,200,000

Source: *UNAIDS Report on the Global HIV/AIDS Epidemic*, June 2000

These figures make it very clear that the countries of Eastern and Southern Africa bear a disproportionately heavy share of the AIDS burden, not only in the context of Sub-Saharan Africa, but much more so in relation to the rest of the world.

This AIDS burden is unravelling hard won development gains and having a crippling effect on future prospects. The magnitude of the epidemic is such that few of the countries of Eastern and Southern Africa can hope to attain cherished development goals in the areas of human and economic well-being. This is borne out by the severe downturn in many development areas:

- HIV/AIDS is slashing life expectancy. In more than half of the countries named in Annex Table 1, AIDS will reduce life expectancy by 17 years, so that instead of rising

and reaching 64 years in 2010–2015, a gain which would have been expected in the absence of AIDS, it will fall back on the average to 47 years.

- HIV/AIDS is increasing adult and child death rates. More than anything else, the massive increase in funerals testifies to this. Much of Southern Africa is bracing itself for infant, child and adult mortality rates to double by 2010.
- Because AIDS is at its worst in the 15–49 age group, it is changing the entire structure of populations, resulting in a small number of young adults having to support large numbers of young and old people.
- AIDS sicknesses are placing intolerable strains on health care systems, through exploding tuberculosis epidemics, the heavy occupancy of hospital beds by AIDS patients, and the large proportions of already inadequate health budgets consumed by AIDS care.
- AIDS mortality is placing intolerable strains on social security systems, both formal and informal, through a massive increase in the number of orphans.
- The epidemic is contributing to food and livelihood insecurity in the subsistence agriculture sector because a family which experiences AIDS sickness has less time and fewer resources for its agricultural activities (including marketing). The impact was expressed dramatically by a farmer in Malawi who noted that “today we spend more time turning the bodies of the sick than turning the soil” (Malewezi, 2000)
- HIV/AIDS is reducing business profits—in sugar estates in Kenya, in manufacturing companies in Zambia, in mining in South Africa, in coffee plantations in Tanzania.
- The disease is constraining economic growth—AIDS cost Namibia almost 8 percent of GNP in 1996, it is estimated to cost South Africa two percent of GNP every year, while for Kenya it is estimated that by 2005 the GNP will be 14.5 percent smaller than if there had been no AIDS (ONAP, 1999).

The Impact on Young People

Around half of the people who acquire HIV become infected between the ages of 15 and 24. In 1999, nearly three million of those who became infected with the virus belonged to this age group. For all of Sub-Saharan Africa, young women, aged 15–24, who are infected, are twice as many as men—at the end of 1999, there were an estimated 5,300,000 young African women living with HIV/AIDS, compared with 2,600,000 young

	Female (%)	Male (%)
Botswana	34	16
Burundi	12	5.7
Ethiopia	12	7.5
Kenya	13	6.4
Lesotho	26	12
Malawi	15	7.0
Mozambique	15	6.7
Namibia	20	9.1
Rwanda	11	5.2
South Africa	25	11
Swaziland	n.a.	n.a.
Tanzania	8.1	4.0
Uganda	7.8	3.8
Zambia	18	8.2
Zimbabwe	25	11

Source: UNICEF, *The Progress of Nations 2000*, pp. 4–5.

men. In some of the severely infected countries of Eastern and Southern Africa the proportion of infected young women is even higher (Table 2). The imbalance between the sexes is even more marked for the 15–19 year-old age group: “in countries such as Ethiopia, Malawi, Tanzania, Zambia and Zimbabwe, for every 15 to 19 year-old boy who is infected, there are five to six girls infected in the same age group” (World Bank, 1999, p. 8).

National HIV/AIDS Strategies

National responses to the challenge of HIV/AIDS were constrained in the early stages by a variety of factors:

- The nature of HIV/AIDS itself. Because of the long incubation period, infected persons retain a healthy appearance and continue to function for several years before succumbing to the disease. This created a false sense of security. In addition, the epidemic does not strike all at once in one concentrated outbreak, but spreads itself over time and over geographical areas. This results in its detrimental effects being experienced in piecemeal fashion, through the loss now of one person, now of another. It was only relatively late in the epidemic that the cumulative impact of this steady, constant erosion of human resources drew attention to the urgent need for national action.
- The initial conception that HIV/AIDS was essentially a health issue that should be dealt with by health ministries.
- The absence of a sense of urgency, arising in part out of early erroneous expectations that, though catastrophic, the disease would spread much more slowly than has in fact been the case.
- Pressing socio-economic needs that appeared to have greater urgency and that commandeered the attention of over-strained government departments. Government response has tended to be similar to that of individuals. For many individuals, responding to survival needs gets a higher priority than taking action to prevent HIV infection. Likewise, for many governments, responding to national economic and security needs got higher priority than strategies for dealing with the HIV/AIDS epidemic.
- Major economic problems, related to structural adjustment programmes and debt servicing obligations, consumed the attention of national leaders.
- Different forms of political transition—frequently accompanied by major outbreaks of civil strife—with the ensuing transformation of society, absorbed the time, energy and best resources of politicians and policy-makers. In addition to Uganda's emergence from a civil war, the period of the epidemic has seen the establishment of self-rule in Namibia, South Africa's transition from apartheid, the ending of civil war in Mozambique, prolonged war along Ethiopia's borders, extensive civil strife in Rwanda, and the adoption by many countries of a more liberalised, multi-party political system.
- Natural disasters, particularly the droughts of 1991/92 and 1994/5 and the more recent floods in Mozambique.

At the internal levels of countries, there were additional constraining factors:

- the lack of wholehearted political leadership and commitment. Uganda, the one country where this was forthcoming from a comparatively early stage in the epidemic, is unique among the countries of the sub-region in now experiencing a substantial decline in prevalence rates;

- inadequacy of management capacity. In addition to its inherent weaknesses, capacity has been steadily undermined by staff losses to AIDS itself, but that this was happening was not always well understood.
- lack of coordination of interventions, with no clear picture of who was doing what, what worked, what did not work;
- difficulties in establishing partnership and collaboration arrangements because of funding problems, organisational difficulties and extensive staff turn-over;
- the smothering silence about HIV/AIDS, its transmission and its consequences. At first, some countries denied its existence as a national problem. Later, when this position could no longer be sustained, it was acknowledged at quite a superficial, notional level. Even today, it remains enshrouded in a cloak of silence, secrecy and shame that compromise national efforts to respond to its challenges.

The countries of Eastern and Southern Africa have made headway by putting in place various strategic plans for dealing with the epidemic. For the greater part, these plans have also been accompanied by the establishment of national AIDS councils and secretariats. The councils comprise high-ranking personages—mostly cabinet ministers but sometimes with representation from civil society—while the secretariats constitute the major national planning, coordinating and resource mobilising bodies. Actual implementation is usually entrusted to district level bodies which are closer to the grassroots.

The principal merit of these arrangements is that they demonstrate country understanding that “lowering incidence and mitigating the epidemic's impacts must be a *nationally* driven agenda” (Piot, 2000, p. 7). Other merits are that they

- express extensive political commitment;
- embody a multisectoral approach which deals with HIV/AIDS as a development issue that transcends health;
- facilitate extensive information gathering and knowledge sharing;
- work in a combination of top-down and bottom-up approaches which incorporate all actors and acknowledge very directly the role and responsibility of communities.

Although experience with the existing arrangements is still limited, it would appear that some further elements need to be put in place to sustain the intense, creative action which is required to make headway against HIV/AIDS in the countries concerned. Dominant among these are sustained, dedicated, resource- and action-backed political will and leadership, from the highest political level, down through ministries and other agencies, to communities. This leads to high-profile advocacy, widespread publicity, public acknowledgment of interventions and successes, and unflagging support throughout the public and private sectors. It also facilitates the necessary policy changes and legislative measures, makes it easier for difficult choices to be made, and enables the introduction of culturally sensitive life-sustaining changes. The successful experiences of Uganda are testimony to the power of such leadership in arresting the spread of HIV.

One of the most important gains from outspoken, realistic and dynamic leadership would be a crumbling of the walls of silence, isolation and cultural dislocation that surround HIV/AIDS. Until there is thorough-going realism in acknowledging it as a problem at all levels, responses will be half-hearted, desultory, inadequate.

There is also need for

- emphasis on capacity building at all levels, with a clear perception that a prime need is to protect the management system itself. In this context, there is also need for a greater readiness to combine “global tools with local wisdom” (D. Zewdie, 2000), and hence to seek to shore up depleted human capacity by volunteer and technical assistance experts from outside the country;
- a clear mandate throughout all of society that stresses the individual and collective responsibility of every person to take action for the prevention of HIV transmission and the mitigation of AIDS impacts;
- the forging of stronger partnerships where wholehearted cooperation between government, NGOs, religious bodies, trade unions, business and communities can become the order of the day;
- more and better information, not merely about health concerns, but about the way HIV/AIDS is affecting health, education, and other social services in the delivery of their mandated services; about the poverty and gender aspects of the epidemic; about its effects on village level agriculture and productive potential; about responses to the orphans situation; about the impact of the disease on the economy both of the nation and of households; about the way business is being affected;
- the loosening up of bureaucratic structures and requirements to allow for quick responses to situations as they emerge and a freer flow of resources to areas of need.

The HIV/AIDS Strategic Frameworks that governments have established are evidence of their commitment to accord high priority to the fight against AIDS. Incorporation of the points that have been raised will strengthen these plans and frameworks even further so that they can indeed achieve their stated objectives of reducing HIV transmission and successfully managing the extensive impacts of the disease.

Chapter 2

Vulnerability to HIV/AIDS

However one regards it, education is a person-intensive activity. It caters for large numbers of students, with the number of teachers or instructors being proportionate to the number of students, and the number of education officials being closely related to the overall size of the system. This makes education particularly vulnerable to the way HIV can scythe its way through its operations, affecting teachers and education officials as the present generation and students as the next generation.

Box 1: Factors that Increase Vulnerability to HIV Transmission

- Multiple sex partners
- Occasional or regular migration for wage work
- High levels of alcohol consumption
- Proximity to transport or trading centres
- Frequent interaction with market centres
- Low status of women
- Limited economic independence of women
- Major economic differentials between men and women
- Physically damaging sexual practices
- Widespread exchange of cash or favours for sexual services

Source: Barnett, 2000, p. 1

To understand and cope with the impact of HIV/AIDS on education necessitates some understanding of the complex socio-economic and socio-cultural environment in which education systems in Eastern and Southern Africa operate. Almost all of the factors outlined in Box 1, which were developed for the subsistence agricultural sector, apply also in education. Of special concern are the issues of gender, poverty, migration and sexuality. Some thought must also be given to the school as a high risk institution.

HIV/AIDS and Gender

In spite of the fact that, world-wide, more adult men than women are HIV positive, women are more at risk of contracting HIV than men. There are physiological and cultural reasons for this. In Sub-Saharan Africa these reasons have worked their way out into the open with 55 percent of the HIV-positive adults being women and 45 percent being men. From an educational aspect, it is important to understand some of the socio-cultural factors contributing to this.

In the majority of societies in Eastern and Southern Africa, women lack complete control over their lives and are socialised from an early age to be subordinate and submissive to men, particularly men who command power such as father, uncle, husband, or male guardian (cf. Box 2). Socially promoted male dominance and lack of self-assertiveness on the part of women make it very difficult for them to refuse sex or to insist on the use of condoms with a partner who may be HIV-infected. This leads to many women being infected by their sole sex partner—their husband, and increases the likelihood that the wife of a man who has died of AIDS will herself soon succumb to the disease. At the International HIV/AIDS Conference held recently in Durban, it was noted

that the fact of being married posed one of the gravest risks of HIV infection for many women in Africa and large parts of Asia.

Box 2: Engendering Attitudes and Dispositions

Gender Attitudes

The view is almost universally held that a woman is not an independent human being but is one who must by nature depend on a man and serve a man. Her role is a subservient one—to meet the physical, psychological, economic and sexual needs of a man, to be obedient to him and to show him unquestioning loyalty, to bear and rear his children, and to arrange for his comfort. This view is shared by men and women alike. In relation to the girl child it leads to the attitude that essentially a girl is a wife-in-waiting. Hence her most important task during childhood is to learn what is needed so that she can become a good wife and good mother. The school education of a girl may be useful, but it is not perceived as being absolutely necessary since she will be able to depend on a man for her livelihood. This attitude underlies many of the problems girls experience in having to shoulder their large burden of household chores and responsibilities, getting parental permission to attend school, obtaining the necessary school fees, developing an inquiring, questioning mind, and making their mark in school.

Child-Rearing Practices

The girl child is socialized to look after others, especially through the care of children and attention to adults; the boy child is socialized to look after himself, largely in the company of his age-mates. Much of the young girl's life is spent in the vicinity of the home, much of the boy's is spent roaming about. This leads to a quiet, caring, somewhat submissive disposition in girls, and to an adventurous, aggressive, attention-seeking disposition in boys. Both sets of attitudes surface in the classroom, where the teaching is structured to respond positively to those who are more aggressive and attention-seeking, that is, to boys. In the process, girls suffer.

Source: Kelly, Msango & Subulwa, 2000, pages 34–35.

Further gender dimensions that put women and girls at great risk of HIV infection arise from

- economic necessity which obliges many women and girls to exchange sexual favours for the food or money needed for their families, personal upkeep or education;
- the pressing sexual attention which many women and girls experience from their employers, superior officers, teachers, and others on whom they are in some way dependent;
- equating female ignorance of sexual matters with innocence and knowledge of sexual and reproductive health issues with moral laxity;
- the commonly-held myth that a man can 'cleanse' himself of HIV by having sex with a young girl or virgin;
- the widespread practice of dry sex;
- cultural requirements that following on the death of her husband a woman be ritually cleansed by intercourse with a member of her husband's family.

These deep-rooted gender attitudes and the practices to which they give rise fuel the transmission of HIV. A crucial role for an education system that seeks to form attitudes and practices that will minimise HIV transmission is to work strenuously and systematically for greater gender equality, the championing of women's rights, and the

empowerment of women. As will be seen, several programmes which education ministries in Eastern and Southern Africa have introduced into their schools deal with these issues from the perspective of life-skills. While this is commendable, there is the further need for education systems to address the gender inequality issue more deeply so that over time new cultural understandings and practices may emerge that will show more respect to women and girls, be more sensitive to their rights, and more accommodating to their being in charge of their own lives. Only then will it be possible for women to experience the truth of the adage: "it's my life, it's my choice." Until that time comes, women and girls must contend with the disempowerment that comes from the approach that "it's my life, but his choice," an approach that makes them exceptionally vulnerable to HIV infection.

HIV/AIDS and Poverty

Unlike other infectious diseases, HIV/AIDS does not respect social barriers. It affects rich and poor alike. Nevertheless, poverty seems to facilitate the spread of the disease and worsen its impact. One overarching reason for this is that where poverty prevails, responding to immediate short-term survival or satisfaction needs assumes greater importance than protecting long-term benefits. This is very strongly the situation with HIV/AIDS, where no immediate harmful consequences are experienced and the infection appears to lie dormant for several years.

The majority of countries in Eastern and Southern Africa experience high levels of poverty and income inequality. In Zambia, for instance, poverty levels have worsened in recent years, with an estimated 72 percent of the population now living below the poverty line, while in South Africa, despite its better resourced systems, about 60 percent of children live in poverty. Situations like these increase national vulnerability to HIV infection. Factors contributing to this vulnerability include

- the lower nutritional status of poor people;
- their poorer state of general health;
- their lack of access to adequate health services;
- the smaller likelihood of treatment for sexually transmitted diseases which they may have incurred;
- their lack of access to information and the means of protecting themselves in sexual encounters;
- the overcrowded conditions in which they live;
- the survival needs which cause poor women and girls to enter into sexual relationships and to protect their expected income by not insisting on condom use;
- the economic needs which propel young men from poor families to leave home and migrate from one high risk locale to another in search of work;
- the virtual absence of pleasurable experiences, other than sex, available to poor people.

But if poverty exacerbates vulnerability to HIV/AIDS, the reverse is also true: HIV/AIDS aggravates poverty. It does so by thrusting households back on ever more limited resources as it removes wage-earners from employment, reduces the ability to engage in small-holding or agricultural work, deflects resources to medicines and health care, and draws down on savings or capital. The disease also aggravates the poverty situation through the reduction of employment opportunities as industry adjusts to its impact, and through the decline in economic growth arising from the loss of skilled human resources and the use of resources for consumption rather than investment.

The poverty–HIV/AIDS interaction impacts on education mostly at individual and community levels. Notable manifestations are the withdrawal of children—especially girls—from school because of inability to meet school costs, the irregular school attendance of children from AIDS-infected homes, the failure to provide for the education of orphans, the inability of communities to provide as much support for schools as they did in the past, and the establishment by communities of schools for their own children. In many cases, education systems have failed children from poor homes, especially where the poverty is exacerbated by HIV/AIDS. The community school is a community attempt to respond to this failure. It is an initiative that deserves considerably more public support than it appears to be attracting.

HIV/AIDS and Migration

Occasional and regular migration for wage employment are characteristic of almost all countries in the Eastern and Southern Africa sub-region. There is much movement from rural to urban areas and from smaller towns to bigger cities. There is much movement within rural areas for seasonal employment in tea, coffee, and sugar plantations and on various types of commercial farms. There is a regular influx of young men to mining areas. In recent years, industrial reorganisation and the closure of mines and factories have led to reverse migration, from industrial and urban centres to rural areas. The extent of these and other forms of migration can be gauged from Zambia's experience. Its 1998 Living Conditions Monitoring Survey found that ten percent of Zambians had lived in their present location for less than a year and nearly forty percent had lived in their present location for less than five years.

In South Africa this migratory labour system was codified by the apartheid regime into a rigorous system of laws that did not allow families follow men to their place of work. As a result, the migratory labour force sought an outlet in a variety of sexual practices which put them at high risk of HIV infection. The effects are now being experienced across South Africa. Throughout the sub-region, these migratory movements break down the social cohesion that binds communities together and establishes acceptable codes of conduct. This increases the likelihood that sexual activity with non-regular partners, or with multiple partners (one at home, one or more at the place of work), will occur, thereby increasing vulnerability to HIV infection.

Although work in education is not classified as migratory, students and education personnel may share some of the HIV infection risks of more mobile workers:

- Providing term-time boarding accommodation for students, in schools and third level institutions, enhances the risk of HIV infection for both the students (virtually all of whom are sexually active) and the surrounding populace.
- There is considerable risk for trainee teachers who may have to make their own temporary accommodation arrangements when posted to a school for practice teaching.
- Many teachers, finding themselves posted to schools which have little by way of institutional accommodation must hunt around for suitable housing; until they have found some, they cannot bring their families with them. It is much the same with education officials who are transferred from one location to another, but without adequate provision being made for their families to accompany them from the outset (this is not unique to education but happens in all areas of public sector employment).
- Education personnel are frequently sent on training courses that last from a few weeks to a few years. In the majority of cases, spouses can accompany them on programmes that last for more than one year. But generally they are separated from their spouses

and families if the programmes last for less than a year, a factor which makes them vulnerable to casual sex (or quasi-steady temporary relationships) and HIV infection.

In recognition of these and similar risk problems for education personnel, Malawi and Uganda both underscore the importance of locating teacher training programmes, both pre-service and in-service, close to the individual's place of residence, in order to limit long absences from home. They also advocate that education ministries adopt policies which will encourage the assignment of teachers near their families.

The issue of boarding and hostel accommodation must also be addressed. Information here is almost non-existent, pointing to the need to assess the HIV status of residential compared to non-residential students. Some information on this in relation to universities may be forthcoming from a study commissioned by ADEA's Higher Education Working Group on HIV/AIDS and Universities in Africa which is to be presented to the Association of African Universities in February 2001.

A Dangerous Lack of Knowledge

Many young people run the risk of HIV infection because they lack essential factual knowledge and information. Information on how the disease is spread and prevented is critical for any learner in the sub-region, but the evidence of surveys is that many do not have this information. Thus, a survey of Grade 4 learners, conducted in many African countries in 1999, showed that vital life-protecting information is not always there. More than 30 percent of the learners in each of the countries named in Table 3 did not know that HIV/AIDS could be contracted through exposure to the blood of another person. There was a similar lack of knowledge about the possibility of spreading HIV by the sharing of needles or sharp instruments. It may also be significant that the two countries with the highest prevalence rates, Botswana and Zambia, had the lowest levels of knowledge about HIV transmission.

	Knowledge of HIV/AIDS Mean Score (%)	Pupils Reaching Desirable Mastery Level in Life Skills (%)	HIV Prevalence (15–49 year-olds) (%)
Botswana	42.3	14.9	35.80
Malawi	72.8	69.4	15.96
Uganda	65.6	51.1	8.30
Zambia	47.2	26.1	19.95

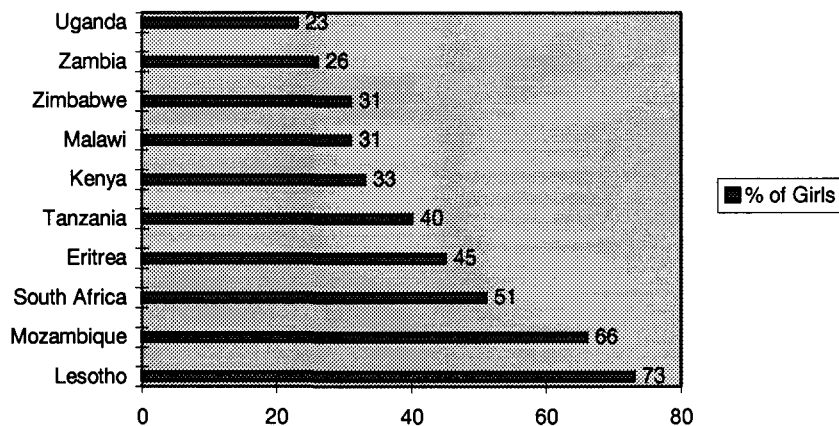
Source: Chinapah & Others, *MLA Project Report*, 2000, Box 3.1 & Table 3-4.

In its recent report, *The Progress of Nations 2000*, UNICEF also brings out that “information about AIDS and its deadly danger is not getting out (to young people) or it is not being absorbed” (UNICEF, 2000, p. 6). Referring to information from Demographic and Health Surveys, the report points out that in Mozambique, where prevalence is a high 13.2 percent, a massive 74 percent of girls and 62 percent of boys, in the 15–19 year age-range, did not know any way to protect themselves against HIV/AIDS. In Tanzania, where 8 percent of the adult population is infected, 51 percent of girls could not name a single way of avoiding infection, nor could 35 percent of boys. In Zambia, 23 percent of girls and 10 percent of boys, in Zimbabwe 17 percent of girls and 8 percent of boys, and in Uganda

16 percent of girls and 11 percent of boys were unable to name even one way of protecting themselves against HIV infection.

Even where awareness is relatively high, a significant proportion of sexually active girls (aged 15–19) do not see themselves as being at risk of HIV infection—52 percent of the girls surveyed in Zambia and 50 percent of those in Zimbabwe thought they faced no such risk. Finally, the report highlights the widespread misconception of girls who think that a person who looks healthy cannot be infected by HIV and hence cannot transmit it. For the sub-region, the proportion of girls who thought along these lines varied from 73 percent in Lesotho, through 66 percent in Mozambique and 51 percent in South Africa, to 26 percent in Zambia and 23 percent in Uganda (Figure 1).

Figure 1: Percentage of Girls (15–19 y.o.) who do not know that a person with HIV/AIDS may look healthy



Source: UNICEF, *The Progress of Nations 2000*, p.7

HIV/AIDS and Sexuality

These figures bring out starkly the need to provide all young people with much better information on HIV/AIDS. They need to know the facts. That is a first essential for all the countries of the sub-region. But the facts alone will not save people from infection. Several of the countries report extensive knowledge about the epidemic. Notwithstanding this, incidence increases and prevalence grows. UNICEF points out that for the necessary behavioural changes to occur there must also be information campaigns to address the underlying attitudes, values and skills needed to protect oneself. It is precisely at this level that the greatest difficulties are encountered because of the problems in surmounting the communications barrier when dealing with issues of sexuality.

Educators, in common with the education systems to which they belong, tend to shy away all too easily from dealing in an existential manner with the basic issues of child and adolescent sexuality. In so far as they broach this subject at all, they remain content for the greater part with an abstract presentation of themes and principles, with a rigid presentation of coldly true propositions, with an enumeration of biological and physiological facts. The perspective is that of genitality, but not of a sexuality that involves the human being as a whole. In this process, the educators remain unaware that there is an enormous communications gap, that they and the young people they are dealing with are not on the same wavelength. The educator can present much information on dangers and high risk situations. Some may provide an authoritarian list of 'do's and

don'ts'. Some may even try to use fear to motivate the young person to adopt sexually safe behaviour.

But these approaches fail to speak to young people where they are. They do not enter into dialogue with the underlying cultural expressions which motivate young people from within more powerfully than anything the educator may propose from without.

Crucial aspects of these underlying cultural expressions include:

- the power of peer pressure and the group;
- the message implicitly learned from parental failure to discuss sex with their children, that sex is something which should not be discussed between adults and the young, but only between the young themselves, as equals;
- the socialisation process which teaches boys that they must be “physically strong, emotionally robust, daring and virile.” and that they should not depend on others, worry about their health, or seek help when they face problems (UNAIDS, March 2000);
- the widespread disbelief in the possibility of total sexual abstinence, particularly on the part of boys (and even some suspicion and concern when there are signs of such abstinence);
- the veneer of ‘respectable’, approved sexual behaviour encountered in society, while it is common knowledge that large numbers of adults are following a different sexual code;
- social expectations that condone in men and boys what they condemn in women and girls;
- the widespread and more-or-less accepted violence against women and girls;
- the way in which society condones or overlooks forced sex, at least so long as it does not extend beyond certain legally defined limits;
- the enormous mix of cultural values and countervalues coming from the weakening and progressive demise of traditional cultural systems, the importation of systems in which immediate pleasurable gratification assumes a dominant role, and the presentation by the entertainment industry of situations and role models which give prominence to temporary relationships and casual sex;
- the failure to appreciate—because society has failed to inculcate—the real value of human sexuality as contact with and surrender to the personality and not merely to the body of the partner;
- the inadequate inculturation and socialisation into respect for the other as a person towards whom responsibility must be manifested and whose rights must be respected.

Education programmes which seek to respond to these powerful underlying forces and concerns stand a good chance of being successful in enabling young people maintain or adopt behaviour which will protect them against HIV infection. These are areas about which school programmes must communicate. Some of this may be achieved in certain life-skills programmes. But usually the need is for a deeper treatment than that being given at present.

The School as a High-Risk Institution

It has become traditional to refer to the those aged 5–14 as constituting the window of hope. Prevalence is so low among them that programmes targeted at this group provide a special opportunity to prevent infections and reduce the transmission of the disease.

In the countries of Eastern and Southern Africa, the majority of children in this age range are attending school, mostly primary school. While they experience very low HIV

prevalence rates, a number of school circumstances place them at special risk, so that in addition to being a window of hope they also constitute a window of concern. Risk factors at school include the following:

- A large proportion of those attending primary school are already sexually active. There are indications from South Africa that some children become sexually active around the age of twelve, 46 percent of primary school children in Malawi are reported to be sexually active, while reports about street children in Zambia point to their being sexually active from the age of eight (Box 3).

Box 3: The Vulnerability of Young Street Children to Sexual Exploitation

Mpulungu, on the shores of Lake Tanganyika, is Zambia's principal inland port. As an important trading and border post, it also has a high HIV prevalence rate (13.2 percent for the district in 1999). Poverty rates are very high and school enrolments low. Living on the street, because of economic necessity or because orphaned by AIDS, is an unquestioned fact of life that begins at an early age for a large number of children. Though all children are affected, boys who live on the street—*mishanga* boys—are more obvious than girls

When they are very hungry or cold, young *mishanga* boys, aged 8–10, go to their “sugar mummies”, giving sex in return for some material assistance and shelter. In the process, many contract HIV.

Local mores show little concern about sexual play among children of this age. One strongly held misconception is that a boy who is too young to impregnate a girl cannot transmit the AIDS virus since this is believed to be passed to another through the sperm but not through the semen.

In these uninhibited but lethally misinformed circumstances, the infected *mishanga* boy spreads the infection received from his “sugar mummy”, infecting girls who are his own age or slightly younger.

How relevant is it to talk about safe sex for such children? Where will they get condoms? How can they use them? Will they fit?

How can an educational programme protect such children? How can the erroneous views on HIV transmission be corrected when taboos prohibit factual discussion?

Source: Personal Communication, anonymous Mpulungu NGO

- Those attending primary school are of very mixed ages. Because many children begin school late, they are older than they should be for their class. This situation is compounded by the common practice of repeating one or more grades. In Mozambique, Lesotho and Burundi extremely high repetition rates of 22–38 percent are reported for children across all primary grades (ESAR III, p. 73, 1999), while in Zambia about 45 percent of those in primary school have repeated one or more years.
- The school does little to help its pupils develop behaviour patterns for the responsible management of their sexuality.
- Children in primary schools and adolescents rarely communicate with their parents or other adults about sexual and reproductive health issues, but rely greatly on information acquired casually or from their peers, some of which may be false or misleading.

- Many school children are in danger of sexual harassment from teachers, their peers, and strangers. Poverty, intense competition for academic success and advancement, long walking distances to and from school, and travelling always by the same route, contribute to these dangers.

Responding to the risk situation that schools unwittingly pose points to the importance of mainstreaming the HIV/AIDS perspective in all aspects of policy formulation, planning, and action in education, and re-designing education curricula around HIV/AIDS.

Chapter 3

The Impact of HIV/AIDS on Education Systems in the Sub-Region

The Absence of Comprehensive Information

Evaluating the impact of HIV/AIDS on education systems in the countries of Eastern and Southern Africa is constrained by the lack of comprehensive and reliable data. It is only very recently that some countries have begun to collect specific information on the way HIV/AIDS is affecting school enrolments, teachers, education costs, and so forth. Many still do not do so. The absence of good information is an indication of the sluggish response of education ministries to the disease. It is also an indication of the silence that still envelops HIV/AIDS. It is mentioned in the data-gathering instruments even less than it is mentioned in policy discussions and action plans. This situation is now changing, but the absence of system-wide facts and figures means that currently little is available beyond dipstick indicators and projections from computer simulations.

Ideally, each ministry should have an HIV/AIDS-related information system which would show, by category, and disaggregated by gender,

- the epidemic-related trends in school enrolments;
- the extent and trends in teacher, ministry official and student mortality;
- the number of employees currently HIV-infected or sick with an AIDS-related condition;
- the number of employees maintained on the payroll but unable to work;
- the number of employees with HIV/AIDS in their immediate families;
- the extent of HIV/AIDS-related sporadic absenteeism, sick leave and compassionate leave;
- the impact of such absenteeism/leave on the ministry's ongoing activities, both in schools and colleges and in the various ministry offices;
- the number of employees, especially females, in need of more flexible timetables that will facilitate their provision of care to sick household members;
- the number of hours or days given to funerals; and
- the funeral costs which the education ministry bears.

Bearing in mind the information limitations, the pages that follow will examine the impact of HIV/AIDS on education systems in the countries of Eastern and Southern Africa in terms of school enrolments, orphans, teachers, management, resources, and quality of provision.

HIV/AIDS and School Enrolments

HIV/AIDS affects school enrolments in three principal ways:

1. demographically, through its impact on the size of the population of school-going age—the number of children who could attend;
2. socio-economically, through its impact on household arrangements and social fabric—the number of children able or willing to attend; and
3. psychologically, through its impact on the emotions of children—the number of children fit to attend.

HIV/AIDS will slow population growth rates in countries of the sub-region. Apart, however, from Botswana and Zimbabwe, it is unlikely to lead to reductions in population size. Because of the way it strikes at those aged 15–49 it will radically alter population structures, thereby necessitating extensive changes in the way societies organise themselves. These structural changes will impact on the ability and willingness of children to attend school (or of parents to require them to do so). The slower population growth will result in the number of children of school-going age being smaller than it would otherwise have been.

Four factors contribute to the slower—or even negative—population growth:

1. large increases in adult mortality;
2. significant increases in AIDS-related child mortality, with the possibility of a doubling in infant and child mortality rates;
3. a lower fertility rate—HIV impairs a woman's fertility, resulting in an infected woman bearing 20 percent fewer children than she otherwise would; and
4. reduction in births because of the premature death of women in their child-bearing years.

This demographic development will result in the number of pupils of school-going age being smaller than it would otherwise have been. A 1992 AIDS assessment and planning study for Tanzania projected that “in the worst-case scenario, at the primary level there would be 22 percent fewer children to be educated, and at the secondary level, the relevant age groups would be reduced by about 14 percent” (World Bank, 1993, p.68). By the year 2010, the combined primary and secondary school enrolments in Namibia are likely to be eight per cent lower than in 1998, while

- in Kenya, the number of children of primary school age will be 13 percent lower than if there had been no AIDS;
- in Swaziland, 23 percent lower;
- in Uganda, 12 percent lower;
- in Zambia, 20 percent lower; and
- in Zimbabwe, 24 percent lower.

The sickness of a productive adult places its own range of demands on household resources. The death of the adult increases the strains. The situation is aggravated if sickness or death in another branch of the family requires the incorporation of one or more orphans. The consequence is increasing household poverty and a rapid escalation in dependency ratios (cf. Box 4). This AIDS-generated increase in household poverty reduces whatever may have been available for education, with little being forthcoming for school-related cash costs. The result is that children will not be enrolled or those who are already enrolled will drop out.

School enrolments will also be affected by the non-participation or drop-out of children who fall sick, who are needed in the home as care-givers or as child-minders, or whose labour is needed to supplement family income.

Children from families which have experienced AIDS may find school attendance hateful and repellent because of the AIDS-related stigma and scorn they may have to endure. For others, the deterrent is the trauma they have experienced in seeing a parent or other significant and loved adult enduring remorseless suffering and a dehumanising death. Still others may experience such trauma in the school itself, as they witness the physical

Box 4: The Impact of HIV/AIDS on Household Economies in Botswana

One consequence of the high HIV prevalence in Botswana is that up to one half of all households are likely to have at least one infected member. In addition, one quarter of households can expect to lose an income earner within the next 10 years. As a result, the analysis predicted a rapid increase in the number of very poor and destitute households in the coming decade.

In aggregate terms, the analysis predicted an eight percent fall in national household level per-capita income, and an increase of five percent in the number of people living in poor households. Although overall measures of income inequality are unlikely to change significantly, the income and dependency ratios of the poorest households will significantly worsen. Per-capita household income for the poorest quarter of households is expected to fall by 13 percent, while every income earner in this category can expect an extra 4 dependents as a result of HIV/AIDS.

Source: Greener and Colleagues, 2000

deterioration of a teacher or fellow-student. Psychologically, AIDS is racking numerous children, leaving them unfit for school participation.

The trauma is accentuated for children who become aware that they will soon be orphaned and who are being inducted at a very young age into adult roles and responsibilities.

The psychological burden is increased in families which question the value of incurring the costs of sending children to school, because they foresee the possibility that even these children will die young before the families have been able to reap any return for what they spent in educating them.

Some countries already have evidence of stagnating or declining enrolments. In Zambia, the net attendance rate fell from 67 percent in 1996 to 65 percent in 1998. In Swaziland it fell from 80 percent in 1996 to 77 percent in 1997, the decline for girls being larger than that for boys. Zimbabwe reports that over 15 percent of children do not enrol in school, and of those enrolled approximately 30 percent drop out before they complete the seventh grade.

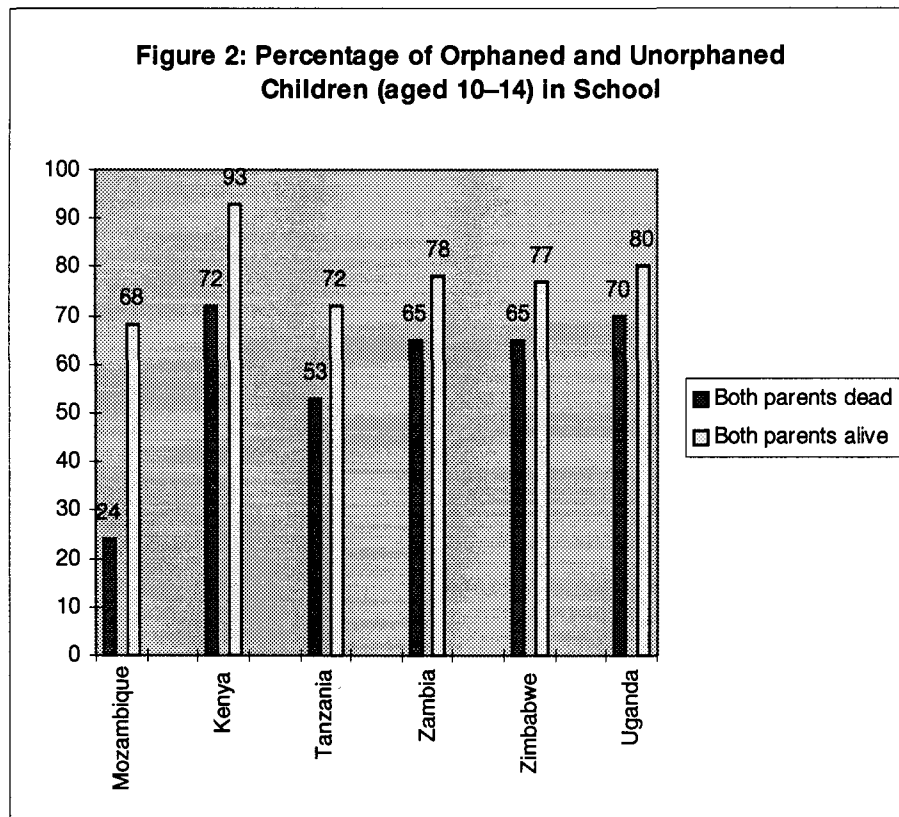
HIV/AIDS and Orphans

One of the most visible and tragic outcomes of HIV/AIDS is the growth in the number of orphans. Recent estimates are that in the sub-region there are more than 18

million below the age of 15 who have lost one or both parents (Annex Table 2). In about 70 percent of the cases, these children have been orphaned by AIDS. In almost all countries the number of orphans will rise during the coming decade, reaching a total of almost 24 million.

The orphans problem is of such scale that it is quantitatively and qualitatively different from anything hitherto known. It surpasses in extent the orphan situation experienced during the world wars of the 20th century. It surpasses in extent the refugee problem that has plagued the world for almost a century. It is in danger of surpassing in extent the ability of society to deal with it. In addition to its other effects, the orphans problem is casting up two major problems, one at each end of the age range. Increasingly, the burden of orphan care is falling on the elderly many of whom lack the physical resources and the health, energy and vigour to be able to rear a second, and sometimes even a third, family late in their lives. The age-old question—who will care for the carers?—is fast becoming a major question in regard to these elderly care-givers. At the other end of the spectrum are the “juvenile adults”, young people who have been thrust into adult roles to fend for themselves or head a household while they are still children.

Orphans run greater risks of being denied education than children who have parents to look after them (Figure 2). In Mozambique, for instance, only 24 percent of children whose parents had died were attending school, compared with 68 percent of those with both parents still living. Orphans who are left to their own resources can seldom pay school or training fees. Grandparents and other family members who take over the care of orphaned children may also have difficulty in meeting school costs, may give priority to their own children, or may depend on orphan labour for survival. In extreme cases, which are all too numerous, orphans turn to the street where their physical needs and financial desperation make them vulnerable to crime, substance abuse and sexual exploitation. This places a significant number at risk of contracting HIV through virtually inescapable income-generating prostitution.



HIV/AIDS and Teachers

In almost all countries, teachers and educators constitute the largest occupational group. They are also a very high risk group for HIV infection. This arises from their relative affluence in a poor society, their mobility, and the circumstances that frequently separate them from their families. Increased understanding of the dynamics of HIV transmission may be changing this situation so that the HIV risk for new recruits to the ranks of educators is less than in the past. But for the majority of serving educators, who entered service before the early 1990s, HIV infection rates are likely to be higher than those in the general adult population. Hence higher proportions of them may die from AIDS in the coming decade.

Box 5: Best Practices—Orphan Care in Malawi

In 1992, Malawi's National Orphan Care Task Force developed the subregion's first guidelines for the care of orphans. The main points of these guidelines are:

- The first line of approach in orphan care must be community based programmes. The Government will coordinate the activities of service providers.
- Formal foster care will be expanded as the second most preferred type of care.
- Hospitals should record next of kin, so that relatives can be traced if children are abandoned.
- The Government will protect the property rights of orphans, and these rights should be widely publicised.
- Self-help groups should be developed to help affected families with counselling and other needs.
- NGOs are encouraged to set up programmes of community-based care in consultation with the Government.
- The needs of all orphans should be considered on an equal basis, regardless of the cause of death of the parent or parents, or their gender or religion.
- The Government will encourage donor support for resources to help orphan programmes.

Source: UNICEF/UNAIDS, 1999, p. 13.

Because AIDS-related information systems have not been developed in most education ministries, good information on teacher infection and mortality is at a premium. But the little information that is available shows the kind of losses that the education system faces:

- in Kenya, the Teaching Service Commission has reported that teacher deaths rose from 450 in 1995 to about 1,500 in 1999;
- Uganda's education ministry reported 948 teacher deaths in 1997, up from 792 in 1996; it is estimated that 500 of the 1997 deaths were due to AIDS (the completeness of the reporting is not certain);
- between January and the end of April 2000, 21 teachers in one of Zambia's urban education districts died; this was the equivalent of an annualised loss of about 9 percent (the loss may have been exceptionally high because of the deployment of sick teachers into the urban centre so that they might be near to medical services);
- Cote d'Ivoire is reported to be losing teachers at the rate of five per teaching day (900–1,000 a year);

- an estimated 860,000 children in Sub-Saharan Africa, two-thirds of them in eight countries of the sub-region, lost their teachers to AIDS in 1999 (Annex Table 3);
- schools have closed in the Congo because AIDS has left them without teachers;
- at the micro-level, a school in Uganda which had 20 trained and two untrained (licensed) teachers in 1989 was operating in 1993 with four trained and seven untrained teachers;
- severe losses through death are occurring in teacher education programmes, with colleges and the university School of Education in Zambia reporting student deaths in the 1.5–3.0 percent range.

Education systems are also losing teachers and other educators to other areas of employment which offer better remuneration. The attrition which has been a long-standing running sore for education has been aggravated by the search for educated personnel to replace those lost to AIDS in other sectors of government, business and industry.

Losses are also occurring due to AIDS-related sicknesses:

Though mortality represents the final outcome, it may be that morbidity resulting from AIDS takes the higher toll. It is improbable that once a teacher develops full-blown AIDS that he or she could contribute much professionally. Since, on average, it is about a year from the development of AIDS to death, a fair assumption is that each new AIDS case results in the loss of one year of professional time. But the immune system can be breaking down for a long period of time, and the infected person can be beset by a series of illnesses long before diagnosis of full-blown AIDS. A conservative assumption might be that, on average, each infected teacher loses six months of professional time before developing full-blown AIDS and then, 12 months thereafter, dies (Goliber, 2000, p.27).

Two other aspects of the loss of educators are important for their impact on the education system. One is that the capacity of teacher education programmes to keep up with teacher attrition will be undermined by their own staff losses. The second is the problem of finding replacements for specialist teaching and other staff. When the loss is that of a general educator, there is some possibility of others moving over to cover the needs. This is not possible when the loss is that of a highly specialised educator, such as an A-level teacher of mathematics or science, or a college lecturer in infant teaching methods.

Teachers are also suffering from overwhelming stress and psycho-social trauma. They are deeply affected personally by the incidence of HIV/AIDS among their relatives and colleagues, and by fear and uncertainty about their personal infection status. Though these are major causes of concern for them, they are areas in which they may receive little support. Thus, it has been found that less than one-third of a sample of teachers who had experienced AIDS sickness or death among their relatives had talked about the problem with friends or relatives. The remainder felt either unable or unwilling to do so.

Unhappily, the HIV-related stress which many teachers experience is aggravated by the expectation that they will incorporate HIV/AIDS education (and possibly reproductive and sexual health) into their teaching. Many feel poorly equipped to do so, saying they have not received the necessary training or support materials to enable them to teach in this area. Several show by their teaching and responses to questionnaires that their knowledge and understanding are very deficient. Others are afraid to raise issues of sexuality with their students lest they tread on taboo areas, give offence to parents, or be accused of teaching immoral practices to children. Many are personally very sensitive on the whole subject of HIV/AIDS, knowing or suspecting that they themselves or one of their family may be infected.

HIV/AIDS and the Management of Education

Throughout the sub-region, capacity to manage and plan for the education sector is at a premium. The majority of managers have not received extensive professional preparation for their responsibilities, but hold their posts by virtue of their seniority or the experience gained as they rose through the ranks. On the basis of such experience, many must single-handedly take charge of their given area of expertise.

HIV/AIDS wreaks havoc with such a fragile system, since it removes the one element that is irreplaceable, understanding built on experience. An education ministry suffers total loss when it experiences the death of technical, management, planning or finance personnel through AIDS. Its ability to plan, manage and implement programmes and activities is seriously impaired. And this loss occurs at the time when the ministry stands in greatest need of its best human resources, when it depends on all the wisdom of its institutional memory, to plan for and manage the turbulence that HIV/AIDS is creating throughout the sector.

The central management and leadership tasks for an education ministry in a heavily infected country are to equip its clients and personnel with the tools needed to reduce the likelihood of HIV transmission, to extend care and support to those who have been infected or affected, to manage the system so as to mitigate the impacts of the disease, and to work proactively and creatively to enable the system transform a situation of tragedy and reverse into one of optimism and prospect.

Reducing the likelihood of HIV transmission necessitates mainstreaming HIV/AIDS into all ministry programmes—formal education programmes in all its institutions, from the elementary grades to the universities; non-formal workplace programmes for its educators, managers, and support staff.

Extending care and support to infected and affected individuals necessitates close attention to

- personnel issues (leave, accommodation, payment of benefits, working hours, etc.),
- the establishment of client-friendly confidential contact points where the client (student, educator or official) can access guidance, counselling and medical services,
- the freeing up of bureaucratic structures to allow for speedier and more person-sensitive decision-making and communication,
- policies that affirm the valuable contribution that persons living with HIV/AIDS can make, that rule out all forms of discrimination and stigma, that give expression to and protect human and legal rights (above all, women's equality with men),
- policies and actions that ensure that all clients of the system, but especially orphans and other vulnerable children, have access to the services which address their basic needs for education, HIV-related information, and protection from abuse, exploitation and maltreatment.

The first requirement in managing an education system to mitigate the impact of HIV/AIDS is for information—good information on how all areas of the sector are being impacted, the responses being made, and what these are leading to. The information will guide policy and planning, but this should be much more open than in the past. Above all else, policy, planning and implementation should be multisectoral, building on strong partnerships with other government ministries and departments and with the various organs of civil society and industry. The AIDS crisis is not compartmentalised. It affects people in all aspects of their lives. Likewise, the response cannot be compartmentalised

but must be global in two ways—reaching into every aspect of people's lives and involving every agency that deals with people. The need is for an education ministry and its many partners to “lower their respective flags and harmonise their responses so as to focus their collective resources to have their biggest impact in the areas of most need” (Minna, 2000).

Capacity building and the development of leadership are crucial for successful impact mitigation and creative, positive management of an embattled system. Both are under threat from HIV/AIDS, yet both must be developed through training, the appointment and retention of the best people, the provision of the necessary support personnel and services, and deepening of understanding not only of the ways the disease is impacting on the system but also of the ways in which these impacts can be forestalled, negated, or even turned to good account.

HIV/AIDS and Resources for Education

For it to meet its stated objectives and provide its mandated services, education needs extensive human, financial and material resources. HIV/AIDS reduces the availability of all three. The way in which it erodes human resources has already been documented in the previous pages. The only further point that needs to be made is to note that HIV/AIDS is also occasioning severe staff losses and reduced productivity in crucial support areas for education, such as examinations, curriculum development, or publications.

HIV/AIDS affects the availability of financial resources for education through its impact on the availability of private and public funds for the sector.

Owing to AIDS-occasioned reductions in family incomes households tend to have fewer disposable cash resources. The disease also obliges them to change their priorities in the disposal of those resources, with a large increase in the proportion going to medical care, cleansing materials, transport and purchased foodstuffs (in lieu of what would otherwise have been home-produced). Education does not rank high within these priorities. The disease also constrains the support that the commercial and industrial sector can provide for education. Because of the disease, commercial and industrial concerns experience reduced profits because of lower productivity, higher medical and insurance costs, extensive staff replacement and training costs, and the costs of educational programmes for the prevention of HIV.

HIV/AIDS also reduces the availability of public funds for education. The mechanisms at work here are similar to those affecting the availability of private funds: when AIDS is present, the national income declines (or does not grow as it otherwise would), costs increase, and priorities change. National income is affected by reduced productivity (arising from loss of experienced personnel, repeated illnesses, absenteeism for funerals, and low work levels of infected and affected employees), a sluggish tax-base, disinvestment, reduced savings, and a reduced capacity to manage resources. Priorities change in response to pressures for increased allocations to health and welfare, and for increased investments in capacity building and training to make good for staff losses. Costs increase in the same way as for private employers: the public sector faces higher medical and insurance costs, extensive staff replacement and training costs, the additional costs of new HIV/AIDS-related posts and structures, the costs of HIV education and sensitisation programmes, and the frequently recurring contractual costs for burials and transport costs for funerals.

Extensive public funds are also tied down by salaries for sick but inactive employees. In the education sector, these payments count against the approved budget and hence they reduce the availability of resources for the engagement of replacement teachers and other educators.

At the level of material resources, school development has traditionally relied heavily on community involvement. In rural areas, this takes the form of labour, the provision of building materials, and minor construction work. In urban areas, community involvement tends to express itself in financial contributions to school developments. All of this involvement is impaired by HIV/AIDS. The loss of active members makes it difficult for rural households to provide for their own needs (and for those of families which have experienced AIDS losses), leaving them without the time and energy to take part in school developments. Similarly, the potential of urban households to contribute to school developments is negatively affected by the poverty-AIDS interaction, the extensive home-based care which they must provide for AIDS patients, and the dedication of time and resources to orphan care.

HIV/AIDS and the Quality of Education

It can be expected that HIV/AIDS will have adverse effects on the quality of education. It seems very unlikely that learning achievement will remain unaffected by such factors as:

- frequent teacher absenteeism;
- repeated bouts of teacher sickness;
- shortages of qualified teachers;
- increased reliance on less qualified teachers;
- sporadic student attendance;
- intermittent student participation, following an irregular “drop-out/drop-in” pattern
- low teacher morale;
- considerable student and teacher trauma;
- inability on the part of both teacher and student to concentrate on school work because of concern for those who are sick at home;
- repeated occasions for grief and mourning in the school, in families and in the community;
- a widespread sense of insecurity and anxiety among young learners, especially orphans;
- fear by girls and young boys that they may be sexually abused or maltreated (a Ugandan study found that in one district 31 percent of girls and 15 percent of boys reported having been sexually abused, mainly by teachers; Gachuhi, 1999, p. 12);
- uncertainty and distrust in the relations between learners and teachers (who may be caricatured by the community as those responsible for the introduction of HIV);
- unhappiness and fear of stigmatisation and ostracisation on the part of both teachers and students who have been affected by HIV/AIDS;
- teacher uneasiness and uncertainty about personal HIV status.

Compounding these problems are those of reduced resources, rather generalised poverty, a sense of unreality about the curriculum's relationship to real life, a disconnect between the world of the school and the world of work, and a pervasive doubt about the need for school education when it seems certain that many will die young because of AIDS. Of relevance to the last point is the grim estimate from UNAIDS (2000, p. 25) that

in any country in which 15 percent or more of all adults are HIV infected, at least 35 percent of boys now aged 15 will die of AIDS.

The outlook for education of much that has been presented in this chapter is bleak. At the very least school effectiveness will decline, given that a significant number of teachers, officials and children die, are ill, lack morale, and are unable to concentrate. Ultimately, there be a real reversal of development gains, further development will be more difficult, and current education development goals will be unattainable within the foreseeable future.

Chapter 4

The Response of the Education Sector to HIV/AIDS

This chapter examines the two basic ways in which education systems have responded to HIV/AIDS:

1. by modifying the curriculum, and
2. by adopting strategic and organisational approaches.

The Curriculum Response

Almost all countries in Eastern and Southern Africa have adapted their school curriculum, or are in process of doing so, in the expectation that this will help to stem the tide of HIV transmission. In the majority of countries, the approach is to use Life Skills programmes. Some countries use this designation to refer to education programmes that are primarily concerned with equipping learners with skills such as decision-making, problem solving, effective communication, assertiveness and conflict resolution. This is the sense in which Malawi uses the term when it refers to Life Skills Education. Others extend the term to include HIV/AIDS education and aspects of reproductive and sexual health. This is the way Namibia uses the term in its extra-curricular life skills training programme, *My Future is My Choice* (Box 6).

Box 6: Aims of *My Future is My Choice*

The focus of *My Future is My Choice* is to protect young people (ages 15–18) from getting infected with HIV and STDs.

My Future is My Choice aims to:

- provide young people with skills to delay sexual intercourse
- prevent young people from becoming infected with HIV and dying of AIDS
- provide young people with facts about sexual health, pregnancy, STDs and HIV/AIDS
- improve the communication between boys and girls, between friends, between young people, their parents and their community
- improve the decision making skills of young people

- provide young people with the skills they require so that they can make informed decisions about their sexual health
- provide young people with the information and skills required to face peer pressure around the use of non-prescription drugs and alcohol

Source: *My Future is My Choice. Extra Curricular Life Skills Training Manual*, Government of Namibia and UNICEF, March 1999, page 1

It has been suggested that the absence of consensus on the definition, scope and methods for including life skills education in the school curriculum may account for the sporadic implementation of such programmes and the delays in embarking upon them (Gachuhi, 1999).

Zimbabwe's Programmes

Zimbabwe is one of only two countries where the population is projected to decline because of HIV/AIDS. With one of the highest HIV prevalence rates in the world, it began to offer a school-based HIV/AIDS and Life Skills Education Programme in 1992 for students in primary and secondary schools. The following year it formalised the compulsory teaching of HIV/AIDS in all schools from Grade 4 (8/9 year-olds) to Form 6 (19 year-olds). About one-fifth of the programme deals with bio-medical information, the remainder with developing life skills such as problem solving, informed decision making and avoiding risky behaviour. In a parallel development, an inservice HIV/AIDS training programme was introduced for serving teachers. In the seven to eight years that it has been running, this programme, which follows the cascade design, has reached about one-third of all teachers in the country. In addition to teachers, all national, provincial and district education officers have received training through the programme. Over 6,000 schools are now teaching the prescribed curriculum, which is supported by specially prepared materials.

A major drawback of the training model employed is that it takes so long to reach the basic target group—the school children. Meanwhile, they remain at risk, they are brought together in the high risk school situation, and they receive little guidance, information and support.

There is no evidence of impact studies to determine whether those who passed through the programme have lower HIV incidence rates than those who did not. An evaluation carried out in the mid-1990s found that teachers were not familiar with the experiential and participatory methods on which the success of programmes of this nature depends. The evaluation also found that teachers continued to be embarrassed to deal with sensitive quasi-taboo areas related to sex and HIV/AIDS. Subsequent investigations also found some student-questioning of the value of using teachers for this subject, since teachers were so likely to be themselves HIV infected.

South Africa's Life Skills Programme

South Africa's Life Skills programme was developed jointly by the Department of Health and Department of Education for learners in Grades 8–12. The syllabus covers the following areas:

- self-esteem, decision-making, attitudes, values
- understanding sexuality, relations with the opposite sex
- reproductive biology; human growth and development
- contraception, preventing unwanted pregnancies

- relationships, negotiation, assertiveness,
- violence and sexual abuse, child abuse, incest, rape
- HIV/AIDS, preventing transmission, how to use a condom
- HIV/AIDS, looking after people with AIDS
- sexually transmitted diseases, prevention, symptoms
- drugs and alcohol.

An assessment of the programme in 277 schools in KwaZulu-Natal—which has an infection rate of 32.5 percent, the highest in South Africa—concluded that “although the Life Skills programme is a key strategy in the state's response to the epidemic, we know little about the programme's effectiveness, or the way in which Life Skills training combines with other resources in families or in communities to influence reproductive outcomes” (Macintyre & others, March 2000, page 5). The assessment found that the coverage and content of the programme varied greatly between schools. Basically, the programme was being offered only in part (if at all) in schools where school heads judged students to be at high risk, but more completely in better-resourced schools.

Each provincial education department is responsible for training teachers in the use of the programme. However, provinces have found that master trainers and teachers lost to the programme need to be constantly replaced. Those working on the programme need to be regularly re-trained, as do officials at middle management level and representatives of school governing bodies. Given the size of South Africa's education system (21,300 primary schools with 8.4 million learners; 4,966 secondary schools, and 2,542 combined schools, with over 4 million learners) adapting and extending the Life Skills programme just to primary schools would mean training 64,000 primary school educators and 21,000 lay counsellors. Implementing the programme on such a large scale is proving difficult.

A Kenyan Programme

Since 1998, Kenya has been implementing a pilot programme—Primary School Action for Better Health—which targets upper primary level students (ages 9–14) in 245 primary schools. The broad goal of the programme is to reduce HIV transmission by bringing about positive behaviour changes in sexual relations and delaying the onset of sexual activity. The programme seeks to

- equip adult community representatives to lead a sustained learning and communication process that will establish behaviour patterns that reduce the risk of HIV/AIDS transmission;
- make resource materials readily available to support education, communication and behaviour change activities in the targeted schools;
- promote changes in the knowledge, attitudes and behaviour of primary students that will reduce the risk of HIV/AIDS transmission;
- capitalise on existing systems by enhancing their operations, rather than seek the development of new ones;
- work through the existing primary school curriculum by selecting key carrier and communication subjects and by developing materials and lesson plans for key topics.

Key aspects of the programme are multi-level community participation, capacity building of community and other participants, and extensive involvement of young people themselves. As part of the programme, each school is also required to develop its own school action plan for health. Having started so recently, the programme has not yet been evaluated.

Programmes in Uganda

From 1985 to 1995, Uganda had a comprehensive School Health Education Programme which aimed at imparting health education to all primary level students and thereby influencing a reduction in STD and HIV infection. Evaluation of the programme in 1994 revealed what has since been observed in other settings: knowledge increased, but there was little discernible change in health behaviour and sexual practices.

Further initiatives were the Life Skills Programme and the Population and Family Life Education Programme. The former sought to train youth in the customary life skills areas of interpersonal relationships, self awareness and self esteem, problem solving, effective communication, decision making, negotiating sex, critical thinking, withstanding peer pressure, and the formation of friendships. The latter sought to equip students with essential knowledge, skills, attitudes and practices that would prepare them for responsible parenthood and honourable relationships with the opposite sex.

Evaluation of the impact of the trial period of the Life Skills Programme pointed to the need for a more widely agreed upon methodological approach to the teaching of this area, to the imperative of developing teachers' skills and confidence to facilitate experiential learning activities in life skills lessons, and to the importance of giving life skills a higher curriculum profile by making it examinable.

Conclusions

The four programmes that have been presented give some idea of what schools are attempting in the area of HIV prevention. There are similar programmes in Malawi, Botswana, Swaziland, Zambia and other countries in the sub-region. Although the details differ, common characteristics and frequently encountered problems help to identify the way forward:

- The majority of the programmes target older children, those aged 9 and upwards. In the light of what was brought out in Chapter 2 above on vulnerability within society and within the school, programmes should target children at an early age, from the day they enter school.
- Programmes appear to have been developed from the top, with minimal participation of classroom teachers, parents, and young people themselves. In addition, programme delivery is almost exclusively in the hands of teachers, again with minimal involvement of parents and young people. This approach has the effect of assimilating the life skills programmes to other curriculum areas which, too often, are seen as having little relevance or reality outside the classroom. The improvement in knowledge without any concurrent behaviour changes, and the wish to have life skills as an examinable subject, suggest that much may be going into the head, but little into the heart. At first sight, programmes appear to be successful. But where they should really count, they are less effectual.
- Consideration of bio-medical topics and barrier methods of HIV prevention needs to grow out of an understanding of relationships, respect for the other, and rights. Presentation of the bio-medical and mechanistic aspects outside the context of the learner's developing sexuality is likely to focus attention on these areas, and the factual knowledge involved, as if these provided the complete answer to HIV transmission.
- The problem of teacher knowledge, understanding and commitment is universally experienced. This is further complicated by the lengthy cascade model for teacher preparation, by legitimate concerns about the dilution and even misrepresentation of content, and by the teacher's dubious status as a role model when she or he may be known to be infected.

- Almost all programmes are characterised by considerable lack of articulation between the various components. In particular, they have been launched in schools before teachers received training and/or before the necessary support materials were developed, produced or disseminated.
- Responsibility for the programme and its components appears to rest with the education ministry alone, with very little evidence of collaboration with other partners or a multisectoral approach.
- The extent to which programmes reduce HIV transmission, STDs, rape or coerced sex has not been evaluated. Only one programme goes so far as to include a reduction in HIV/AIDS incidence among learners as one of its indicators. In the current AIDS crisis, this is the bottom line.

These observations point to the need for considerable re-thinking of education's curriculum response to the epidemic. The weak links in the current response are at programme design and delivery stages. Neither draws sufficiently on parents, significant community members, or community youth members. Both rely too heavily on a centralised approach and on the teacher as the provider of information and developer of attitudes. But because of lack of expertise and training, because of personal sensitivities, and because of remoteness in age and mind-set from younger people, the teacher may not be the appropriate person for this role. In the light of this, the way forward would seem to require close attention to

- involving young people in programme design and delivery, with a firm focus on promoting peer education;
- involving community members, especially local and religious leaders, parents, and youths with standing among their peers, in content specification and delivery;
- using participatory methods and experiential learning techniques;
- developing a learning climate that firmly and frequently re-affirms the principles of respect, responsibility and rights.

Many of these features have been incorporated in programmes targeted at out-of-school youth. These programmes tend to be characterised by the prominent role they accord to young people as peer educators. Because the education is not coming from an outside body, but from contemporaries or the peers themselves, it is more readily assimilated into the peer culture and norms. In other words, the approach recognises the powerful socialising influence that the youth have over each other and seeks to win over to its side the potency of peer pressure. Learning and putting into practice the positive lessons learned from these out-of-school HIV prevention projects (cf. Box 7) should make in-school programmes more effective in equipping young people to defend themselves.

Box 7: Best Practices—Lessons Learned from an HIV Prevention Project for Out-of-School Youth in Zambia

1. Involve the target audience in programme planning and monitoring so as to ensure that interventions are appropriate and respond to the audience's needs.
2. Adopt a varied innovative approach to HIV/AIDS education based on extended and personalised contact with the target audience.
3. Recognise that young teenagers and even high-risk youths can be effective advocates for HIV/AIDS prevention.
4. Increase the likelihood of behaviour change by adopting a holistic approach that addresses issues both directly and indirectly related to HIV/AIDS.
5. Use both same-sex and mixed group sessions.

6. Establish positive and close relations with the community so as to foster programme maintenance and sustainability.
7. Establish open communication channels among all sectors of the programme.
8. Pay attention to the need for regular and effective monitoring and evaluation.
9. Work hard on building youths' self-respect so that they may develop the confidence needed to consider various options and challenge accepted but risky behaviour.
10. Work collaboratively with other sectors and organisations so as to increase the potential for synergy and avoid duplication.

Source: *Early Intervention: HIV/AIDS Programs for School-aged Youth*. USAID, ABEL Technical Paper No. 7, 1997

HIV prevention programmes aimed at out-of-school youth provide one further lesson. This is the importance of marrying top down and bottom-up approaches. Curriculum interventions by education systems are characterised more by imposition from above than by listening to below. Promoting more bottom-up planning and design for HIV prevention work will almost certainly lead to a wide variety of small, local curricula, with great diversity in content, methodology and delivery arrangements. This should be encouraged. What is needed in this area more than in any other is an educational programme that will speak to learners where they are. Uniformity is a very secondary concern. This means that education ministries must be prepared to forego the tidy neatness of centrally designed uniform arrangements and to accept in their place programmes which originate in the schools and communities, respond to their identified needs, and can be offered within their capabilities. In the HIV/AIDS climate, the school curriculum will be a successful tool for prevention education only if education ministries—and their officials at all levels—exercise this tolerance for uncertainty and uncontrolled diversity.

The Strategic and Organisational Response of Education to HIV/AIDS

Structures for the HIV/AIDS Response

If it is to be successful in responding to demands arising from the HIV/AIDS crisis, it will normally be necessary for an education system to establish new *ad hoc* structures for this purpose. This has been done in many countries in the sub-region. Zimbabwe has established an HIV/AIDS National Education Secretariat which aims at preventing the transmission of HIV and other STDs among students, teachers and other staff in educational institutions. Recognising that the major constituents of the education process are teachers and pupils and the tools they use in teaching and learning (the curriculum, textbooks and other educational materials), the response to HIV/AIDS in Zambia's Ministry of Education is to target interventions at these constituents; the response is coordinated by a high level HIV/AIDS focal point, assisted by a full-time HIV/AIDS officer and by part-time focal point persons at provincial, district and school levels. Structures for driving South Africa's education programme in relation to HIV/AIDS are also in place (Box 8), but the activities appear to be only commencing.

Box 8: Best Practices—the Structure for Driving South Africa's HIV/AIDS Programme

- In the office of the Minister—an advisor on HIV/AIDS
- In the office of the Education Director-General—media and publications coordination

- In the Planning and Monitoring Branch—policy on HIV/AIDS for learners and educators
- In the Human Resources and Management Directorate—labour relations and HIV/AIDS guidelines for the workplace
- In the Financial and Physical Planning Directorate—impact assessment
- In the Directorate of Corporate Services—headquarters HIV/AIDS workplace policy
- In the Chief Directorate, General Education—HIV/AIDS coordination
- In the Directorate for School Education—Life Skills Project Committee (with the Department of Health and the Department of Welfare)
- In each of the nine provinces—two HIV/AIDS contract posts for HIV/AIDS-in-education coordination

The establishment of these structures is a move in the right direction. One of their strengths is their link to wider national structures, ensuring that they can be effective channels for the implementation of national strategic plans. However, the information about them and their associated responsibilities suggests that some of them may be too small to be able to deal effectively with what Nelson Mandela referred to as the “tragedy of unprecedented proportions (which) is unfolding in Africa.” In this, they run the risk of being seen and acting as “add-ons” instead of being integral to the entire thinking and functioning of education systems in the countries of the sub-region. Increasing this risk is some tendency to make HIV/AIDS responsibilities additional to those already shouldered by individual managers. This fails to capture the sense of priority and urgency which recognises that preventing HIV infection, providing care and support, and protecting the education system itself require the dedicated commitment that comes from a full-time assignment. There is also some sense that mandates are not clear, lines of responsibility are not clearly demarcated, and easy, rapid access to funding is not assured.

South Africa's strategic plan, *Call to Action: Tirisano (Working Together)*, specifies three strategic areas for HIV/AIDS work in education: awareness, information and advocacy; HIV/AIDS within the curriculum; and HIV/AIDS and the education system. The strategic objective for this third area is to develop planning models for analysing and understanding the impact of HIV/AIDS on the education and training system. This is a feature which is less apparent in other models within the sub-region. All are rightly concerned with controlling and reducing HIV transmission. There seems, however, to be less realisation that the education system itself is under threat and that in the absence of systemic interventions to deal with this threat the system may be unable to play its role in establishing the behaviour patterns that will reduce HIV transmission.

Policies and Strategies for Addressing HIV/AIDS

Some education ministries in the sub-region have developed policies and guidelines for learners and educators in their institutions. Thus, the Zambian Ministry of Education undertakes that it “will provide knowledge, foster awareness and promote life asserting attitudes for staff in the system”, while it will adopt a number of interventions aimed at pupil support, among them intensified support for community schools where a large number of orphans and vulnerable children are found.

The most comprehensive policy statement, however, comes from South Africa's Department of Education. The policy, which was formally issued in 1999 as a gazetted measure, specified that

- The constitutional rights of all learners and educators must be protected equally.
- There should be no compulsory disclosure of HIV/AIDS status.

- The testing of learners as a prerequisite for attendance at an institution, or of an educator as a prerequisite of service, is prohibited.
- No HIV+ learner or educator may be discriminated against, but must be treated in a just, humane and life-affirming way.
- No learner may be denied admission to or continued attendance at an institution because of his or her actual or perceived HIV status.
- No educator may be denied appointment to a post because of his or her actual or perceived HIV status.
- Learners and educators who are HIV+ should lead as full a life as possible.
- Infection control measures must be universally applied to ensure safe institutional environments.
- Learners must receive education about HIV/AIDS and abstinence in the context of life-skills education as part of the integrated curriculum.
- Educational institutions will ensure that learners acquire age- and context-appropriate knowledge and skills so they can behave in ways that will protect them from infection.
- Educators need more knowledge of, and skills to deal with, HIV/AIDS and should be trained to give guidance on HIV/AIDS.

The Department of Education has complemented this policy by issuing guidelines for all teachers in the face of the HIV/AIDS emergency. The guidelines call for a concerted struggle against the pandemic by all organs of society, for openness, for recognition of the dignity of those who are infected, and for care for those affected by HIV/AIDS. They set out the role of educators as

- exemplifying responsible sexual behaviour;
- spreading correct information;
- leading discussion among learners and parents;
- creating a work environment which does not discriminate against those who are infected or affected;
- supporting those who are ill; and
- making the school a centre of hope and care in the community.

In addition, schools are encouraged to develop their own policy on HIV/AIDS, consistent with the constitution and the law, national policy, and HIV/AIDS guidelines to schools, but so far very few have done so.

Countries in the sub-region could take a leaf from South Africa's book and consider developing similar HIV/AIDS policies and guidelines for their learners and educators.

Chapter 5

Providing Leadership for Education's Response to HIV/AIDS

The prerequisites for education's response to HIV/AIDS are the same as those for the response at the national level and in other sectors. The need is for

- dynamic, sustained, publicly manifested, resource- and action-backed political leadership at the highest level;
- the express support, backing and commitment of political, governmental, non-governmental, religious, business, educational, and other national and community leaders;
- openness about the disease, its prevalence and its impacts at all levels—personal, household, community, institutional, sectoral, government, business, production;
- expanding and sharing information about the disease, its incidence, prevalence and impacts;
- a sense of urgency and crisis that judiciously combines the development of strategic understanding and planning with the need to take immediate action to reduce prevention, care for the infected and affected, and mitigate impacts—and thereby to save lives.

Manifest Commitment

Translating these prerequisites into educational terms, the first essential is that the education minister and all senior ministry personnel throw their full weight into the sector's struggle with HIV/AIDS, use the best available human resources in the strategic areas of prevention, care and impact mitigation, and demonstrate through sustained and public communications that until it has been overcome HIV/AIDS is at the heart of the education agenda. This commitment will manifest itself in establishing and staffing the necessary structures, even at the expense of other operations; developing policies and strategies that respond to the changing circumstances; ensuring extensive and recurring advocacy, sensitisation and publicity campaigns; and monitoring the HIV-related activities of those responsible for coordination, curriculum and materials, information gathering and dissemination, planning, and training.

Acting out this commitment may require courageous decisions; for instance,

- to revisit education policies and plans, even in their global conception, to ensure that they are one hundred percent HIV/AIDS compliant,
- to re-examine the very structures of educational provision to ensure that they extend in practice as well as in principle to those who are being marginalised by the disease,
- to review educational financing and cost arrangements in view of the way HIV/AIDS impacts on household budgets,
- to adopt diverse pedagogical approaches—peer teaching, multigrade teaching, distance learning, teaching or non-teaching involvement of community members—to compensate for the loss of qualified teachers;
- to re-orient the school curriculum unambiguously to vocational skills, to meet the needs of children who must head households and of society for a replenishment of AIDS-depleted skills.

In simple terms, much of this reduces to educational leaders always giving HIV/AIDS issues a high profile—internally in the operations and life of the ministry, externally in presentations to the public.

On top of all these concerns, the leaders in the education ministry must integrate into the heart of their operations and demonstrate in their interactions a humane understanding for all their subordinates. While concerned about the broader issues surrounding the disease, they must never lose sight of the suffering that, directly or indirectly, HIV/AIDS is inflicting on their colleagues and subordinates. This deep respect for the human value of every member of the ministry will help it to be a united ministry, and by the same token an effective ministry.

Establish Partnerships

A second essential is the establishment of wide-ranging and active partnerships. The education sector alone will not prevail over HIV/AIDS. This can only be accomplished by combining its understandings and efforts with those of other sectors and of civil society. Both the urgency of the situation and the magnitude of the crisis demand a great willingness to share with others, to participate, plan and work with them, to join in their efforts, and to welcome their participation in the ministry's efforts.

Establishing partnerships at the top level, especially with relatively affluent international agencies, may prove comparatively straightforward. Establishing them at the grassroots level of service delivery, and ensuring that ministry officials down the line accept the partners on equal and open terms, are more challenging tasks for educational leaders; but they are of the utmost importance in the context of HIV/AIDS since it is at the grassroots level that major action must be taken in relation to prevention and care. A major responsibility here is for leaders to listen. The grassroots and communities are at work. Leaders must listen and respond to what they tell them. Instead of imposing their own priorities, leaders must bend all their efforts to supporting frameworks for local initiatives.

This could be summarised by saying that in the context of HIV/AIDS educational leadership must pay special attention to the C-factors: the commitment, cooperation, collaboration, coordination, consultation, cross-sectoral compact, and community connectedness needed to sustain a culture of curing, care and concern throughout the sector.

Build Capacity

A third task for leaders in education is the mobilisation of the necessary resources. In addition to the efforts to raise the resources needed for traditional educational concerns, they must pay urgent attention to enhancing the capacity of the education system to protect itself. HIV/AIDS has placed the system under siege. The haemorrhage of human resources threatens its ability to function. Capacity is being steadily eroded just at the time when the need for it is greatest. Educational leadership is faced with the special challenge of stemming this attrition, making good for what was lost, and establishing a cadre of officials who can plan for all aspects of the system's response to the epidemic. This may necessitate such measures as

- developing special conditions of service;
- entrusting responsibilities to the private sector;
- the recruitment from abroad of specialist management, planning, and economics staff—supported by international agencies, or coming through volunteer organisations, or employed on regular contract terms;
- a radical overhaul of the ministry's structures to allow for the better deployment of scarce personnel.

Some of these may seem to be war-time measures. But the struggle with AIDS is a war, “a more debilitating war than war itself” (Malewezi, 2000) because of the way in which it eats away at human resources. A prime responsibility of the war-time leader is to protect, conserve and build up key general staff.

Promote Radical Re-thinking about Education

When it first made its appearance in the late 1970s and early 1980s, HIV/AIDS brought something new into the world. The world has not been the same since. Likewise, education cannot be the same. The content, structures and programmes that responded to the needs of a world without AIDS no longer suffice in a world with AIDS. But how the new content, structures and programmes should look is not altogether clear. A major responsibility for educational leadership is to stimulate the radical re-thinking of educational structures and provision that HIV/AIDS necessitates.

Difficult matters that have to be addressed include:

- delivering education services so that vulnerable, affected or infected, children and youth can benefit;
- designing creative initiatives that would respond to the special needs of orphans and widows;
- determining the kind of education that should be provided for all young people in the AIDS-dominated circumstances of human society so that children learn what they need to learn in terms of essential literacy and numeracy, life skills and values related to HIV/AIDS, work-oriented skills, social and coping skills;
- operating the entire education system in more flexible (non-formal) ways: promoting subsidies for children in distress, adjusting school calendars and timetables for AIDS-affected children, establishing single-sex schools and boarding hostels, providing more ‘second chance’ basic education for never-schooled children, or for those whose schooling has been random;
- avoiding the creation of a dual system, with sub-standard provision for ‘poorer’ children;
- making-good personnel losses through staff replacement, training and deployment;
- promoting within the system, within institutions and within society extensive sensitisation to the all-pervasive impacts of the disease;

- making the institutions and content of education dynamic forces for reducing the spread of HIV infection;
- ensuring that life skills education gets down deeply enough to deal in a constructive way with the issue of sexuality
- providing for life skills education in a way that will enhance the real engagement and subsequent behaviour change of students;
- establishing a culture of care in schools and their communities which can counsel, track and guide children affected by HIV/AIDS;
- providing support to schools as community-based organisations in the forefront of the fight against AIDS.

It is difficult to accommodate these issues within the current models and paradigms of educational services. Something very new and very different is needed. Nobody knows yet what these new models might look like. What is needed is a whole new range of thinking, plans, and schemes—ideas which have not yet been thought up, but ideas which educational leadership should try to arouse.

Chapter 6

The Role of the International Community

Keep HIV/AIDS High on the Education Agenda

A major task for the international community is to help education ministries get the encounter between HIV/AIDS and education firmly on to the education agenda and keep it there at the top. This has three implications:

1. appreciating the gravity of the HIV/AIDS crisis in education. This implies helping education ministries get to grips in reality as well as in words with the magnitude of the HIV/AIDS crisis. The evidence is there for them in the emerging chaotic conditions in the sector in terms of demand, supply, clientele, resources, and planning. What is needed is for them to take that evidence on board and plan accordingly.
2. breaking the barriers of silence which surround the disease at system, institutional and individual levels. Systemic and institutional silence breed ignorance and complacency, the attitude that it can be business as usual with just a modest amount of tinkering at the edges. Individual silence compromises the position and human rights of the individual infected or affected, and also provides a conducive environment for the further transmission of the virus.
3. centralising HIV/AIDS in planning for the educational sector. This means ensuring that every education sector plan is informed by HIV/AIDS matters. Each should have components on HIV/AIDS education, on HIV/AIDS in the education service, and on HIV/AIDS impact on the education and training sector—in the classroom, in the school, in the community, and in management.

Facilitate Dissemination of Knowledge of Best Practices

A second task is to facilitate the sharing and coordination of knowledge in this area, the establishment of networks and discussion lists, the dissemination of best practices. There has been striking growth in recent years in concern about the impact of HIV/AIDS on education. There has also been exponential growth in initiatives to deal with the problem, particularly at the levels of curriculum interventions in schools and programmes directed towards out-of-school youth. But there is little coordination among or between these interventions and initiatives. Individuals, organisations and agencies are experimenting, but without always knowing what the successful and less successful experiences of others have been. There is a pervasive sense of selfless dedication and

commitment, boundless hope moderated by agonising desperation, but all shot through with limited knowledge of what has been tried elsewhere and little real understanding of what is likely to work. It is almost as if, not being quite sure what to do, people feel that doing something would be better than doing nothing.

This points to the need for a profound understanding of the problems the epidemic poses for the sector and a coordinated understanding of existing initiatives, successful or otherwise. This is an area where the international agencies could be of significant help. At national, regional and international levels, they can stimulate and support the development of a comprehensive knowledge base for HIV/AIDS and education so that practitioners know who is doing what, which interventions have worked, which have failed. This will ensure that their efforts to grapple with the epidemic are informed by lessons learned from what is happening elsewhere.

At a very practical level this would call for the development and maintenance within each country of a living matrix of the interventions, activities and studies being undertaken by the education ministry, related ministries, NGOs, international agencies, religious bodies and others. Provision should be made to share these matrices between countries, at least those which are contiguous to each other. Similar matrices, covering activities and interventions at regional and international levels, should also be developed and maintained.

An AIDS-in-Education Coordinating Agency

The international aid community should also give thought to establishing an AIDS-in-Education coordinating agency within each heavily infected country. The purpose here would be twofold: to be the principal organ for providing coordinated agency support to the education sector in adapting to the imperatives of HIV/AIDS, and to channel into a single more productive stream the intervention rivulets that agencies themselves conceive or are requested to support. The coordinating agency would also seek to keep up the pressure to maintain HIV/AIDS at the heart of the education agenda. It would serve as a clearing house for information, stimulate and support various practical interventions and investigations, and be the agency through which all the external agencies would channel their resources, initiatives, and information to the national—public and private—education sector. This would be the principal body with which the local education ministry would deal on issues relating to HIV/AIDS and education. It would also be the principal channel of advice, assistance and support to NGOs, CBOs and non-governmental providers that are dealing with educational aspects of the epidemic.

The agency's first task would be to find out who is doing what at the local level, to bring these people into contact with one another, to get them talking and sharing. Hence it should establish local networks of practitioners and investigators. It should also identify where further investigations need to be conducted. But more importantly, it should mobilise support for activities and interventions that show promise of success in coping with the impacts or in reducing the likelihood of transmission.

The agency could be a sub-unit of UNAIDS; it could be an organ established for this purpose by the wider international family; it could be an NGO to which the international agencies and the educational community entrust this coordinating task. But the coordinating agency would not be just UNAIDS or an office of an aid agency in another guise. It would represent all the cooperating partners, without territoriality or competition, and its focus would be very expressly on the education sector (while

acknowledging that the response to the epidemic must be multisectoral). Initially, and so that it can be immediately effective, it should be established at national level, but should maintain close links with similar bodies in neighbouring countries so that there can be wider sharing of practices and information.

The establishment of such a coordinating agency would give more direction to the efforts of the international agencies; it would free the HIV/AIDS focal person in an education ministry from being pulled in a variety of directions, it would promote the sharing of information. It would also facilitate improved coordination and cooperation at regional and international levels. Establishing such a body would require a great measure of coordination among the international and bilateral agencies, the adaptation of many of their procedures and checks, and above all the subordination of their own institutional identity to the greater needs of the HIV/AIDS crisis.

An International HIV/AIDS Education Commission

The previous chapter has drawn attention to the need for radical new thinking and approaches on how to tailor the delivery and content of education to the needs of an AIDS afflicted populace. Such thinking should inform every response to the crisis. Moreover, in the absence of such thinking and the interventions to which it would lead, the international Education For All targets will remain forever unattainable in the most severely affected countries. The commitments of Jomtien (1990) and Dakar (2000) will remain forever illusory. The goal of poverty eradication will remain a slogan, without ever becoming a reality. The gender gap in education will not be narrowed, but will be widened significantly since girls and women suffer disproportionately from the impacts HIV/AIDS is having on educational provision and take-up.

The international community could help to move this re-thinking along by establishing a commission that would actively foster it. This could be along the lines of the Delors Commission which UNESCO established to report on "Education for the Twenty-First Century". As with the Delors Commission, the HIV/AIDS Education Commission should be requested to formulate suggestions and recommendations that would serve as an agenda for policy-makers and practitioners, by proposing approaches that are both innovative and feasible, given the diverse HIV/AIDS situations in different countries. The world AIDS situation has greatly deteriorated since the Delors Commission did its work in the mid-1990s. The changed circumstances call for a major international initiative to develop innovative ideas and policies on education for an AIDS-dominated society.

Support to NGOs and CBOs

The HIV/AIDS crisis in education and other sectors calls for more extensive support for NGO and CBO initiatives. The importance of these bodies as grassroots organisations in boosting the coping capacity of communities and individuals cannot be over-stated. They are also significant providers of educational services, by non-formal provision to out-of-school youth and provision at the margins of the formal sector, for instance, through community schools, to large numbers of disadvantaged children. In many respects, NGOs and CBOs constitute the principal form of organised support for children orphaned by AIDS or rendered vulnerable by its consequences. They seek to strengthen family and community capacities to identify and act on the wants of children in need; they strive to ensure that orphans have access to basic services; they provide street children and other children in need with the skills they require for life.

Notwithstanding the salience and potential of NGOs and CBOs for channelling assistance directly to families and communities, major multilateral and bilateral agencies tend to marginalise them. Instead, they show a strong preference for dealing with governments, while throwing a few crumbs in the direction of the grassroots bodies. Possibly issues of sovereignty, accountability, and procedures make this understandable. Possibly this may have been a suitable *modus operandi* in an AIDS-free world. But it does not serve where AIDS is rife, where governments are trying to free up hospital facilities by encouraging home-based care, where communities are the only bodies with sufficient flexibility and perception to respond to the real educational needs of young people.

The HIV/AIDS situation makes it imperative that international agencies make more extensive use of the entire non-governmental sector as part of their effort to respond more dynamically to critical human needs. Things are different because of AIDS, and this is one of the differences. Obviously, there must be proper financial management and accountability. But let the international agencies support NGOs and CBOs in developing these and getting their systems right. Equally obviously, a large agency cannot deal with a host of small local organisations. But it is possible to identify lead NGOs that would disburse lower down the line and that would help the smaller bodies build the capacity they need to manage their affairs in an effective and accountable manner. The bottom line in all this is that services should reach the people who need them. NGOs and CBOs can ensure this.

Bolster the Human Capacity of Depleted Education Ministries

Carol Bellamy of UNICEF startled many participants at the World Education Forum, held in Dakar in April 2000, when she stated that in parts of Africa “as many as 40 per cent of senior education managers may be ill and dying”. Education ministries that are affected in this way cannot cope with their ordinary ongoing tasks. Much less can they deal proactively with the potential impacts of an epidemic of incalculable proportions.

The international response to this situation should surely include the possibility of support to education ministries with managers and planners of all kinds who would strengthen local staff in carrying out their responsibilities, help in the training of replacement staff, and contribute to the ongoing dialogue on the sector's response to the epidemic. Such personnel assistance should be at absolutely no cost to the recipient country or ministry. It should not be financed out of funds otherwise destined for the ministry. It should be over and above commitments already made or being considered. It should not involve the customary local costs of accommodation or services. This is a human crisis situation of unparalleled magnitude. It deserves a response of equal magnitude, in human resource and financial terms.

Chapter 7

Conclusion: A Framework for Action

A twofold message emerges from the discussions on the previous pages:

1. HIV/AIDS is already having a major negative impact on education systems, and the situation is set to get considerably worse; and
2. education systems have not yet been unambiguously successful in rallying themselves either to manage these systemic impacts or to reduce prevention on the scale that is needed.

Basic reasons for these depressing conclusions relate to the failure to internalise the all-encompassing gravity of the disruption that HIV/AIDS is creating for the education sector and to the expectation that, notwithstanding inadequate analysis, preparation and support, schools will provide quick-fix solutions for the HIV transmission problem. Underlying reasons include inadequate analytic, planning and management capacity on the one hand, and reluctance to grapple with the deep aspects of sexuality, gender violence, and sexual stereotypes, on the other.

There are, however, things that can be done. What is needed is to recognise the problem, and then think, plan and act more systematically. A framework for action embraces structures, activities and partnerships.

Structures

Structures need to be established or strengthened at the top political level, at the central ministry level, and at lower levels. This could entail one or more of the following:

1. Appointing a special HIV/AIDS Advisor to the Minister
2. Creating a focal point within the central ministry or, where this already exists, strengthening and expanding the office by
 - establishing a widely representative National Task Force for HIV/AIDS-in-Education (the ministry, other relevant government bodies, NGOs, international

donor agencies, religious bodies, teacher unions, parents, the media, the National AIDS Council or Secretariat)

- establishing a coordinating unit for gathering and maintaining information on the activities and impacts of every player in the field (the ministry, NGOs, international donor agencies, religious bodies, other)
 - establishing a monitoring and evaluation unit to maintain the momentum of activities, propose adjustments, etc.
 - establishing a publicity wing for the widespread dissemination of messages through the media, all educational products (e.g., covers of exercise books, headings on exam papers, paintings on official vehicles), competitions, etc.
3. Establishing HIV/AIDS-in-Education Committees at central, provincial, and district levels and in every institution
 4. Establishing an HIV/AIDS-in-Education focal point in every province, district, and administrative unit, and for every school governing body or education board
 5. Establishing a confidential HIV/AIDS contact point in headquarters, and in all province, district and education board offices

Activities

Working at the sectoral level with and through other branches of the ministry, and at the multisectoral level with other government ministries, the international community, NGOs and other organs of civil society, the focal point in the education ministry should ensure that activities are undertaken in the areas of advocacy and sensitisation; coordination; curriculum; information and channels of communication; materials; monitoring, evaluation and research; planning; publicity; school activities; and training for capacity building. In these areas (which have been presented in alphabetical order), plans should be drawn up for specific activities, along the lines of the model below.

Advocacy and Sensitisation

- Hold national and provincial HIV/AIDS-in-Education Conferences at two levels
 - for the public
 - for teachers/educators
- Hold information, advocacy, planning workshops for parents, teachers, educators, students in all districts, in every teacher education institution, and for every school governing body or education board
- Promote action-based research in colleges and schools to identify households in distress, and provide these with support (as part of co-curricular activities) through home-based care, assistance with income-generating activities, education provided by college and school students to out-of-school children in their homes, etc.

Coordination

- Develop and maintain a living matrix of interventions, activities and studies being undertaken by the ministry, NGOs, donor agencies, religious bodies, others
- Disseminate information of what works and what does not work
- Identify geographical areas, pupil levels, personnel levels that are not being reached, and take steps to have these covered
- Mobilise the necessary personnel and resources

Curriculum

- Facilitate the preparation by educators, communities and young people, of reproductive health and HIV/AIDS programmes (and materials) for every school grade (from the first grade onwards) and for every level of teacher education
- Facilitate the preparation by educators, communities and young people, of life skills programmes (and materials) for every school grade (from the first grade onwards)
- Develop programmes for training teachers in counselling and stress management

Information and Channels of Communication

- Collect data, information, statistics on the extent of HIV/AIDS at all levels of all education institutions and in all education offices
- Design and implement an AIDS-Related Management Information System
- Disseminate HIV-prevention and AIDS-impact messages through all available channels (print, radio, television, advertisements, electronic)
- Make extensive use of educational broadcasting to carry HIV prevention messages

Materials

- Procure extensive supplies of existing AIDS-related curricular materials from every available source, inside and outside the country
- Disseminate and use these at once in all schools and institutions
- Simultaneously, modify these to suit local conditions, and/or develop materials more sensitive to local conditions

Monitoring, Evaluation and Research

- Monitor all activities on an ongoing basis
- Conduct formal periodic evaluations of activities being undertaken and make the necessary adjustments
- Conduct studies to assess the impact of the disease on institutions, personnel, costs, productivity, outcomes
- Determine how HIV/AIDS is affecting the school participation and performance of the poor, rural children, girls, orphans, other vulnerable children
- Conduct studies to assess the impact of interventions on prevention, transmission, behaviour change

Planning

- Build AIDS-informed estimates into all projections for school enrolments, teacher requirements, infrastructural needs, school supplies, and educational materials
- Develop/extend/support multigrade arrangements in response to demographic changes and changes in student/teacher numbers
- Monitor and estimate the likely extent of teacher and other human resource shortfalls
- Determine with teacher education experts how teacher shortfalls can be made good
- Develop special strategies for reaching orphans, street children, children heading households, children with special needs, and other specially vulnerable children
- Develop schemes for bringing good quality, comprehensive education out to children whose vulnerability debar them from attending school in the traditional way
- Provide for a flexible school calendar and timetables to respond to the varying needs of HIV/AIDS infected or affected students and teachers

Publicity

- Launch and sustain a country-wide publicity campaign—using education to prevent HIV transmission
- Produce and disseminate newsletters, fliers, information briefs, etc.

- Maintain a flow of information/publicity through church bulletins, private radio stations, and similar less traditional media
- Obtain and use publicity materials (or suitable entertainment materials) in use elsewhere (e.g., the television and print materials developed by the South African NGO, Soul City)

School Activities

- With the active involvement of teachers, NGOs, communities, young people and suitable students, deliver reproductive health, HIV/AIDS and life skills education at all levels
- Promote clubs, societies and interventions for peer education
- Ensure access of all school personnel to user-friendly health services and the adequacy of information, counselling and supplies

Training for Capacity Building

- Train personnel at all levels, as required by the foregoing; for instance
 - teacher educators and teachers in HIV/AIDS materials, in reproductive health and HIV/AIDS education, in counselling and stress management;
 - administrators, statistical officers in the AIDS-Related Management Information System;
 - coordination officers in developing and maintaining a living matrix of interventions/activities
- Establish workplace HIV/AIDS education programmes within the ministry, its branches and institutions.

Partnerships

Every agency or body that addresses HIV/AIDS prevention, care or impact mitigation must work with a wide range of partners. For an education ministry this would involve:

- establishing a dynamic working relationship with the National Secretariat and AIDS Council
- encouraging or facilitating the active participation of NGOs, religious bodies, and all organs of civil society
- involving teachers and students as much as possible (in the development, design, and execution of activities or materials, as peer educators, etc.)
- involving parents/communities in curriculum issues
- encouraging parents/communities to communicate, from an early age, with children on sexuality, respect for others as persons, and about HIV prevention
- involving all non-governmental providers of education
- making special provisions to work with and build up community schools and their coordinating bodies
- working closely with other relevant government ministries, integrating education's programmes into theirs where appropriate, and vice versa
- bringing the media on board from the outset.

Conclusion

The national education policy in Zambia is entitled *Educating Our Future*. In recent addresses, the Zambian Minister of Education has asked what future there can be for many children in the country if, with current prevalence rates, half will die young because of AIDS, while the half who survive to school-going age are traumatised by their experience of terrible family sickness and death, come from communities which are so weakened by AIDS that they cannot produce the food required for their families, and face being taught by teachers who are frequently sick or absent from class attending to family sickness or funerals. Putting it starkly, given the magnitude of the HIV/AIDS crisis, Zambia—and other countries with high HIV prevalence rates—may have no assured future to educate. Further, they may have no system for delivering education.

Something must be done, and be done urgently, to enable severely affected countries rally their resources and get their education systems up and moving, not just in reaction to the problems posed by HIV/AIDS, but proactively

- managing the impacts,
- anticipating and providing for the difficulties,
- using the system to enable all who are involved understand more about the epidemic and its consequences,
- using the system to develop a great sensitivity to ensuring the full exercise of their human rights by those who are HIV-infected,
- using the system to help young people prepare for a productive life in a different kind of society,
- using the system to form attitudes and behaviour patterns that will reduce the likelihood of the transmission of the virus.

The challenge to the countries of Eastern and Southern Africa is to take the necessary steps. The goal is an AIDS-free society. Each country must pledge to walk on the journey towards that goal, knowing it will be long. Every education ministry must recognise that each step of that journey will demand that it do things differently. Every education ministry must work with its partners with one purpose in mind, winning. There has been delay—some of it unavoidable. There has been some lack of a sense of urgency—all of it avoidable. It is time now to move on. “The time for action is now, and right now” (Nelson Mandela, 14th July 2000).

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