Contextualizing HIV/AIDS in educational planning and management

A training needs assessment for educational planners and managers in Ethiopia

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Table of contents

List of abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
EFA	Education for All
EMIS	Educational Management Information System
ESDP	Education Sector Development Programme
FDRE	Federal Democratic Republic of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Coordination Office
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IIEP	International Institute for Educational Planning
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-Governmental Organization
PLWHA	People living with HIV/AIDS
SNNP	Southern Nations, Nationalities and Peoples
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TVET	Technical and Vocational Education and Training
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	Voluntary counselling and testing

List of tables

List of figures

List of boxes

Executive summary

Evidence shows that African education systems are being impacted by the HIV/AIDS epidemic. The impact of the epidemic could be far reaching in view of the distinctive nature of the educational sector in terms of its organization, the numbers and kinds of people involved, the degree of vulnerability, and the matchless role that education plays in fighting HIV/AIDS.

Given that HIV/AIDS is already having an effect on education systems, educational planners and managers at various levels need to recognize the nature and extent of the impact, as well as equipping themselves with the necessary conceptual and analytical tools to capture and monitor the impact, and design strategies and programmes for prevention, care and impact mitigation.

At present many educational managers think that activities related to HIV/AIDS are the responsibility of specialized agencies, such as the HIV/AIDS Secretariat, rather than being part and parcel of the responsibilities of each and every actor. Until now responses to HIV/AIDS within the education sector have been ad hoc, but this situation is neither effective nor sustainable. The present situation is largely a function of the lack of capacity to properly conceive and analyse the impact of the epidemic on the system, and to design cogent intervention programmes as part of organizational strategic planning.

The aim of this study was to identify crucial capacity gaps that exist within the educational planning and management system in Ethiopia. It assessed training needs for educational planners and managers in the context of HIV/AIDS in Ethiopia, and covered the key institutions and individuals responsible for planning and management of education at ministry headquarters, education bureaus of selected regional states, education desks of selected districts, secondary schools, one teacher training college and a civil service college. In addition, the study sought to identify and analyse existing training programmes that cater for building capacity in the areas identified in this study.

Findings

- There is a policy and operational gap between national policy development and its translation and implementation at the sectoral level. The sector as a whole, and its constituent regional bureaus, district offices and individual institutions, has neither specific policies nor definite operational strategies for HIV/AIDS. For example, there are no mechanisms to deal with staff HIV-related absenteeism, or other support systems for infected and/or affected students, teachers and other education personnel. This is partly due to the fact that the Civil Servants' Proclamation does not make specific provisions for addressing HIV/AIDS in the Ethiopian Civil Service.

- The HIV/AIDS response is generally seen as an intervention that exists outside of the 'traditional' educational planning domains. It is considered to be the prerogative of the specialized agencies set up specifically for that purpose. As a result HIV/AIDS is left outside the mainstream issues of educational planning and management. Consequently

mainstreaming of HIV/AIDS in the education sector has not been achieved, and even those appointed as focal points on HIV/AIDS do not see it as their primary responsibility.

- This study notes that there is no single dedicated HIV/AIDS unit at any level of the education sector in Ethiopia. There are only ad hoc structures, such as steering committees, technical groups and focal persons, which are partly responsible for implementing HIV/AIDS related activities.

- There is no systematic inbuilt funding of HIV/AIDS-related activities in the sector. Activities are generally dependent on donor support and are supported by project type, rather than budgetary funding. Similarly, school-based anti-AIDS clubs mainly depend on ad hoc funding from Non-Governmental Organizations (NGOs). The latter actually provide a mechanism for collaborative work between the ministry and other key actors in the sector.

- The current Educational Management Information Systems (EMIS) at national, regional and institutional levels do not take into account the monitoring of prevalence as well as impact of HIV/AIDS in the system. There are no systematic or reliable data on the extent to which the pandemic has been affecting the education sector and this makes it difficult to design and implement effective interventions.

- HIV/AIDS has been integrated into the Ethiopian education system through curricular and co-curricular activities, notably school-based anti-AIDS clubs. However, the link between the two is neither clear nor strong, and it is not possible to know if they cross-fertilise or compete with each other. Furthermore, the impact of these interventions on positive behavioural change has been found to be rather limited. Apathy and the lack of capacity of those that are supposed to provide guidance and leadership functions, particularly teachers, has been the critical constraint.

- At all levels of the education sector poorly trained human resources, and inadequate leadership, ownership of and commitment towards HIV/AIDS are a serious impediment to an effective response to the epidemic.

- Targeted training on the various links between HIV/AIDS and education is a vital part of the strategy to bring about fundamental changes in the way the education sector in Ethiopia views and responds to HIV/AIDS.

- Since there is neither a national training policy for civil servants nor human resource development plans within individual institutions, institutions tend to react to occasional and externally induced training provision rather than identifying their own training needs and addressing them through tailor-made training programmes. Training of staff is seldom included in institutional plans and therefore not internally or systematically budgeted. Locally organized, highly professional training courses are desirable to ensure that they reach a critical mass of practitioners.

- Training needs vary from basic information provision on current status and best practice to levels of analysis requiring some degree of sophistication. Considering educational planners and managers as target groups, major priority areas of training include:

    - designing and developing sectoral HIV/AIDS policy and strategic plans;

- strategic planning and management of education;
- establishing and operationalizing HIV/AIDS units at various levels of the sector;
- responding to the HIV-induced changing management context;
- developing information systems to capture and analyse HIV/AIDS-related data;
- HIV/AIDS project preparation and management;
- HIV/AIDS project monitoring and evaluation;
- exploring and sharing national and international comparative best practices;
- developing communication and advocacy skills.

- Functional units are basically staffed with people that receive inadequate professional training to even undertake their 'mainstream' activities, let alone to formulate an effective HIV/AIDS response. This makes the challenge even more daunting. As one moves from the central to the local level, training needs become more oriented towards building concrete skills to enable practitioners to carry out their day-to-day activities, such as capturing data on HIV/AIDS and helping people living with HIV/AIDS (PLWHA). Designers of training programmes need to address different needs at different levels.

- Some local training programmes exist, but these are very generic. It is fundamental that HIV/AIDS is made the core focus around which training is organized and delivered. Efforts will be necessary to make sure that training content, organization and methodology are relevant and responsive to the specific training needs identified. The importance of post-training impact monitoring, supervision and follow-up cannot be overemphasized. Technical assistance needs to be sought from experienced agencies such as the International Institute for Educational Planning (IIEP/UNESCO) for curricular design, material development and active and interactive delivery methods.

- Ethiopian educational planners and managers need to make the most of all the opportunities currently on offer. These include the government's ongoing efforts for capacity building and, in particular, its endeavour to introduce strategic planning and management within all systems and install a national information and communication technology infrastructure that networks all districts, high schools and higher educational institutions.

1. Introduction

1.1 Overview of the HIV/AIDS epidemic in Ethiopia

With a population of about 70 million, Ethiopia is the third most populous country in Africa after Egypt and Nigeria. About 85 per cent of people live in rural areas, surviving on low productivity subsistence agriculture. Poverty is rampant in Ethiopia, with 45 per cent of the total population being categorized as 'absolutely poor'. Life expectancy at birth is only 48 years (World Health Organization, 2004) and in 2000 roughly 45 per cent of the population was aged under 15 (United Nations Population Division, 2003).

Ethiopia is currently experiencing a 'generalized' AIDS epidemic, in other words, an epidemic where HIV is spreading beyond high-risk sub-populations. Although Ethiopia's population constitutes only 1 per cent of world population, it contributes about 4 per cent of the world's HIV/AIDS cases (UNAIDS, 2004).

Recent statistics show that the overall HIV infection rate in the country is about 4.4 per cent. The situation is worse in urban areas. For example, the HIV prevalence rate in Addis Ababa is estimated at 11.7 per cent (UNAIDS, 2004), while in rural areas it is estimated at about 3.7 per cent. The Ministry of Health, however, cautions that the database for estimating rural prevalence is not detailed enough to give a realistic picture.

In 2003, it was estimated that there were about 1.5 million people living with HIV/AIDS in Ethiopia, of which 1.4 million were adults aged 15-49. The remaining 120,000 were children under the age of 15 (UNAIDS, 2004). Approximately 10 per cent of these totals were estimated to be full-blown AIDS cases. The highest concentrations of infected persons are among young adults aged between 20 and 29, while AIDS cases peak at between 25 and 29 for both sexes. Infection rates are higher among women than men between the ages of 15 and 19, which perhaps reflects earlier sexual activity among young women with older male partners.

It is believed that adult (i.e. 15-49) deaths attributed to AIDS account for about half of all deaths in Ethiopia (FDRE-MoH, 2002). It is projected that a total of 5.25 million Ethiopians will have died by 2014 if the present trend continues (FDRE-MoH, 2000).

HIV/AIDS attacks mainly the most productive segment of the population, deforming a country's demographic structure and increasing the dependency ratio at household, community and national levels. At the domestic level, taking care of the sick exhausts family savings and labour. It means that the burden of responsibility shifts to the very young and the very old and, in the case of the former, this has serious implications for education.

HIV/AIDS also leads to reduced quality and quantity of labour, substantial losses in skills and experience and subsequent production losses. A recent survey of 15 firms in Ethiopia showed that over a five-year period, 53 per cent of illness among staff was AIDS related (cited in UNAIDS and World Health Organization, 2001). The Joint United Nations Programme on HIV/AIDS (UNAIDS) indicated that during the four years between 1997 and 2000, the financial expenditure of Akaki Fiber Products Factory attributable to HIV amounted to

244,960 Birr, of which 43 per cent was due to lost productivity and 48 per cent to expenditure on medical care and sick leave (UNAIDS, 2001). This expenditure pattern is perhaps also true of other industrial enterprises in Ethiopia.

The direct impact of the epidemic on the provision of social services, especially health services, is inescapable. AIDS patients occupied as many as 42 per cent of all hospital beds during 2000, and the occupancy rate may rise to 54 per cent by 2004 (FDRE-MoH, 2000). Spending on HIV/AIDS diverts limited resources from surmounting other major, but more readily treatable health problems, and also erodes the human resource base in the sector, where skills are hard to replace. By 2014 life expectancy in Ethiopia is expected to have declined by 10 years – from 56.4 years without HIV/AIDS to 46.5 years with HIV/AIDS (FDRE-MoH, 2000).

Within the education sector, HIV/AIDS negatively impacts on enrolment, the attendance of educators and students, the provision of educational services and education financing. The cost of achieving Education for All (EFA) in 33 African countries is likely to increase as a result of HIV/AIDS by between 450 million United States dollars (US$) and US$550 million a year (World Bank, 2002).

HIV/AIDS is not just a medical and health problem; its economic, social, cultural and political dimensions are equally important. A broader, systemic appreciation of the issues permits a more flexible, integrated and co-ordinated response to the epidemic and the challenges it poses. It is with this in mind that this report underlines the need for the mainstreaming of HIV/AIDS in the Ethiopian education system.

1.2 Overview of the education system

The education sector in Ethiopia is undergoing a profound change as part of a much wider socio-political transformation. For a long time, education opportunities were limited to only a few people because education was largely supply constrained and viewed as the responsibility of government alone. This limited the expansion of educational services, as well as educational quality. Enrolment and literacy rates have remained low; relatively higher rates have largely been an urban phenomenon and therefore exclude most Ethiopians.

The introduction of a federal system of governance in the early 1990s fundamentally altered the structure of the education sector and the logic of education provision in Ethiopia. If educational opportunities had been limited for the country as a whole, they were near non-existent for some of the emerging regional states, such as Afar, Benishangul-Gumuz, Gambella and Somali.

The Ethiopian government adopted its New Education and Training Policy in 1994 – a policy that focuses on increasing access to educational opportunities for all, both now and for learners in the future. The government set itself the target of achieving universal primary education by 2015, in line with the demands of the 2000 Dakar Framework for Action on EFA. Based on this, a multi-year Education Sector Development Programme (ESDP) was initiated in 1997/1998, the first phase of which covered the period 1997/1998 to 2001/2002, while the second phase spans the period 2002/2003 to 2004/2005 (FDRE-MoE, 2002*a*).

The education sector has undergone changes in structure, content and quality. Some of the major changes that were introduced include:

- re-configuring the school structure so that primary level now covers grades 1-8 (rather than 1-6), in two cycles (grades 1-4 and 5-8 respectively); splitting secondary education (formerly grades 7-12) into two, two-year cycles: a first cycle (grades 9-10), and second cycle of pre-tertiary preparatory training and learning; reducing tertiary education by one year in response to the introduction of the preparatory stage, and introducing technical and vocational education and training (TVET) opportunities for those not accessing pre-tertiary and tertiary levels;
- self-contained classroom organization for first cycle primary education so that one teacher assumes responsibility for the class, instead of involving several subject teachers;
- teaching children in their mother tongues at primary level. In the past, Amharic, which is Ethiopia's official language, used to be the only language of instruction for primary education;
- introducing a cost-sharing scheme for higher education (as of 2003/2004).

Other issues identified in the strategic plan (FDRE-MoE, 2002*a*) include:

- expanding access and coverage;
- introducing curriculum reform to ensure relevance and quality;
- introducing alternative modes of delivery, including distance education;
- enhancing implementation capacities at the central, regional and institutional levels;
- strengthening the management capacity, internal governance and efficiency of educational establishments by refining their organizational structure, improving staffing and providing training for key managerial and technical staff, and
- training personnel in sufficient numbers to meet the needs of the economy at all levels.

The following strategies have been adopted to address these issues:

- enhance and strengthen community and Non-Governmental Organization (NGO) participation in the sector;
- look for cost-effective programme implementation mechanisms;
- identify and implement alternative approaches to education delivery, such as low-cost, one-room and multi-grade schools, non-formal education, distance education etc.;
- provide the necessary managerial and logistic support to improve the organizational capacity of programmes and activities, and
- strengthen the administrative units at the district level, giving them more responsibility for operational planning and day-to-day management of education. This will encourage them to deliver services more effectively and efficiently, making them more accountable and responsive to the needs of their communities.

As part of its capacity building efforts, the government is setting up an information and communication technology infrastructure that networks the districts (through *woreda*-net), universities and secondary education television broadcasting (through school-net). This initiative will open up immense opportunities for staff training, which has been identified in the past as a barrier to full capacity utilization. For example, during ESDP-I, one of the key reasons advanced for increased pupil:teacher and pupil:section ratios for primary grades 1-8 (from 42 to 60 and from 52 to 70 respectively) was the lack of competent teachers. This

was attributed to a "… lack of sufficient capacity of the teacher training institutions to train the required number of qualified teachers" (FDRE-MoE, 2002*a*). Insufficient qualified teachers and instructors have also been singled out as presenting a major bottleneck to progress in secondary education and poor quality TVET. Poorly trained facilitators have also been said to contribute to the high dropout rates in the adult and non-formal sub-sectors.

The most prominent and persistent challenges identified at the end of ESDP-I include:

- wide inter-regional and gender disparities;
- inadequate community participation;
- lack of professional capacity and commitment on the part of teachers and other sector personnel to implement innovative educational practices, such as continuous assessment, self-contained classroom organization etc.;
- a persistent lack of qualified teachers, especially in second cycle primary, secondary and TVET institutions;
- weak programme management and implementation capacity, largely attributed to high turnover of professional personnel;
- inadequate planning and management capacity at the lower levels of the organizational structure (i.e. district). Skills to interpret policy, collect and analyse appropriate data and to enable schools to take the action needed to meet the minimum quality standards defined for the local situation are critically lacking;
- bottlenecks in providing and facilitating the flow of timely and accurate financial information on projects and programmes, resulting in delays in taking remedial action and speeding up the implementation process (FDRE-MoE, 2002*a*).

A significant effort to develop the human resource base is required if sector development goals are to be realized. To address this, and the other challenges identified, the overall strategy of the ESDP-II will include:

- maximizing the use of available resources, i.e. implementing programmes using alternative, low-cost approaches;
- a stronger and wider role for non-formal education and other alternatives for the expansion of primary education;
- community empowerment and strengthened roles for NGOs and the private sector;
- capacity building through organizational and human resource development;
- strengthening the governance and management roles of the woredas (districts) for them to be able to become more responsive to the needs of the communities, at the same time as being held accountable to deliver the desired services efficiently and effectively;
- enhancing the capacity of teachers (i.e. knowledge, skills and attitude), and
- revitalizing the education system so that it nurtures and produces responsible citizens who are knowledgeable about, and participate actively in, public affairs.

To address the teacher shortage problem, the government intends to develop in-service training programmes, upgrade the professional qualification of untrained teachers, acquaint teachers with changes and innovations in the system and reduce teacher attrition. With regard to secondary education, there are plans to train teachers at first degree level through pre-service programmes and upgrade teachers' qualification through in-service and distance education programmes. Training of school principals is also envisaged, to make school leadership more efficient, professional and democratic.

This second phase of the ESDP (ESDP-II) draws on the four goals of the government's Five Year Educational Programme, which are to:

- realize the goal of achieving universal primary education, through expanding access to and coverage of primary education;
- build the capacity within the education system for sustainable development, programme implementation, continuous innovation and quality leadership at all levels;
- meet the quantitative and qualitative demand for trained personnel at all levels in order to respond to the socio-economic development needs of the country;
- produce good citizens who understand, respect and defend the constitution, and who participate in and contribute to the development of community and the nation.

1.3 Interaction between HIV/AIDS and education

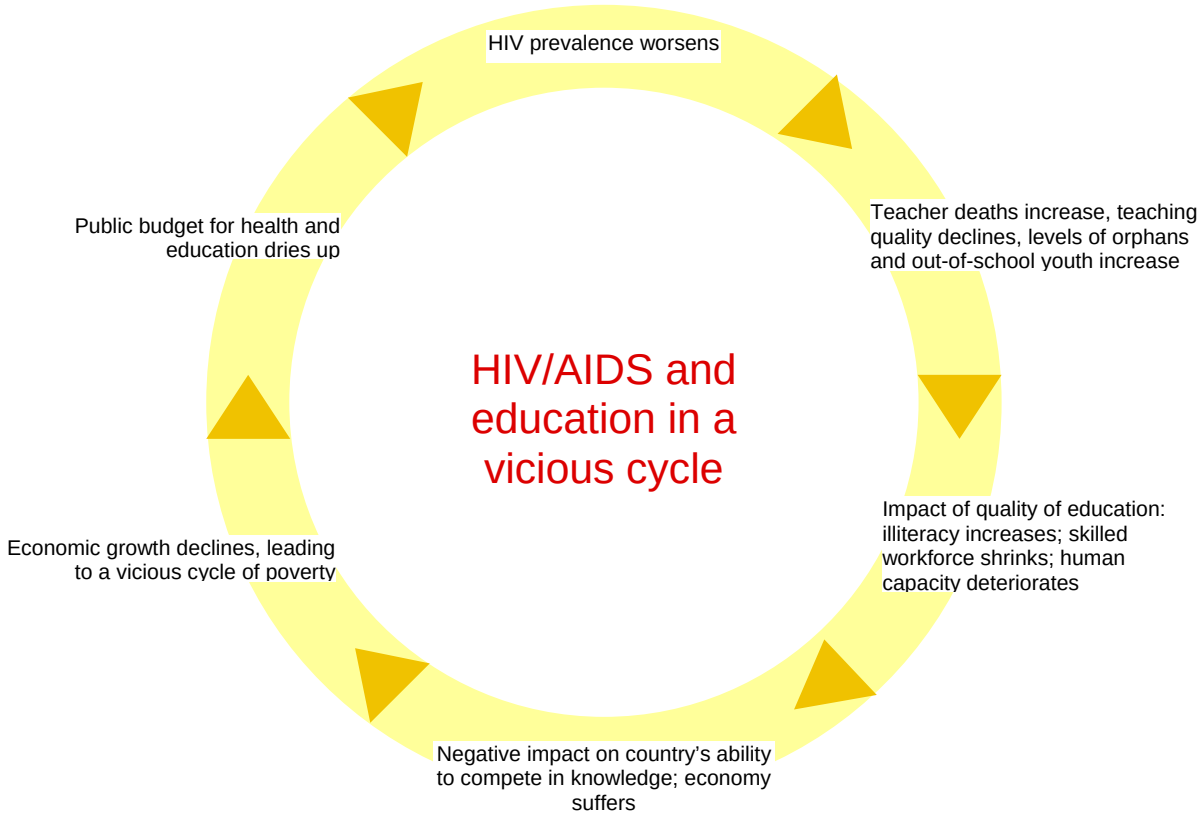
HIV/AIDS prevalence among pupils, students and their families results in reduced demand for education as the number of students available, willing or able to attend classes declines. At the same time, high prevalence also results in reduced supply of education (both quality and quantity), due to increased levels of illness and death among teachers and other sector personnel. The overall impact is shrinkage in the skilled and educated workforce and in the quality of human resources in general.

In Ethiopia, the necessary skills for effective and efficient human resource management, evaluation, monitoring, planning, budgeting and accounting are not sufficiently developed at local levels. Building the capacity of *woredas* through training programmes on educational management, supervision, finance, purchasing and management of resources is one of the government's major strategies (FDRE-Ministry of Information, 2002). The overall success of the development strategy will depend greatly on the availability of trained and qualified teachers and other education personnel.

However, the threat of HIV/AIDS is real and undermines this effort, since HIV/AIDS appears to attack the better-educated, economically active segment of the population. A recent study in Ethiopia showed, for example, that of 927 deaths reported for which educational status was also recorded, only 9 per cent had received less than elementary education, while 21 per cent had received elementary education, 51 per cent secondary education and 19 per cent tertiary education. Thus, 70 per cent of deaths occurred among those with secondary and tertiary education (Kebede, 2003). The peak ages for AIDS cases are between 25 and 29 for both sexes – the period when investment in education starts to pay off.

Despite this, education is the only proven means for preventing HIV/AIDS. Education provides protection against HIV infection, reduces people's vulnerability and provides an infrastructure for delivering HIV/AIDS prevention efforts to large numbers of uninfected people. Crucially, in the case of young pupils, it provides a chance to reach them before they become sexually active and adopt risky behaviour. Education is highly cost-effective as a prevention mechanism (World Bank, 2002).

Figure 1.1 HIV/AIDS and education: the consequences of inaction



Source: Adapted from World Bank, 2002.

1.4 Rationale and objectives of the study

The purpose of this study was to assess the HIV/AIDS-related training needs of institutions and individuals working in the areas of educational planning and management at various levels of the education system in Ethiopia. The study also assessed whether appropriate and adequate training providers exist to address the training needs identified.

On the demand side, HIV/AIDS-related capacity development needs (with special focus on training needs) were identified at the ministry and selected regional and district education bureaus, colleges and schools. From the supply side, training programmes that cater for the assessed needs were identified and their relevance and adequacy evaluated.

2. Review of literature

2.1 Situation analysis – HIV/AIDS prevalence and its impact on the education sector

HIV/AIDS impacts on the process and quality of education by destabilizing the smooth functioning of infected and affected learners, educators, their families, the school system and the macro-economic environment in general.

Demand for education suffers as infected and affected students are less able or willing to attend and complete school. Behaviour that increases the risk of transmission of HIV is widespread among students in Ethiopia. A recent study conducted in a senior secondary school in Addis Ababa found that 53 per cent of male and 24 per cent of female students were sexually active, and that most were having unprotected sex with more than one partner (Gabre, 1990). Results from another study similarly showed that of the sampled students in grade 9 and above, 17 per cent reported being sexually active, 29 per cent had multiple sexual contacts and 59 per cent rarely or never used condoms. These data reaffirm the impression that levels of risky behaviour are high among young people in Ethiopia (FDRE-MoE, 2003).

In 2001 there were about 1.2 million orphans in Ethiopia (FDRE-MoH, 2002), and projections suggest that by 2010 there will be about 6,862,000 orphans who will have lost one or both parents from all causes. Of these, it is estimated that 3,774,000 will be maternal orphans (i.e. children whose mothers, and perhaps fathers, have died), of whom 67 per cent will be orphaned due to AIDS (Hunter and Williamson, 2000, cited in Kelly, 2000*a*).

A Ministry of Education impact assessment study observed that in a sample of 4,418 students over the age of 11 that had reached grade 5 or above, 1,052 (24 per cent) had lost one or both parents. The report also indicated that 504 students had dropped out of school at least once for the following reasons: personal sickness (29 per cent); shouldering family responsibility (18 per cent); inability to cover school costs (13 per cent); death of parents (12 per cent), and sickness of parents (9 per cent). Similarly, the 1,226 students that had repeated at least once did so for the following reasons: personal sickness (26 per cent); shouldering family responsibility (9 per cent); inability to cover school costs (13 per cent); sickness of parents (8 per cent), and death of parents (5 per cent) (FDRE-MoE, 2003).

HIV/AIDS also impacts on the supply of education through attrition of teachers and educational personnel due to death or inability to attend to regular activities due to illness. For example, Berhanu (1999, cited in FDRE-MoE, 2003) showed that in Ethiopia in 1999, some 51,000 primary school pupils, out of a total of 4.3 million, had lost at least one teacher due to AIDS. In addition, 2,858 teachers and 640 support staff were reported to have died within the five-year period from 1997 to 2002, implying that Ethiopia is losing more than 570 teachers to death per year (see also FDRE-MoE, 2003).

In the 39 sample institutions of the Ministry of Education assessment study (17 primary, 20 secondary and two teacher training institutes), a total of 133 teachers were reported to have died within a five-year period alone, averaging 27 deaths per year. More than 85 per cent of those who died were under 50 years of age, more than 60 per cent had qualifications

amounting to at least a college diploma, while 87 per cent had had more than 10 years of teaching experience. Teacher absenteeism was also reported as becoming a more frequent problem, with the majority (65 per cent) citing their own sickness, sickness of a family member or death of another staff member as the main reasons for absence (FDRE-MoE, 2003).

2.2 Response analysis

2.2.1 National policies and strategies for HIV/AIDS prevention and impact mitigation

The government of Ethiopia issued an HIV/AIDS policy in 1998 (FDRE, 1998). The objectives of this policy were to guide "… the implementation of successful programmes to prevent the spread of the disease, to decrease vulnerability of individuals and communities, care for those living with the disease and to reduce the adverse socio-economic consequences of the epidemic" (FDRE, 2002). The government also developed the Strategic Framework for the National Response to HIV/AIDS (FDRE, 2001), covering the period 2000-2004. In this framework, the government pledged to:

- intensify efforts on risk reduction interventions, such as information, education and communication (IEC) and behavioural change communication, condom promotion and distribution, sexually transmitted infection (STI) control and management, and voluntary counselling and testing (VCT);
- intensify care and support and other impact mitigation efforts for infected and affected individuals, families and communities, by focusing on the most vulnerable populations such as commercial sex workers and young people, especially out-of-school youth;
- design gender sensitive interventions, particularly as they relate to behavioural change communication, STI control, and VCT and care and support and impact mitigation;
- enhance the mainstreaming of HIV/AIDS in all interventions by government, non-government and private actors;
- establish a functional institutional framework from the federal to the community level, using national and regional HIV/AIDS councils and secretariats to co-ordinate, facilitate, monitor and evaluate;
- enhance community level responses through risk and vulnerability reduction activities;
- track ongoing activities, distribution of diseases and trends in the epidemic over time, follow-up contributions from all stakeholders and partners and build a functional information sharing and dissemination system as a crucial step towards success in the fight against the epidemic (FDRE, 2002).

The strategy envisages a multi-pronged approach to intervention, reaching out to all segments of communities and using all available channels of communication and institutions. The strategy also promotes sectoral integration of HIV/AIDS issues by providing technical assistance to the different sectors to ensure that appropriate measures are taken for creating awareness of their workers and their families on the disease and for providing the necessary prevention and control services. The medium-term goals include reducing the level of HIV transmission by 25 per cent within five years.

2.2.2 Education sector policy and strategies on HIV/AIDS

The strategic framework and the Ethiopian Multi-Sectoral HIV/AIDS Project provide a basis for the education sector to prepare its own federal and regional level action plans that target in-school youth as agents and beneficiaries of anti-HIV/AIDS activities. In the plan document (ESDP-II) there is a section on HIV/AIDS and education, in which the threat of HIV/AIDS on educational demand, supply and quality is acknowledged and the need to respond to this threat outlined. Possible responses charted in the document include:

- providing life-skills learning opportunities and informing students and teachers about HIV/AIDS to reduce their vulnerability and to enable them to better avoid risky behaviours;
- protecting, supporting and caring for children and others living with HIV/AIDS, through the curriculum (e.g. through integration of HIV/AIDS education in all subjects and for all grade levels) and the various extra-curricular activities, including anti-AIDS clubs and radio and TV programmes produced and broadcasted by the Education Media Agency;
- producing supplementary materials, source books, posters, leaflets etc. in the different languages, and distributing them to schools;
- encouraging NGOs working on HIV/AIDS to use schools as intervention centres and entry points to prevent HIV infection among young people, and
- establishing task forces at various levels within the sector (ministry, regional bureaus, district desks etc.) to follow up activities (FDRE-MoE, 2002*a*).

The Plan also gives attention to drug abuse and population and family life education programmes and activities, to discourage harmful traditional practices. It also sets out to strengthen linkages between schools and health institutions and to undertake HIV/AIDS and other health-related activities in the different sub-programmes (FDRE-MoE, 2002*a*).

Finally, the Plan acknowledged the need for a study on HIV impact on the sector, focussing on teacher supply and student demand, which was duly carried out (FDRE-MoE, 2003). While this represented a positive and worthwhile development, the report only considered the impact of the epidemic on education processes, principally at the school level. The sector must now move to consider the equally serious impact on educational planning and management.

2.2.3 HIV/AIDS programming in the education sector

The first case of AIDS was reported in Ethiopia in the mid 1980s, but it was not until 1996/1997 that a pilot project, called *AIDS/STD* [sexually transmitted disease] *education* was initiated, focusing on secondary school clubs. Three years later (i.e. 1999/2000), saw the first attempts to incorporate HIV/AIDS issues into the school curriculum, the setting up of anti-AIDS clubs and use of educational media in HIV/AIDS control activities.

The Ethiopian Multi-Sectoral AIDS Project, under the HIV/AIDS Prevention and Control Coordination Office (HAPCO), has an implementation manual that outlines the activities of each sector and its ministry. In response to this, in 2001, the Ministry of Education set up a task force, whose areas of focus include a three-year workplace intervention at headquarters and its branches, and activities to be undertaken in educational institutions.

The regional education bureaus have held several consultative meetings and workshops have been taking place to discuss the activities and support mechanisms that need to be undertaken jointly. These activities include:

- assisting teachers, through training, to make HIV/AIDS-related education more effective;
- supporting HIV/AIDS-related research and studies;
- analysis and evaluation of teaching materials;
- producing a 20-minute film (currently in progress), and
- producing an HIV/AIDS teaching guide for teachers.

In addition, anti-AIDS clubs have been set up in secondary schools, guidelines for their activities prepared, and various publications and films produced and distributed. Support materials include:

- *Know and act: AIDS/STD education for school student textbook*;
- *Life skills activities for AIDS/STD education student book*;
- *School health education to prevent AIDS and STD* (student's activities guide and teacher's guide, 2002), and
- *Handbook on population and family life education for secondary school teachers in Ethiopia*.

Some of the studies carried out have included:

- a 2002 impact assessment of AIDS/STD education in Ethiopian senior secondary schools;
- *Needs assessment of AIDS education for Ethiopian primary school* (FDRE-MoE, 1995);
- *HIV/AIDS baseline survey on high school students in Ethiopia* (FDRE-MoE, 2002*c*);
- a preliminary survey of the status and needs of anti-AIDS clubs in primary schools in and around Addis Ababa, and
- *A study on the impact of HIV/AIDS on the education sector and the status and problems of HIV/AIDS education in Ethiopia* (FDRE-MoE, 2003).

Despite these initiatives, more efforts are still needed in the direction of mainstreaming for effective programming of HIV/AIDS in the education sector.

2.3 Gaps in knowledge and programming for HIV/AIDS in the education sector

HIV/AIDS has generally been perceived as a problem for 'others', be it at the level of the individual, household, community, institution or organization. In schools, activities related to HIV/AIDS have been considered as exclusively the business of students, and not of teachers, other workers or the community. The tendency for separating school-based activities related to HIV/AIDS from those that take place outside of the school system serves to further reinforce this point of view. Many teachers show unbelievable apathy and unwillingness to participate in HIV/AIDS-related activities. Similarly there seems to exist little, if any, co-ordination among those few that are willing to assume leadership roles.

The result has been limited positive attitudinal change on the part of either students or teachers towards combating the pandemic. The impact study of the Ministry of Education, for example, found that teachers and students alike harboured misconceptions and negative attitudes towards HIV/AIDS. Some thought they were immune to HIV infection; others attributed HIV/AIDS to God, while others were not certain about the effectiveness of condom use (FDRE-MoE, 2003). Researchers have also found that acquisition of knowledge on the subject of HIV/AIDS does not always translate into positive changes in attitudes and behaviour.

Since there is no education sector HIV/AIDS policy in Ethiopia, the mechanisms for addressing the direct and immediate problems facing the sector are also not clear. Issues of providing antiretroviral (ARV) treatment, other medical benefits or sick leave to staff living with HIV/AIDS are often regarded as outside the jurisdiction of the Ministry of Education. Health issues are viewed as the concern of the Ministry of Health, while sick leave and other welfare needs are considered the responsibility of the Civil Service Commission. Even the Federal Civil Servants' Proclamation No. 262/2002 (FDRE, 2002), whose objectives include, "legislating clear provisions which guarantee job security and fair conditions of service to civil servants" is silent on the subject of HIV, as indicated by the excerpts in Box 1:

Box 1. Selected Provisions of the Federal Civil Servants' Proclamation No. 262/2002 (FDRE, 2002)

On Sick Leave (Art. 36): "(1) Any civil servant shall be entitled to sick leave where he is unable to work due to sickness. (2) The duration of sick leave to be granted to a permanent civil servant in accordance with sub-Article 1 shall not exceed eight months in a year or twelve months in four years, whether counted consecutively or separately starting from the first day of his sickness. (3) Sick leave to be granted in accordance with sub-Article 2 shall be with full pay for the first three months, with half pay for the next three months and without pay for the last two months. (4) Where any civil servant is absent from work due to sickness: (a) he shall, as soon as possible, notify the government office unless prevented by force majeure, (b) he shall produce a medical certificate in case of absence for three consecutive days or for more than six days within a budget year." (Art. 37): "A temporary civil servant who is unable to work due to sickness shall be entitled to sick leave in accordance with the contract he has entered into with the government office."

On mourning (Art. 39): "(1) Any civil servant shall be entitled to leave with pay for three consecutive days in the event of the death of his spouse, descendant, ascendant or any other relative, up to second degree, by consanguinity or affinity. (2) A civil servant shall be entitled to leave with pay for one day in the event of the death of his close relative or friend other than those specified in sub-Article 1, provided that such leave shall not exceed six days within a budget year."

On medical benefits (Art. 42): "(1) A permanent civil servant shall have the right to get all medical services, free of charge, in government medical institutions. (2) A permanent civil servant shall have the right to get medical services, with half pay, in government medical institutions for his spouse and minor children."

On termination of service due to illness (Art. 75): "(1) where a permanent civil servant is unable to resume work within the time specified under Art. 36(2) of the Proclamation, he shall, with no requirement of a medical certificate, be deemed unfit for service and be discharged; (2) the service of any temporary civil servant may be terminated where he is unable to resume work at the end of the sick leave granted to him pursuant to Art. 37 of the Proclamation."

Although this Proclamation was issued after the National Policy on HIV/AIDS, it makes no reference to HIV/AIDS, except where it excludes compulsory HIV testing for civil servants (Art. 61). The provision for medical benefits seems to be generous, but does not take note of the exceptional features of HIV/AIDS or the limited capacity of government medical institutions to survive the pandemic.

There are no support systems for infected or affected staff, just as there are no arrangements for orphans and other vulnerable children. This has a host of negative implications for the productivity and quality of education, and the educational planning and management process in the fight against HIV/AIDS. In the absence of policy guidelines, silent tolerance and empathy by way of continuing to pay workers that fall ill seems to be the practice, even though this goes against the provisions made in the Proclamation. Furthermore, in the absence of budgetary provisions, continuing to pay salaries for teachers that fall sick places further financial pressure on the sector, especially if replacement staff have to be paid at the same time. Other informal coping and support mechanisms include staff members taking on extra teaching load to cover for their absent colleagues.

It could be argued, however, that the problem is not really a lack of policy – there is already a national policy to be adopted by sectors and institutions. The main issue for the sector is that of *ownership* of this policy; and contextualizing it to suit the specific needs and aspirations of the sector and its institutions. This could be ensured through integrating HIV/AIDS aspects into mainstream activities. The importance of strategic planning, strong leadership, definition of the roles and responsibilities of various actors and their co-ordination, and a system of monitoring and evaluation cannot be overemphasized. In addition, adopting such a planning perspective would help to address the issue of resourcing.

Finally, it must be remembered that fighting HIV/AIDS cannot be undertaken in isolation from fighting poverty. HIV/AIDS makes the fight against poverty complicated; the one cannot be disentangled from the other. The fight against HIV/AIDS is therefore synonymous with the fight against poverty – and like poverty, HIV/AIDS needs to be tackled through a well-coordinated multidimensional and holistic approach.

3. Methodology

3.1 Study design

Four levels of analysis were considered to be appropriate for this particular study: federal ministry, regional state education bureaus, district education desks and individual institutions (colleges and schools). Assessment of capacity needs at these different levels was important, not only for the identification of the needs, but also for the identification of the level at which capacity constraints are most detrimental. The strategic issues are those that concern leadership, functional issues and technical skills, as well as the motivation of individuals to inform policy and prepare and operationalize plans. Emphasis was placed on the stock of existing skills and the stimulus for continuous learning.

3.2 Study sites and selection criteria

Data were collected from the Federal Ministry of Education, three regional states – Amhara, Oromiya and Southern Nations, Nationalities and Peoples (SNNP) – and one city – Addis Ababa. These sites were selected on account of their high population totals, high HIV/AIDS prevalence rates, large student populations and high share of the country's schools and teachers. These regions are home to nearly 85 per cent of the total population, 88 per cent and 83 per cent respectively of all students enrolled in primary and secondary schools, 87 per cent of all teachers, and 85 per cent and 80 per cent respectively of all primary and secondary schools in the country. These regions, therefore, provide a general picture of the country situation.

A district from each selected region and a school from each selected district were included. The districts selected included the regional capitals of Awassa in SNNP, Adama in Oromiya and Bahr-Dar in Amhara (see Figure 3.1), because they represent the areas with the highest HIV prevalence rates. For example, the urban sentinel surveillance data showed HIV prevalence rates of 10 per cent in Awassa, 19 per cent in Adama and 23 per cent in Bahr-Dar. Second, data from these districts were thought to be indicative of the scale of intervention of the best-case scenario within each region. Given the higher concentration of NGOs working on HIV/AIDS in these districts, it is plausible that they have better planning and management capacities than other districts. The districts selected were thus viewed as providing a benchmark against which to gauge the extent of the HIV/AIDS problem, as well as the level of response. Kirkos Kifle-Ketema, a sub-city, was included for Addis Ababa using similar criteria.

In total, ministry headquarters, the education bureaus of three regional states and Addis Ababa City Administration, a district education office from each regional state, two institutions of higher learning (Kotebe Teacher Training College and the Ethiopian Civil Service College) and four secondary schools were included in the study. The heads of the respective units were the primary focus of the study.

Figure 3.1 Map of Ethiopia

Source: Perry-Castañeda Library Map Collection, the General Libraries, the University of Texas at Austin, 1999.

3.3 Data collection techniques

Secondary data were collected through a desk review of relevant documents, including policy and strategic plan documents, impact studies, learning materials and guides and research

reports. These served to inform a more detailed analysis of the issues through primary data collection. Primary data were collected through questionnaires and interview guides tailored for the different profiles of interviewees, be they heads of units, concerned staff, informants, college and faculty deans or school directors. Discussion workshops were also organized for key informants. The research team comprised a consultant and four research assistants.

3.4 Data organization and management

Data were organized in a matrix, categorized by level and function. This permitted a careful analysis of the issues at hand and the ultimate identification of capacity gaps and training needs by level.

3.5 Dissemination

A workshop was organized for the educational planners and managers interviewed for the study. The report will be made available to all those concerned, although for effective dissemination and integration of findings in action plans, more effort will be required by way of sensitization.

3.6 Problems and limitations

It was originally planned to start collecting data at the ministry level and work outwards to the regional, district and finally school levels. This was important because the information obtained at a higher level of organization would facilitate the identification of issues for deeper analysis at the lower levels. This stepwise approach did not work, however, for reasons beyond the control of the study team. Schedules of interviews and questionnaire returns had to be constantly changed in a manner that defied initial plans. Schools were also on vacation during the months of July and August, meaning that data could not be collected until September.

4. Findings

4.1 Policy, leadership and governance needs

4.1.1 National level

With a federal structure in place, decentralization of the education system has provided an educational planning and management framework that eases the process of curriculum development, teacher training and expansion of education opportunities.

It is the responsibility of the senior and middle level management at the ministry (i.e. the minister, vice ministers and heads of units) to spearhead activities related to HIV/AIDS. Following the acknowledgement that HIV/AIDS constitutes a real menace to the demand and supply of education, there have been concerted efforts to manage the epidemic in the education sector.

HIV/AIDS issues are discussed in the education system through curricular (integration with subjects) and extra-curricular (e.g. anti-AIDS clubs) media. Workshops, in the form of role-plays, demonstrations and lectures, constitute another main instrument of awareness campaigns. However, HIV/AIDS issues are rarely discussed openly among staff, due largely to problems of social stigma and denial, while the ministry seems to have no mechanism to liaise with teacher associations concerning HIV/AIDS prevention, control and impact mitigation.

The ministry also acknowledges that its efforts to fight HIV/AIDS have been hampered by unsatisfactory leadership. The Ministry of Education is working closely with the Ministry of Health, HAPCO and NGOs in the fight against HIV/AIDS. HAPCO co-ordinates national efforts and provides the framework for funding activities through planning and quarterly monitoring and evaluation. The Ministry of Health provides health personnel to work with educational establishments. The NGOs work with schools and support anti-HIV/AIDS clubs through providing training and facilities. However, the NGOs' efforts have lacked co-ordination; there is no particular mechanism to guide collaboration among the different actors outside of the ministry. Lack of harmonization of plans and activities is therefore a major weakness and has serious consequences for the fight against HIV/AIDS. For instance, this poor co-ordination between different government arms and other actors has prevented the government from tapping into resources from the Global Fund for HIV/AIDS, TB and Malaria.

The ministry has no specific sectoral policy on HIV/AIDS at the moment. The national policy, however, provides a broad mandate for all sectors and stakeholders and sectoral strategies can be evolved from the national strategic framework. The lack of a sectoral policy implies that relevant issues remain largely unidentified and contentious issues remain divisive. For example, whereas provision of condoms in higher education institutions is considered to be acceptable, no similar consensus can be found on provision in schools.

The role of the sector, as defined in the national strategic framework, includes:

- the provision of HIV/AIDS education in primary and secondary schools through the school curricula, so that as many children as possible in the 'window of hope' are reached;
- developing IEC materials and interventions on reproductive health and HIV/AIDS to promote safe behaviour before children become sexually active;
- producing new, youth-friendly IEC materials in local languages and based on the experience of involving people living with HIV/AIDS (PLWHA) in IEC interventions;
- involving students in curriculum development of HIV/AIDS/STI education in schools;
- designing, printing, and distributing age-appropriate printed materials, such as posters, leaflets and brochures on AIDS/STIs that students can easily understand;
- strengthening the existing anti-AIDS clubs in secondary schools and establishing new ones. This will include increasing the appeal and effectiveness of these clubs;
- involving families, religious organizations and other social organizations in the planning of HIV/AIDS/STI education for youths;
- developing in-service training, guidelines and materials on HIV/AIDS for schoolteachers.

The ministry considers these roles to be appropriate and aims to fulfil them by targeting the youth in urban and rural schools as agents and beneficiaries of anti-HIV/AIDS interventions. Clearly this list of responsibilities is not sufficient to deal with the entire amalgam of the challenges of HIV to the education system. The focus appears to be exclusively on prevention education at the expense of the core issue of planning and management in an AIDS-affected context. For example, the list is silent on the importance of developing and maintaining an effective and efficient Education Management Information System (EMIS). The sector's comparative advantage for an effective response lies in its capacity to reach out to a crosscutting section of the society, such as the 'windows of hope', the vulnerable and the youth. However, respondents interviewed for this study felt that this role has not been played effectively because of several problems, of which lack of effective leadership ownership and commitment at all levels have been the most detrimental.

There is no dedicated unit responsible for HIV/AIDS in the ministry. A taskforce (chaired by a vice minister) and a technical working group provide leadership, advocacy and follow up consistent with the terms of reference provided in the national policy and strategic framework. Respondents recognized that this was not the best way to structure the response, and also felt that it did not adequately fulfil the sector's mandate. Some of the weakness emanates from structural deficiencies. Thus, prevention, control and impact mitigation are usually supplementary undertakings. The working group is also reportedly not held responsible and therefore does not carry out tasks as desired.

The curricular interventions for prevention, though not meeting respondent's expectations, were felt to have some positive impact on raising awareness. In fact, integration of HIV/AIDS messages in the curriculum and teacher training programmes is one area where implementation has been reported as encouraging, despite a number of complications. Attitude is the number one problem for the successful implementation of responses and this is manifest at all levels, despite the ministry's efforts to address this and other problems.

To date, there have been very few, if any, training programmes specifically targeted at educational planners and managers with a view to enabling and empowering them to face and outwit the challenges posed by the pandemic. The education sector is also lacking any specific arrangements or mechanisms to respond to problems of long-term illness of teachers

and other education personnel. There is no organized method for coping with staff absenteeism and attrition. It is generally left to ad hoc school-level human resource practices. There are no carefully designed ways of dealing with the welfare of teachers and staff living with HIV/AIDS, such as through transfers, workload sharing and provision of medical care, including ARVs. Whether, and the extent to which, attending funerals has disrupted work in the sector is not known, since no reports are available. Faced with a lack of information on the system, policy options to respond to this problem have yet to be thought out.

Since the sector's human resource management practices abide by the civil service regulations, the families of dead staff members do not receive death benefits from the ministry, and there are no specific legal provisions for retirement benefits to staff with HIV/AIDS. As indicated above, arrangements for ARV and other medical services are considered to fall outside of the jurisdiction of the ministry. There are also no arrangements for orphans and other vulnerable children.

4.1.2 Regional level

The federal political arrangement has given the regional states considerable space for the formulation of region-specific policies and governance. The major problems facing the regions are, however, akin to those facing the districts. In both the regions and the districts there is a lack of capacity for planning, as well as for monitoring and evaluation of implementation, and a shortage of trained and skilled personnel. Despite significant efforts, progress in leadership capacity building at higher levels of governance does not generally filter down to lower levels. Effective and efficient leaders need to be trained for the bureaus so that they can successfully scale up HIV/AIDS interventions.

As with the central level, there are no dedicated HIV/AIDS units at the bureaus. Instead focal persons are assigned the task of co-ordinating HIV/AIDS activities. Most programme activities revolve around prevention efforts; programmes on care and impact mitigation were non-existent. Only Oromiya region reported the existence of an orphans' programme, sponsored by UNICEF.

In all of the regions, HIV/AIDS was reported to affect the education sector in several ways. HIV/AIDS has exacerbated the shortage of teachers due to illness and death, increased student dropout attributed to parental sickness or death, and had a depressive impact on those affected or infected, reducing the productivity and quality of their work. The extent of the impact was rated as significant by SNNP and Addis Ababa regions, severe in Oromiya region and extremely severe in Amhara region.

IEC interventions, with particular focus on awareness creation among the school communities, are the most common strategies for dealing with HIV/AIDS in the education sector. School-based anti-AIDS clubs are the single most important instruments of advocacy. Focal persons at regional bureaus and district education desks are expected to play co-ordinating roles. There is also an initiative in SNNP to dedicate a month of the year to HIV/AIDS, in which several advocacy campaigns and activities will be undertaken. The Addis Ababa education bureau, learning from and adapting Germany's experience, is designing a 'MOVE' campaign.

Regional bureau directors pass on messages reaffirming the importance of protecting one's own and one's partners' life. Similar messages highlight the uniqueness of students (e.g. that they are windows of hope – bridges between the foregone and the forthcoming generation) and the need to protect them as a way of ensuring the continuity of the family, the community and the nation. These messages have led to more open discussions within bureaus, as well as at lower levels. The messages have also contributed to the strengthening of school-based anti-AIDS clubs, the integration of HIV/AIDS into the curriculum, the assigning of focal persons at bureau levels and SNNP's month-long advocacy drive. However, financial, material and technical constraints limit the continuity of their activities and their impact.

Poor or non-existent co-ordination among important stakeholders has limited the effectiveness of interventions. The health bureaus organize training programmes, while the HIV/AIDS secretariat provides funding and technical assistance. NGOs sponsor workshops and provide support for various school-based activities. However, there is no mechanism for overseeing these activities and ensuring that different actors maintain a common standard. In some cases, there are no mechanisms even for an exchange of views and information. As a result, little is known of the views of teacher associations on HIV/AIDS. In SNNP, however, teachers' associations had been invited to comment on the draft curriculum, designed with a view to incorporating HIV/AIDS issues.

Making direct reference to the national policy and the strategic framework for action has facilitated decision making on HIV/AIDS-related affairs in the bureaus. For example, in Oromiya regional bureau, there are some efforts to explicitly address issues in the strategic plan document (covering the next three years). There are also differing opinions on the importance of sector-specific policies on HIV/AIDS. While in Amhara respondents felt that there would be no need to have region- and sector-specific policies on HIV/AIDS, in SNNP this was considered necessary, in view of cultural, intra-sectoral and supra-sectoral realities.

Opinions on in-school promotion of condoms also varied significantly. One view was that condom promotion was necessary because abstinence from sex could not be guaranteed, especially among young people. However, there was also a competing view that condom provision could feed sexual excitement among youngsters. Those who held the latter view argued that condom promotion should be limited to the adult school community. For the youngsters the motto should be 'no sex before marriage and a blood test'.

Due to policy gaps there has been no systematic response to the problem of long illness of teachers or the education personnel in general. Little has been said about the welfare, care, treatment or support of teachers who may be infected or affected by HIV/AIDS; nor is much known about its impact due to lack of data. Capacity and resource constraints mean that it is unlikely that this situation will be rectified in the near future. In any case, none of the regional bureaus covered by this study have initiated an impact study and analysis of the impact of HIV/AIDS on sector staff. In this policy and information vacuum, it has been left to school level management to form the response by, for example, encouraging other staff to take on the work of their absent colleagues.

There was also no concrete data on the extent to which funeral attendance has disrupted educational work. However, disruption due to funeral attendance was reported to be 'the order of the day' and a common phenomenon in the bureaus. There is no specific policy on bereavement, save for Article 39 of the Civil Servants' Proclamation, which grants three consecutive days leave for civil servants in the event of the death of a close family member,

and one day for other relatives or friends (FDRE, 2002). Death benefits are non-existent for Ethiopia's civil servants, and no particular legal provision exists for retirement benefits to staff infected with HIV/AIDS.

Cultural taboos, including secrecy in sexual matters, as well as stigma and possible discrimination against those infected and affected were found to work against openness, despite efforts to create and raise awareness on HIV/AIDS. The complete absence of arrangements for orphans and other vulnerable children to cushion them against HIV/AIDS demonstrated how extensive the gaps are in the sector's impact mitigation efforts.

There were no HIV/AIDS training programmes or materials for educational planners and managers at the bureau level. The only information available covered basic skills for prevention and control targeted mainly at the general public.

The training needs identified for the sector at this level therefore include building skills for:

- addressing the mosaic of different cultures (e.g. SNNP has over 50 ethnic groups);
- encouraging openness about the issues;
- instilling commitment among staff;
- mainstreaming, monitoring and evaluating prevalence and impact.

4.1.3 District level

The move towards district-level decentralization is a recent one, meaning that problems and challenges tend to surface more readily. The major problems found at the district level included:

- lack of an integrated planning approach;
- budgetary constraints;
- inadequately trained and motivated personnel;
- lack of attention from higher authorities;
- low levels of community participation and involvement.

Responses to HIV/AIDS at the district level include distribution of IEC materials, and co-ordination of anti-AIDS movements within the office as well as in schools. There were no units exclusively organized to deal with HIV/AIDS at the district level. However, a focal person was assigned the task of co-ordinating HIV/AIDS activities. Once again the focus of interventions has been prevention, rather than impact mitigation. At times, district health offices, health centres, hospitals and NGOs (such as the Red Cross) have joined with district education offices and schools to undertake activities.

There was a complete absence of any system for monitoring the prevalence and impact of HIV/AIDS on the education sector within the districts, although respondents did report that HIV/AIDS-related illness and death is more of a problem among staff than among students. For example, in a district of Amhara region, on average up to 10 teachers reportedly die each year, and most of these deaths are suspected to be AIDS related. This has budgetary implications because recruitment and selection of replacement staff represent an additional financial burden. Respondents also cited reduced fees and school incomes as further financial

constraints. Higher dropout rates were also reported for students that become unable to attend school due to changes in circumstances surrounding parental illness or death.

Since there are no data on HIV/AIDS prevalence rates, the school budgeting and financing process does not take into account inter-school differences in prevalence within the districts. HIV/AIDS does not even have a budget line; hence schools do not receive finances from the district education offices for their HIV/AIDS related activities.

Identified training needs include:

- building leadership skills;
- designing effective support systems for schools;
- mainstreaming through planning;
- monitoring and impact evaluation.

4.1.4 Institutional level

Major problems reported by schools with regard to leadership included lack of adequate budget, shortage of qualified teachers, particularly at secondary level, poor co-ordination of activities, and absence of motivation among staff. These problems were exacerbated by significant increases in numbers of students.

The colleges reported lack of committed and capable staff at different levels of management, leading to inadequate planning, inadequate management information systems, poor administrative support systems caused by outdated organizational structures and processes, lack of administrative and financial autonomy, and an absence of mechanisms for performance evaluation. The recent Higher Education Proclamation, which grants administrative and financial autonomy to higher educational institutions, and the implementation of the civil service reform programme that highlights results-based performance evaluation, may help to solve some of these problems.

School heads felt that HIV/AIDS has affected the functioning of their institutions. In some cases (e.g. in Addis Ababa), teachers and students who were affected by HIV/AIDS were found to lack the strength to teach and learn properly. In Bahr-Dar (Amhara), productivity reportedly dropped for those workers testing HIV positive. In Adama (Oromiya), HIV/AIDS has led to an increase in the rates of student dropout and absenteeism. In the colleges, HIV/AIDS is believed to have resulted in increased student dropout due to frequent illness, staff absenteeism and staff and student death, as well as high clinical costs as a result of providing treatment for staff and students with HIV/AIDS-related illnesses. This problem was more acute in Bahr-Dar (Amhara).

These reports cannot be confirmed independently, however, as there are no mechanisms for monitoring the impact at the institutional level. Data on current levels of HIV/AIDS are inadequate, either due to a lack of intervention programmes, or because people conceal or deny their HIV status. As a result, the civil service college was the only institution to report staff attrition as a problem.

The dearth of programmes dedicated to supporting terminally ill staff was also attributed in part to lack of information. In particular, the difficulty was in ascertaining if sickness was due

to AIDS. If any special support was accorded to infected and affected students, it was principally out of sympathy, rather than as a result of any systematic initiative. In schools this support took the form of granting sick leave so that students could seek medical treatment outside the college, in-school fundraising to assist students financially or providing counselling for those that ask for it.

Planning for HIV/AIDS falls within top management functions in the colleges and in the lower-middle management in the schools. In none of the institutions could an organized response from staff members be found. Consistent with upper levels within the sector, no institution has a policy on HIV/AIDS. And, while schools generally have some programme of action, none of the colleges had formulated strategies to systematically respond to the pandemic. The reasons cited included the lack of capacity for planning and management arising from lack of ownership and the absence of units responsible for HIV/AIDS. Schools have anti-AIDS clubs, but their activities are not linked to institutional plans. Many such clubs are part-time, volunteer-driven activities, and receive no budget allocation to finance their activities. In some cases, their activities are funded by NGOs on an ad hoc basis. In others, schools provide some, although not enough, basic materials.

There have been limited attempts to incorporate aspects of HIV/AIDS in the curriculum. None of the institutions have treated HIV/AIDS as a stand-alone subject, nor has any effort been made to monitor the quality of pedagogical materials.

Efforts to train teachers on aspects of HIV/AIDS have neither been taken seriously nor organized systematically. As such, few teachers have taken ownership of AIDS education in schools. NGOs and personnel from the health bureaus appear to determine the content of co-curricula activities in schools, rather than the school management. In all of the institutions studied, staff members did receive training on HIV/AIDS although, with the exception of the civil service college, it appeared to focus principally on awareness creation and was conducted by health bureaus and NGOs. Only the civil service college managed to get five members of staff (deans of each faculty and the student services) onto HIV/AIDS mainstreaming training organized by the regional office of the United Nations Development Programme (UNDP) in South Africa.

The training gaps that need to be addressed in order to enhance the capacities of institutions for HIV/AIDS mainstreaming include developing:

- shared HIV/AIDS awareness among leaders of the institutions;
- skills in design and delivery of a curriculum that integrates HIV/AIDS issues;
- skills for collaborative work with stakeholders, and
- skills in appropriate planning and allocation of resources.

4.2 Functional capacity and training needs

4.2.1 Central level

As indicated above, there is no unit in the education sector dedicated entirely to HIV/AIDS. Instead, initiatives are spearheaded by the taskforce, led by a vice minister, with members drawn from women's affairs, the educational media agency, the institute of curriculum

development and research, teacher education and programmes, public relations, the technical working group, which is composed of experts from the above units, and the focal person, who is also the team leader of one of the line departments. Thus, HIV/AIDS is not the primary responsibility of the focal person.

The technical team holds joint consultative meetings with other sectors. The technical working group organizes workshops, gives information on HIV/AIDS and education for organizations outside the ministry, prepares HIV/AIDS materials and distributes them within and outside the sector. It also undertakes mitigation activities, although their effectiveness is often hampered by the absence of a well-defined and appropriate strategic plan. This study found that some of its members had received training in aspects of HIV/AIDS. For example, the co-curriculum team leader participated in a three-week training workshop in South Africa on mainstreaming, and the HIV/AIDS focal person attended a five-day, World Bank-sponsored course held in Kenya on HIV/AIDS and education.

Training needs identified include:

- up-to-date information about developments in HIV/AIDS;
- strategic planning;
- project preparation, and
- monitoring and evaluation for HIV/AIDS mainstreaming.

4.2.2 Regional level

At this level, as at the the ministry, HIV/AIDS-related activities are organized either by taskforces, whose members are representatives from various functional units, or individual focal persons. There are no units dedicated to running HIV/AIDS activities in the regions. SNNP does however recognize the relevance and importance of such a unit, while the regional branches of HAPCO make some funds available based on plans and projects submitted. Since fund allocation is subject to project and action plan preparation, it is possible for some regional bureaus to receive very little of such funding.

The major HIV/AIDS areas of focus revolve around prevention through awareness creation through workshops and anti-AIDS clubs. However, this continues to be hampered in most regions by the absence of well worked out plans, sufficient budgets and human resources.

Limited opportunities and high staff turnover continue to undermine HIV/AIDS training initiatives. Where there was training, it was found to be limited in scope and coverage; training is both supply-driven and supply-constrained, failing to adequately meet the needs and aspirations of those that need to access it. There is also no tradition of attempting to assess the impact of any training received.

Training needs identified include:

- leadership skills;
- impact assessment and mitigation;
- project preparation and management;
- training methodology;
- organizing effective support systems for anti-AIDS clubs;

- skills for bringing about behavioural change, and
- current developments on HIV/AIDS.

4.2.3 District level

At this level, once again, there is no unit dedicated to HIV/AIDS. Instead, committees are formed for the task, or in some cases focal persons are given financial top-ups to assume roles in addition to their major responsibilities. Absence of dedicated units means that adequate and appropriate persons are not assigned to do the job on a continuous basis. It has also made allocation of resources, including budgets, quite difficult. Financing is limited to occasional activities, such as undertaking training. All of this places ownership at stake: by their own assessment district-level structures are not able to carry out activities according to plan. Lack of training materials, shortage of funds to carry out training, and lack of clear responsibilities and mandates for those assigned to the task have reportedly contributed to the problems.

Appropriate training programmes and materials to address the capacity gaps are generally in short supply and, where applicable, they are related to awareness creation. Respondents mentioned 'lack of attention given to the unit' as one reason for the lack of human resource development. Full attention from policy makers, placement of the unit within the formal structure, appropriate manpower and skills, and provision of continuous training, training materials and facilities are all considered to be necessary for effective operations at this level.

Training needs include:

- planning for effective interventions;
- development of project proposals;
- fundraising skills, and
- monitoring and impact evaluation.

4.2.4 Institutional level

All of the schools studied had an HIV/AIDS unit in the guise of an anti-AIDS club. The participants are mainly students, plus a few members of staff who assist in club co-ordination and provide guidance. The key area of focus for these clubs is creating awareness through the use of drama, songs and posters. The schools make no budgetary allocations to support these activities. These clubs are, however, incapable of following work plans – something that respondents attributed to the limited financial and human resources.

In most of the institutions staff working with the clubs had not received any training on HIV/AIDS. Only in one school in the Amhara region did club members report having received training in life skills, counselling and peer education (reportedly organized by an NGO called Path Finder International). The reasons given for the low levels of training included lack of management attention to the units, consideration and treatment of HIV/AIDS as a side issue, failure to develop mechanisms for collaboration with training providers or donors and, in some cases, high turnover of staff.

The units distribute leaflets and newspaper aimed at enhancing or creating awareness within the respective institutions, but also attempting to reach out to their surrounding communities

through drama, music and other displays. Respondents considered the units to have a moderate influence on attitudes and activities within the institutions, but to be generally very weak in the wider communities.

Funding for most of these anti-AIDS clubs depends largely on the support of NGOs, who tend to be concentrated in major towns. The erratic nature of the support they receive is such that clubs face problems ranging from lack of basic facilities, stationery, training materials and equipment, to under-developed communication skills and poor motivation.

Identified training needs include:

- counselling skills;
- effective communication;
- motivation;
- basic health service provision, and
- information on current developments and status of the epidemic.

4.3 Plans and programmes

4.3.1 Central level

HIV/AIDS has not generally been considered to be an issue for the planning unit, apart from through its integration in the ESDP, which focused on awareness creation and bringing about behavioural change through curriculum integration, extra-curricular activities and the use of educational media. This low profile of HIV/AIDS in the planning process is partly due to the lack of a dedicated HIV/AIDS unit to collaborate with the planning unit and facilitate its task.

The unit has made little, if any, attempt to place HIV/AIDS on the educational policy agenda. There has reportedly been no change in roles and responsibilities within the planning unit because of HIV/AIDS. Respondents were uncertain whether the unit should be involved at all in operationalizing policies and strategies related to HIV/AIDS. In any event, they did not think that the unit had the capacity to carry this out.

The most significant capacity gaps identified in the unit were the need to develop indicators to monitor the impact of HIV/AIDS and capacity to mainstream HIV/AIDS in the planning process. The training needs identified therefore include:

- HIV/AIDS mainstreaming in the planning process;
- HIV/AIDS data collection, analysis and manipulation to inform planning and policy decisions, especially at the lower levels (regional, district, school);
- development of basic indictors to monitor the impact of HIV/AIDS on the education sector;
- development of an EMIS to extract reliable data from schools on the impact of HIV/AIDS (e.g. death due to AIDS).

4.3.2 Regional level

Major problems encountered by planning units at the regional level include poor management of information systems and a shortage of skilled human resources. Planning units were involved in HIV/AIDS activities to a limited extent, but they reportedly did not consider them seriously in planning or in day-to-day operations. No change was reported in roles and responsibilities because of HIV/AIDS. Involvement of HIV/AIDS units in the planning process was reportedly further hampered by their absence from the bureaus. Participation of focal persons in the planning process was also said to be very weak.

There was no consistent system of data collection for HIV/AIDS-related issues, such as staff absenteeism, attrition and orphanhood, and no mechanism for monitoring the prevalence and impact of the pandemic in the education sector. It is therefore difficult to assess the degree to which HIV/AIDS has impacted on staff and pupils. The only data regularly collected related to the number of anti-AIDS clubs formed in schools, their members and the awareness creation activities that take place.

Training was deemed important to address these capacity gaps, focusing in particular on:

- how to integrate anti-AIDS activities in educational planning;
- how to collect data on HIV/AIDS;
- manpower planning, monitoring and evaluations in the context of HIV/AIDS.

In most cases, it was reported that staff of the planning unit had not received training on HIV/AIDS issues. Even where some training had been received, as was the case in Oromiya, the individual concerned did not subsequently work on HIV/AIDS-related matters, as it was argued that the training was focused on awareness creation, not on skills development for planning.

4.3.3 District level

The major problems cited included lack of integration and co-ordination of activities that give rise to improper utilization of resources, poor information management systems that have made human resources planning very difficult, and a lack of skilled human resources, aggravated by higher staff turnover, particularly of those with a relatively high capacity for planning and management.

The planning units have some limited degree of involvement in HIV/AIDS activities, but these activities are not considered to be critical to their everyday operations. The units have not initiated studies on HIV/AIDS; nor have they developed a comprehensive system of data collection to monitor the impact. The current system only takes account of staff absenteeism and attrition, not the effects on pupils. As a result, it is impossible to paint a clear picture of the pupils and staff affected and infected by HIV/AIDS.

Important capacity gaps identified by respondents include a lack of commitment to HIV/AIDS, reflected in an inadequate knowledge and skills base, negative attitudes and lack of an integrated response.

Identified areas for training include:

- methodology for training the trainers;
- impact analysis;
- current information on HIV/AIDS;
- information dissemination skills;
- planning for effective care and support.

4.3.4 Institutional level

Respondents identified lack of skilled human resources and budgetary shortages as the major problems at this level. These problems were reportedly compounded by large and rising class sizes. In all institutions, some HIV/AIDS-related activities took place, but in almost all cases HIV/AIDS was not considered seriously in the day-to-day activities of the school or college. No effort had been made to initiate impact analysis studies within the respective institutions; hence there was no consistent system of data collection to monitor prevalence and impact. Most of the respondents did not even know if an impact study had been undertaken in the sector. As a result, no clear picture exists of how many students, teachers and other educational personnel have been infected and affected.

Since HIV/AIDS has never been considered a planning issue in the institutions, it has not been integrated within plans. And because the activities of anti-AIDS clubs are considered to fall outside the mainstream activities of the institutions, they have not been involved in the planning process either. Roles and responsibilities of the persons and units responsible for planning and budgeting have not changed because of HIV/AIDS. These units think that they should be involved in HIV/AIDS-related interventions, but feel that they lack the necessary capacity for an effective response. These capacity gaps are in the areas of skills in management and information handling and processing – to which practically no effort has been made to address.

Some staff have received training on HIV/AIDS issues, but in common with the units at higher levels, training has focused on awareness creation, not developing planning and management skills. Training is therefore deemed important for the following areas:

- providing basic and comparative information on HIV/AIDS and interventions;
- sharing best practices on prevention and control.

4.4 Curriculum development

4.4.1 Central level

Attempts were made to incorporate HIV/AIDS issues into the curriculum for grades 4 to 12, based on the findings of a 1995 needs assessment. The subjects in which HIV/AIDS was incorporated include environmental science (grade 4), basic science (grades 5-6), biology

(grades 7-12), language, physical education, civics and social sciences[1]. HIV/AIDS was not taught as a stand-alone subject.

Pedagogical materials, including curriculum guides, syllabi and reference books for teachers and supplementary reading materials for students, were also prepared to ensure that HIV/AIDS was integrated in the relevant career subjects. Curriculum experts decided on content of the material. All schools in the country use the same pedagogical materials, although there has been no effort to monitor the use of these materials.

Training needs identified at the central level include building skills for:

- the integration of HIV/AIDS into the curriculum;
- HIV/AIDS curriculum development, including materials development;
- mainstreaming HIV/AIDS in day-to-day activities.

4.4.2 Regional and district levels

The problems identified at the regional level were largely akin to those at the district level. Key problems identified by respondents included:

- lack of a properly conceptualized organizational strategic plan, which was largely attributed to inadequate training on plan preparation;
- poorly integrated co-ordination systems;
- limited integration of HIV/AIDS into the curriculum and teaching materials;
- lack of monitoring of the introduction and use of pedagogical materials;
- restricted access to training materials;
- inadequacy and improper utilization of resources.

Efforts have been made to train teachers on HIV/AIDS issues. All the units were reportedly involved in some HIV/AIDS-related activities, but there was a strong feeling among respondents that the units needed to be more actively involved in operationalizing HIV/AIDS-related policies and strategies. Most thought that there was limited capacity within their respective units to respond to the pandemic.

Staff training on HIV/AIDS has been largely limited to awareness creation. The training offered also appears to be supply- rather than demand-driven, organized by local NGOs rather than government institutions.

Training needs identified include:

- the selection of specific HIV/AIDS topics and their integration into different subjects;
- curriculum evaluation procedures;
- methodology of teaching HIV/AIDS at different levels, including peer education;

[1] Units in which HIV/AIDS has been incorporated include: 'Blood transmitted diseases' for grade 4 environmental science; 'Harmful cultural traditions' for grade 5 basic science; 'Diseases' (unit 2) and 'Reproductive system' (unit 6) for grade 6 basic science; 'Circulatory system' (unit 6) for grade 7 biology; 'Reproductive system' (unit 1) and 'Peoples and diseases' (unit 2) for grade 8 biology; 'Micro-organisms and diseases' (unit 6) for grade 9, and 'Reproductive system' (unit 5) for grade 10 (Institute for Curriculum Development and Research-MoE, 2002).

- analysing the impact of HIV/AIDS on human resources and development in general training;
- bringing about behavioural change to tackle the spread of HIV, and
- team building.

4.4.3 Institutional level

With the exception of the colleges, curriculum design and development does not take place at the institutional level. Issues raised by staff therefore related principally to curriculum implementation. Shortage of qualified teachers, lack of teaching of HIV/AIDS as a core responsibility, inadequate budgets and poor co-ordination of HIV/AIDS in co-curricula activities were cited as key problems in this respect, particularly in schools. There has been little effort made to train teachers on how to handle HIV/AIDS. In common with the regional and district levels, training has focused on awareness creation, rather than combating the spread and mitigating the impact of the pandemic. All levels felt lack of commitment to HIV/AIDS to be a serious challenge.

Treatment of HIV/AIDS in textbooks (environmental sciences, basic sciences and biology) was found to be inadequate; such content could not be expected to bring about any significant change in behaviour. HIV/AIDS is treated in a limited way by these texts and like any other sexually transmitted disease, with no special focus on risks and consequences, or on its socio-economic ramifications. Latest information and developments in the area are also missing from the textbooks. Teachers and school managers lack up-to-date information that reflects the dynamic nature of the pandemic, implying a clear need to explore mechanisms for the continuous flow of information. The implication is that school-based activities have made little headway in bringing about positive attitudinal change among students (FDRE-MoE, 2003).

Respondents from the colleges singled out the design of a learner-centred curriculum and learning materials as a particular problem. The integration of HIV/AIDS in education also appears to be limited to the co-curricula activities of anti-AIDS clubs.

Training needs identified include:

- effective integration of HIV/AIDS in the curriculum;
- development of proper delivery methods;
- dissemination of information on the current status of the pandemic and its impact;
- promotion and sharing of best practices.

4.5 Human resource management

4.5.1 Central level

Further training has eased somewhat the problem of lack of skilled human resources. However, budget cuts mean that the availability of short-term training to respond to changing needs and circumstances has worsened. Despite this, shorter, locally organized training programmes are preferred, due to their cost-effectiveness.

The human resources unit is involved in HIV/AIDS activities, and staff felt that they should be involved in operationalizing policies and strategies related to HIV/AIDS within the sector. However, in common with the planning unit there has been no change in roles and responsibilities because of HIV/AIDS.

Monitoring of the prevalence and impact of the pandemic on human resources within the sector has not been consistent. A study analysing changes in demand and supply of human resources due to AIDS was completed recently, but has not yet triggered any changes in the sector's human resource deployment policy.

In teacher training colleges, trainees are provided with HIV/AIDS training through workshops, anti-HIV/AIDS clubs and guest speakers from the Ministry of Health and NGOs, including PLWHA. However, some capacity gaps still exist, such as:

- preparation of HIV/AIDS policy and strategy at sectoral level;
- interpretation of latest available statistics on HIV/AIDS;
- impact analysis;
- establishment and implementation of VCT;
- design and development of IEC materials for different target groups.

4.5.2 Regional and district levels

At the regional and district levels the most readily discernible impact has been the loss of teachers and other educational professionals, leaving students without educators and educators without managers. Increasingly, those becoming sick are filing requests for early retirement and job transfer, leading to a shortage of trained and skilled personnel, as well as budgetary constraints. In one of the districts of Addis Ababa in just four months three sick people asked for early retirement, while two others asked to be transferred to lighter jobs.

There is a system of annual reporting for staff deaths, but it does not record whether causes are directly linked to HIV/AIDS. There is no systematic or consistent system of monitoring prevalence in the sector. Neither has there been any analysis of changes in demand and supply of human resources due to HIV/AIDS. No changes have been introduced in human resource policies at the regional level in response to the pandemic, despite respondents' assertions about the relatively high levels of awareness of the implications of HIV/AIDS – an awareness created through mass media, daily personal encounters and observations, and through participation in seminars and workshops.

Training needs identified include:

- planning for an effective response;
- capturing data on HIV/AIDS;
- monitoring and impact analysis;
- designing support systems for PLWHA and affected.

4.5.3 Institutional level

Shortage of skilled manpower and budgetary problems constraining provision of training to upgrade skills were some of the most serious problems identified at this level. None of the units involved in the study could report that they had staff working for them who had received training on HIV/AIDS issues.

There is no consistent monitoring of HIV prevalence and its impact on human resources. Staff deaths are reported without necessarily associating them with AIDS. The units tend to be aware of the implications and the potential impact of HIV/AIDS, but this awareness is created more through media coverage, personal encounters and observation than through school-based activities. Very few schools consistently involve human resource units in AIDS activities and the units have not redefined roles and responsibilities in response to the epidemic. Despite these shortcomings, there was a consensus that units should be involved in operationalizing polices and strategies pertaining to HIV/AIDS.

Some of the capacity gaps mentioned include:

- problems of attitude among the staff;
- inadequate basic skills for an effective response;
- lack of knowledge on HIV transmission and prevention methods;
- lack of skills for caring for PLWHA.

5. Summary and conclusions

Despite the expansion of educational opportunities and enhancement of educational quality, illiteracy is still pervasive in Ethiopia. It appears that HIV/AIDS will postpone the attainment of EFA in Ethiopia (World Bank, 2002). There are still wide inter-regional and gender disparities in access to education. Community participation in and responses to education have been weak, especially at the district level. Shortage of qualified teachers is still an acute problem at all levels. Professional capacity in educational planning and management of education is still under-developed. Skills to interpret policies, collect and analyse data, and enable schools to take appropriate action to meet the minimum quality standards defined for the local situation are critically lacking. The system is characterized by poor information supply and management, while insufficient budgetary provisions do not allow for expansion of quality educational opportunities.

5.1 Policy streamlining

There is a national HIV/AIDS policy and strategic frameworks are in place, but these have yet to be mainstreamed at sectoral, regional, district and institutional levels. For example, the existing civil servants' regulations hardly distinguish between a clerk with limited training and responsibilities, and a teacher or school director with much heavier responsibilities, who represents a greater training investment and may be far more difficult to replace. Such policy gaps make it difficult for the education sector to respond appropriately and effectively to the HIV/AIDS epidemic. There is an urgent need to design sectoral and institutional policies that are consistent with and elaborative of the national policy.

Box 2 Suggestions for a more effective learning-teaching process

- Capacity building for teachers on effective teaching methods, especially in caring and counselling for those living with HIV/AIDS.
- Need to review all educational materials related to HIV/AIDS.
- Provision of supplementary materials outlining latest information on HIV/AIDS.
- Examination of the methodology of all HIV/AIDS materials.
- Development of appropriate teaching aids.
- Supply of adequate teaching materials, including films, posters etc.
- Use of varied teaching methods like drama, poetry, class presentations etc.
- Instituting strong classroom supervision.
- Encouraging peer teaching and exchange of information and experience.
- Exchange of experience between schools.
- Strong co-ordination between government, NGOs and the community.

Source: FDRE-MoE, 2003.

5.2 Integrating HIV/AIDS into the education system

Currently HIV/AIDS is integrated in a few selected subjects and co-curricula activities, such as anti-AIDS clubs. This truncated approach does not factor in the multi-faceted nature of HIV/AIDS and may therefore fail to bring about desirable behavioural change (FDRE-MoE, 2003). The capacity of co-curricular activities to bring about a positive change in behaviour among school communities is also seriously constrained by the lack of adequate support in terms of leadership, effective advocacy, facilities and financial resources. Dependence on piecemeal external assistance to run activities renders such interventions unsystematic, inconsistent and ultimately unsustainable. HIV/AIDS needs to be addressed through well-designed curricula and co-curricula interventions. It should also be taught as a stand-alone subject.

5.3 Mainstreaming HIV/AIDS in the educational process

At present HIV/AIDS is considered either as a side issue or as the responsibility of specialized agencies outside the educational system. The EMIS must be re-examined and redesigned to take full account of HIV/AIDS issues on a continuous basis. At the moment, little data is systematically collected on HIV prevalence and impact, making it difficult to strategically and systematically respond the challenges it poses.

Lack of ownership and commitment by those responsible for planning and management emanates not only from inadequate information and ignorance, but also from lack of participation and empowerment. Everybody should be empowered to feel that they own the process by integrating HIV/AIDS in planning at all levels. Proper planning enables effective control, monitoring and evaluation during implementation and ensures leadership commitment. It also facilitates co-ordination of efforts, activities and resources through systematic integration. At the moment, those in control of financial and material resources are separated from those that do the actual work and make a difference. Budgeting should automatically follow planning, avoiding the chronic resource hunger that front-line units (e.g. anti-AIDS clubs – see Box 3) have traditionally faced. Channelling of resources in a consistent and harmonized budgetary framework also facilitates co-ordination and reduces leakages.

Box 3 Problems facing anti-AIDS clubs

- Lack of clarity of purpose and absence of operational guidelines.
- Lack of training for teachers.
- Inadequate resources to undertake sustained anti-AIDS activities, including IEC material and textbooks.
- Inadequate facilities.
- Low participation of students, teachers, and school administration in the fight against AIDS.
- Limited time available during the school day for HIV/AIDS education programs.
- Impact of cultural taboos, preventing or limiting open discussions about sex.
- Weak outreach support from the district education offices.

Source: FDRE-MoE, 2003.

Central to this approach is the need to start planning with whatever meagre resources are available. There *are* activities that can be carried out with the sector's existing resource capacity – e.g. bringing about attitudinal change requires little in the way of financing. Generally HIV/AIDS-related activities are funded through external sources. This study did not find any instances in which institutions allocated a budget line for HIV/AIDS. A separate budget line would, in addition to instilling a sense of ownership, reduce the vulnerability and disruption of crucial activities caused by the irregular flow of external support.

At the moment, steering committees, technical teams and focal persons spearhead HIV/AIDS responses within the sector. The focal person is considered to fulfil facilitative and co-ordinating roles. However, all focal persons have another full-time job. There is a need to establish HIV/AIDS units staffed with full-time, qualified staff with adequate support facilities. Having a full-time dedicated unit and personnel with clear mandates would enable the institution to build capacity and institutional memory. This is vital for ensuring that key functions are not crippled by changes of personnel.

5.4 Educational media

The sector has an educational media agency, which has the potential to reach many schools through its radio and TV programmes. There is a need to enhance such capacity in order to reach as many schools as possible in all regions and districts.

5.5 Teachers as role models and agents for change

It has been said that teachers may not be the most appropriate people to lead HIV/AIDS control activities. Using teachers represents a top-down, centralized approach, compared to using peer educators for example. Teachers also lack the appropriate expertise and training, and may experience problems of personal sensitivities or remoteness in age and mind-set from younger people (Kelly, 2000*b*). Other commentators have argued that teachers are themselves victims of the pandemic and may not occupy enough of the moral high ground to carry the message. These concerns are, however, either exaggerated or distorted.

Influencing the knowledge, skills and attitudes of teachers is instrumental to bringing about fundamental changes in the school system. Teachers serve as change agents and can pro-actively carry the HIV/AIDS message. In short, they can 'walk the talk'. Teacher training institutions should therefore reform their curricula to focus more on informing behavioural change rather than mere information supply.

5.6 Influence of the school environment

Since the external environment influences the culture and practices of schools and institutions, school-based programmes should be linked as much as possible with other community-based efforts. Parents and other civic groups such as the youth, women and parent-teacher associations provide entry points and play a complementary role in HIV/AIDS response interventions in academic institutions.

5.7 Priority areas of training for capacity building

Most programmes within the education sector target students and revolve around providing basic information on HIV/AIDS, its transmission mechanisms and prevention methods. This is, however, a very narrow focus for such a multi-faceted problem. The current approach and practices are not well suited for equipping the education sector as a system to strategically respond to the challenge. Educational planners and managers at different levels need to acquire more knowledge and skills if they are to integrate HIV/AIDS issues into their mainstream activities.

Efforts to organize training programmes in HIV/AIDS mainstreaming and in multisectoral responses have been limited in scope, coverage and target. Training programmes tailored to the special needs of educational planners and managers are not generally available. The education system should be able to address the immediate needs of the sector at the same time as projecting the future needs, such as the need to protect and replace teachers, as well as a longer term need to ensure stability and quality of supply of education.

Training needs vary from basic information provision on current status and best practice, to levels of analysis requiring some degree of sophistication. At grass-roots level, the most pressing needs are for concrete skills that assist actors in their day-to-day activities, such as capturing data on HIV/AIDS and helping those infected or affected, rather than for developing understanding of conceptual issues. These training needs ought to be addressed differently at each of these different levels (see Table 5.1).

There is also a need for a national HIV/AIDS training policy that is demand- rather than supply-driven, and consequently not supply-constrained. The training approach should be pro-active rather than re-active. Most training should be offered locally in order to reach large numbers at relatively affordable costs. Course duration might vary from a few days to several weeks, depending on the nature and objectives of the course and its target group. Training should also be as active and interactive as possible.

Training courses may be organized either at central or regional levels. A carefully worked out training plan, with a pool of financial resources earmarked for the purpose and a system for monitoring its impact, may result in training needs being addressed in a properly sustainable manner. Central and regional government needs to implement a mechanism for allocating the necessary funds, while at the same time encouraging other funding providers (NGOs etc.) to channel their financial assistance in a harmonized budgetary support system that allows for simple follow-up and monitoring of activities and results.

Once training needs are identified, the response planned and the necessary budget made available, the next task is the identification of appropriate training providers. IIEP may work with local training providers with a view to enhancing the latter's capacity, so that the effort becomes sustainable.

Table 5.1 Training needs by level and function

Function	Central level	Regional level	District level	Institutional level
Policy, leadership and governance		▪ Catering for the mosaic of cultures. ▪ Encouraging openness about the issues. ▪ Instilling commitment among staff. ▪ Mainstreaming. ▪ Monitoring and evaluation of prevalence and impact.	▪ Mainstreaming through planning. ▪ Designing effective support systems for schools. ▪ Developing leadership skills. ▪ Monitoring and impact evaluation.	▪ Developing shared awareness among leaders. ▪ Developing skills for design and delivery of curriculum that integrates HIV/AIDS. ▪ Facilitating collaboration with stakeholders.
HIV/AIDS focal groups	▪ Building knowledge on multi-dimensional aspects of HIV/AIDS. ▪ Supplying up-to-date information on developments in HIV/AIDS and technical assistance. ▪ Strategic planning. ▪ Project preparation. ▪ Monitoring and evaluation ▪ HIV/AIDS mainstreaming.	▪ Building leadership skills. ▪ Impact assessment and mitigation. ▪ Project preparation and management. ▪ Training methodology. ▪ Organizing effective support systems for anti-AIDS clubs. ▪ Bringing about behavioural change. ▪ Providing information on developments in the area.	▪ Planning. ▪ Developing project proposals. ▪ Building fundraising skills. ▪ Monitoring and impact evaluation.	▪ Building counselling skills. ▪ Promoting effective communication. ▪ Motivating staff. ▪ Providing basic health services. ▪ Providing information on developments in the area and status of the epidemic.
Plans and programmes	▪ HIV/AIDS mainstreaming in planning process. ▪ Data gathering and analysis. ▪ Developing basic indictors to monitor impact. ▪ Getting reliable data from schools on impact.	▪ Integrating anti-AIDS activities in educational planning. ▪ Data collection. ▪ Manpower planning. ▪ Monitoring and evaluation.	▪ Methodology of training trainers. ▪ Impact analysis. ▪ Supplying current information on HIV/AIDS. ▪ Building information dissemination skills. ▪ Planning for effective care and support of PLWHA.	▪ Building management and information handling and processing skills. ▪ Providing basic and comparative information on HIV/AIDS, interventions and best practices for prevention and control.

Function	Central level	Regional level	District level	Institutional level
Human resource management	▪ Preparing sectoral HIV/AIDS policy and strategy. ▪ Interpreting latest available statistics on HIV/AIDS. ▪ Impact analysis. ▪ Establishing VCT. ▪ Designing and developing IEC materials for different target groups.	▪ Planning for effective responses. ▪ Impact analysis. ▪ Building skills for caring for PLWHA.	▪ Encouraging leadership for change. ▪ Monitoring and impact analysis. ▪ Data collection. ▪ Designing support systems for infected and affected staff and students..	▪ Developing motivation skills. ▪ Team building. ▪ Building skills for an effective response. ▪ Supplying information on HIV transmission and prevention methods. ▪ Caring for PLWHA. ▪ Providing information on current trends and practices.
Curriculum	▪ Integrating HIV/AIDS into the curriculum. ▪ Mainstreaming HIV/AIDS in day-to-day activities.	▪ Selecting HIV/AIDS topics and integrating them into different subjects. ▪ Methodology of teaching HIV/AIDS at different levels, including peer education. ▪ Curriculum evaluation procedures. ▪ Analysing impact of training. ▪ Team building.	▪ Analysing impact of HIV/AIDS on human resources and development in general. ▪ Developing skills for bringing about behavioural change.	▪ Integrating HIV/AIDS into curriculum. ▪ Developing delivery methods. ▪ Supplying information on current status, impact and best practices.
Educational media	▪ Developing strategies for effective use of media for HIV/AIDS prevention in the school system. ▪ Designing information materials for the media and broader advocacy. ▪ Sharing best practices.	▪ Planning for effective media programmes. ▪ Impact analysis. ▪ Caring for and supporting PLWHA. ▪ Mainstreaming.	▪ Designing teaching materials. ▪ Broadcasting effective programmes, taking into account diverse needs and values of society. ▪ Promoting attitudinal change.	▪ Supplying information on transmission mechanisms, character of HIV and prevention methods. ▪ Caring and supporting those infected and affected. ▪ Bringing about behavioural change.

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