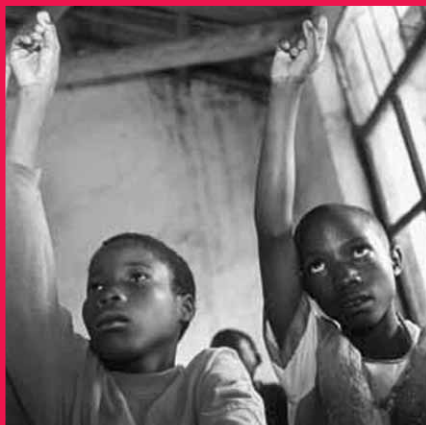


HIV is a small virus. But once it penetrates into the human body, it is a big problem

The sound of silence

Difficulties in communicating on HIV/AIDS in schools



Experiences from India and Kenya

"this question (access to condoms) is not relevant to our country. Only those whose characters are bad should know and have access to condoms."

Foreword

The last ten years have seen unprecedented efforts to ensure that every child has a quality basic education. Running in parallel has been the huge surge in global HIV infections – with current estimates higher than the projected ‘worst case scenarios’ of the eighties.

Education and HIV/AIDS. Two issues which have often fallen under different spheres of responsibility, yet they are so interlinked: goals of universal primary education are increasingly unattainable as AIDS epidemics force children to drop out of school, and education is a necessary part of any response to abate HIV incidence.

There is a great untapped potential for the knowledge gained through so much talent and commitment in these two separate fields to be dovetailed. This report is part of an attempt throughout ActionAid to start this process by:

- mainstreaming HIV/AIDS into education work by engaging people working on education to prioritise HIV/AIDS
- ensuring that HIV/AIDS responses draw on wider learning about what is effective in the field of education.

It is under the rubric of this second objective that the research took place. One of the key responses to the AIDS crisis has been the provision of school-based HIV/AIDS education. However, this work has often been led by those specialising in HIV and has not sufficiently drawn upon sound pedagogic practice.

The research therefore attempts to place HIV/AIDS education within the wider context of education in resource-poor settings, and to understand some of the difficulties encountered in providing HIV/AIDS education in schools.

Collaboration on the project drew a wide cross-section of ActionAid staff (education, HIV/AIDS, gender, marketing, policy), researchers, government officials, schools and civil servants. The nexus tying these disparate groups together is the belief that a world without AIDS is possible.

Ultimately, if an education system cannot keep its young people alive for ten years after the end of formal education, then it is most certainly failing its students. Aiming high is a necessity.

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List of abbreviations

NACC	National AIDS Control Council
NACO	National AIDS Control Organisation
NGO	Non-governmental Organisation
DIET	District Institute of Education and Training
EFA	Education For All
UPE	Universal Primary Education
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
Reflect	Regenerated Freirean Literacy through Empowering Community Techniques
DFID	Department for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
KIE	Kenya Institute of Education
TANSAC	Tamil Nadu State AIDS Control Society

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Executive summary

Formal education is often assumed to have significant influence on how people make informed decisions about their health – including very important areas such as sexual behaviour. With estimates of 11.8 million young people aged 15 to 24 living with HIV/AIDS (UNAIDS, 2002) it is now vital to understand better how educators are, and should be, responding to the challenges posed by the epidemic.

The educational response to the HIV/AIDS epidemic is an important aspect of ActionAid's work. Our underlying belief that every person has the right to information on HIV has led to concern that barriers or silences in communication around HIV/AIDS are impeding efforts in the classroom. This assertion is based upon anecdotal evidence from some of our community partners, and twenty years of experience in participatory empowerment and learning approaches which encourage communication of difficult or 'silent' issues. An unchallenged culture of silence can only serve to exacerbate the AIDS epidemic and increase confusion, denial and stigmatisation.

This report attempts to elucidate how HIV/AIDS education is implemented and received by schools in India and Kenya – two countries chosen partly for their differences, but also a similarity: the existence in each of the chosen regions (Nyanza, Kenya and Tamil Nadu, India) of a state-sponsored HIV curriculum. Through a mixture of quantitative and qualitative approaches, the research catalogues the reported attitudes of 3,706 teachers, pupils, parents and other key stakeholders in the educational community. In doing so, the report aims to answer the following four questions:

- 1** What is the parental and community demand for school-based HIV/AIDS education?
- 2** What role does the school have in teaching young people about HIV?
- 3** How is HIV/AIDS education being taught in the classroom?
- 4** What difficulties exist in successfully delivering school-based HIV/AIDS education?

The research indicates that in both Kenya and India teachers and schools play a pivotal role in teaching young people about HIV and AIDS. On the whole, parents appear to support schools in this endeavour, partly as it relieves their own responsibilities for discussing HIV/AIDS. However, perceptions of risk of HIV appear not to be 'personalised' with an underlying attitude that HIV only happens to 'them' and not 'us'.

Unfortunately, attempts to deliver HIV/AIDS education in schools are severely constrained by a wider crisis in education, and more specifically by social and cultural restraints in discussing HIV/AIDS, sexual relations and power inequalities. These constraints manifest themselves in the practice of 'selective teaching' in which messages on HIV/AIDS are either not communicated at all, or restricted to overly-scientific discussions without direct reference to sex or sexual relationships.

HIV is a small virus. But once it penetrates into the human body, it is a big problem

Female student, India

Key findings

1 Parental and community demand for HIV/AIDS education

The research suggests that in both countries young people and their families perceive HIV to be a serious threat, and there is a strong belief that education can act to mitigate that threat. As a consequence, there is a strong demand for young people to be taught about HIV.

Key findings include:

- 68% of Kenyan parents reported knowing their child was being taught about HIV in school, compared to 12% of Indian parents.
- Teachers perceive parental support for school-based HIV/AIDS education to be lower than it is.
- The majority of young people, parents and teachers in both countries view HIV to be a very big problem nationally. However, in Tamil Nadu, HIV was seen as less of a problem in the local area or school, whilst most Kenyan respondents viewed HIV to be a big problem locally.
- Striking differences exist between countries on perceived frequency of risk behaviour in schools. 74% of Indian parents reported that casual sexual relationships between students never happened, compared to 15% of their Kenyan counterparts.

2 The role of the school in HIV/AIDS education

The research suggests that a number of social factors influence young people's perceptions about HIV, including religious influence, the media, family and peers. Parents often feel uncomfortable talking about sensitive issues with their children and, particularly in India, the media is perceived as giving out harmful messages. Consequently, the school is viewed by the community as a trusted and important place for young people to learn about HIV. Within this context, teachers were perceived as paramount in teaching young people about HIV/AIDS.

Key findings include:

- 87% of Indian teachers and 90% of Kenyan teachers viewed their profession as having responsibility for teaching young people about HIV and AIDS.
- In Kenya, teachers viewed responsibility for teaching young people about HIV as being diffused throughout the community – including parents (88%) and religious leaders (85%).
- Respondents in both countries thought that young people learn about HIV from a number of sources. Teachers and television were among the top three most commonly cited sources across all respondent groups and in both countries.
- Parents (particularly mothers) and religious leaders appear to play a far greater role in teaching young people about HIV in Kenya than India: 42% of Kenyan parents reported often talking to their children about sex and HIV. In comparison, 63% of Indian parents reported never talking about sex or HIV to their children.

3 Silences in communicating on HIV/AIDS

Given the sensitivities that surround sex and HIV, teachers reported finding it difficult to discuss HIV/AIDS with their students. Our findings suggest that 'selective teaching' often takes place. Teachers appear to be selecting which messages to give or else choosing not to teach HIV at all. An overly-scientific emphasis during lessons leads to discussions of HIV without any direct reference to sexual relationships. In other cases sex is discussed, but only within the 'acceptable' boundaries of abstinence.

The occurrence of selective teaching is alarming. Discussion of HIV without direct reference to sex, or advocating abstinence without mentioning safe sex, cannot work. On the contrary, it bonds notions of HIV to immorality, and leads to a 'them, not us' attitude. This, in turn, leads to even further discrimination. It also fails to help the many young people who are sexually active, making it less likely that they will seek advice or personalise their risk of becoming HIV positive.

Silences in communication over the issue of condoms, or messages other than abstinence arise out of a paradox of safer sex. In the context of young people, the paradox or tension can occur between two assumptions: a societal assumption that young people do not, and will not, have pre-marital sex, and the necessary assumption needed to discuss condoms: that young people do have pre-marital sex.

Key findings include:

- It appears that selective teaching is taking place in both Kenya and India with both students and teachers (to a lesser extent) claiming that lessons are not being taught. For example, 95% of teachers in Tamil Nadu claimed that the HIV component of the Total Health Programme was being taught compared to only 53% of students. In both countries selective teaching appears to be more common in rural areas than urban areas.
- Selective teaching is also manifested in HIV/AIDS education which does not directly refer to sex. This appears to be more common in Tamil Nadu than Nyanza: 35% of the Indian students reported having been taught about HIV and never having been taught about sex (compared to 7% of Kenyan students).
- In Kenya, selective teaching of HIV appears to be linked to negative stances towards condoms and safe sex. Surprisingly, Indian respondents, particularly students, appeared to have less negative attitudes towards condoms than their Kenyan counterparts (28% of Indian students were against students having access to condoms compared to 57% of Kenyan students).

4 Obstacles to teaching HIV/AIDS – a wider crisis in education

Apart from the social and cultural constraints that exist in teaching HIV/AIDS, there are, in addition, a number of obstacles faced by teachers which are symptomatic of a wider crisis in education. Efforts in the classroom are severely hampered by oversized classes, overstretched curricula, and a dearth of training opportunities and learning materials. Moreover, the large numbers of children who are out of school do not have any access to school-based HIV/AIDS education.

Key findings include:

- 45% of Kenyan teachers said they did not have enough knowledge to teach about HIV/AIDS, compared to 20% of Indian teachers.
- The majority of teachers in both countries reported never having been on a training course on HIV/AIDS (70% in India, 54% in Kenya).
- About half of the teachers in both countries said they did not have enough time to teach HIV/AIDS (52% in India, 54% in Kenya).
- Interviews and focus group discussion in both countries suggest that the cultural barriers included both the 'paradox of safe sex' (discussed above) and gender specific issues in which teachers (particularly female teachers) felt unconfident teaching students of the opposite sex.
- 24% of Kenyan students stated that teachers did not set good role models when it comes to sexual behaviour, compared to 12% of students in India.

Key recommendations

• Extending beyond the classroom

If HIV/AIDS education is to succeed, it must target all sectors of society including religious leaders, the media and families. Pre-existing systems of knowledge transfer should be taken advantage of: parents and the extended family should be targeted for adult learning programmes that encourage them to communicate openly, positively and accurately on HIV/AIDS.

• Locally relevant HIV/AIDS education

There needs to be a move away from an overly scientific approach to HIV/AIDS education. Learning materials should stimulate children to understand the human side of HIV so they can connect the issue to real life. Learning resources on HIV/AIDS should be locally driven – drawing upon local statistics of prevalence and local case studies.

• Challenging social and power inequalities

Education that leads to positive behaviour or social change needs to look beyond skills and, in this particular context, challenge social, gender and power inequalities. HIV/AIDS education should focus on power and communication issues in wider human relationships, and in this way some of the power issues involved in sexual relationships can be addressed.

• Prioritisation and resource mobilisation for education

If the education system is to be an effective vehicle to prevent the further spread of HIV/AIDS, then improving the basic functioning of the system is a prerequisite. A massive injection of financial resources is needed at every level; internationally, nationally, in communities and in schools themselves to provide good quality education. Only on this foundation can HIV/AIDS adequately be addressed in schools.

Introduction

Background

The scale and effects of the HIV/AIDS epidemic were slow to be recognised as a global threat. However, recent discussions of the 2002 southern African famine and potential security crisis – both perceived as fuelled by HIV (De Waal, 2002; Singer, 2002) suggests that the severity of the situation is being acknowledged. In response, there have been commendable efforts to capitalise on the potential of formal education as a ‘weapon in the fight against HIV’ (Kelly, 2000).

There are three interlinked ways in which education is perceived to affect vulnerability to HIV infection;

1 General level of education

Both UNICEF and the World Bank emphasise the importance of ‘education for all’ and increasing general levels of education as a protective measure against HIV (Bundy, 2002). Their stance relies on increasing evidence of a negative correlation between a person’s general level of educational attainment and their HIV vulnerability: i.e. the more education a person has, the lower the risk of HIV (Hargreaves & Glynn, 2002).

At earlier stages of the epidemic it appeared that the opposite was true, with highest levels of HIV to be found in high socio-economic groups and correspondingly higher levels of educational attainment. Gregson and others suggest that these more ‘educated populations’ were initially at higher risk to HIV but are now better positioned within society to stem the spread of the virus (Gregson, 2001; Vandemoortele, 2000).

2 Relationship between general level of education and demographic factors

Education is linked in a number of ways to demographic and health factors such as levels of fertility and life expectancy (Sen, 1992). In a review of the links

between a mother’s education and her child’s health, Cleland estimated that a one year increment in mother’s education leads to a 7 to 9% decline in under-five mortality (Cleland, 1988).

With regards to HIV vulnerability, it is argued that education is correlated with a range of social and cultural factors associated with infection. These include age of sexual debut, age of first marriage, number of children, access to information and culturally specific practices likely to increase vulnerability to HIV, such as wife inheritance and polygamy (DHS 2000).

3 HIV/AIDS education for prevention

Prevention efforts to curtail the spread of the HIV/AIDS epidemic have been premised on links between education and behaviour change. The underlying assumption is that teaching people how to protect themselves from HIV can lead to a reduction in risk behaviour and hence a reduction in HIV incidence (UNAIDS, 1997).

In response, donors, governments and civil society have rushed into providing HIV/AIDS education as quickly and widely as possible – with school-based HIV/AIDS education being implemented in the vast majority of resource-poor countries (UNAIDS, 1997). Young people are particularly targeted, because they are seen as a ‘window of opportunity’ and ‘our hope for an AIDS-free generation’ (Bundy, 2002).

Knowledge of how HIV/AIDS education is being implemented in schools is sparse and often anecdotal. Research suggests that HIV/AIDS education, particularly in the school-place, is not always being implemented as envisaged. This is partly because of resistance from communities and teachers, but also due to lack of training and adequate learning materials (Bennell, Hyde & Swainson, 2001).



Howard Baker/ ActionAid

The work of ActionAid

ActionAid works in partnership with poor communities to fight poverty and its causes. ActionAid's recognition, 15 years ago, that HIV/AIDS was a significant threat to the development of poor countries, has led to pioneering work in prevention, community-based care and advocacy, including developing the *Stepping Stones* methodology and supporting community-based organisations, such as TASO in Uganda.

ActionAid's work concentrates on encouraging and supporting local innovation and action and trying to change the global political and social structures that make poor communities vulnerable. ActionAid works with local partners in 15 African and 4 Asian countries to ensure that people and communities affected by HIV/AIDS are at the centre of developing effective responses to the epidemic.

Within the field of education, ActionAid campaigns for free and universal primary education. This campaigning is based on over 30 years of innovative work with communities, enabling them to demand their basic right to education and supporting governments to deliver quality education for all.

ActionAid's approach to learning is encompassed within its key educational programme, *Reflect*, which challenges power and social inequalities by creating democratic spaces for critical analysis.

Strengthening links between education and HIV

Since 1999, ActionAid has been actively involved in linking these issues through:

- mainstreaming HIV/AIDS work into education by engaging people working on education to prioritise HIV/AIDS (within ActionAid and the wider international education community)
- ensuring that HIV/AIDS responses draw on wider learning about what is effective in the field of education
- developing community programmes, such as *Reflect Plus*, that incorporate responses to HIV/AIDS into adult learning projects at community level
- encouraging South-South learning and playing a pivotal role in the creation and implementation of *Strategies for Hope*
- dovetailing expertise in HIV/AIDS and education by creating networks between policy makers, practitioners and academics working in these often distinct spheres of responsibility; this work to date has focused on Mozambique, Malawi and the UK
- collecting life histories on how people's work in education has been affected by HIV/AIDS; the focus is on telling powerful stories – to give a human dimension that people can relate to – and to hook wider research/data on HIV/AIDS and education around this.

Methodology

Pilot study

In the first few months of 2002 ActionAid offices in Tanzania, Malawi and Kenya each carried out small-scale pieces of research into how education is affected by HIV/AIDS. Although the methodology varied between the countries, each research team attempted to assess the opinions of local communities on two distinct but interrelated topics: **i)** how HIV/AIDS education is being communicated, and **ii)** how schooling has changed as a consequence of increasing prevalence rates of HIV. The research threw out a range of issues that were considered important enough to merit the investment in this current, more substantial body of research.

Scope of the research

The main research took place in India and Kenya during the summer of 2002. ActionAid offices in these countries had already identified HIV/AIDS education as an issue of concern and were keen to build on the experiences of the pilot study mentioned above. It was decided to undertake a situational analysis and to identify key policy and programme positions – to inform work in the individual countries and to contribute to wider learning across ActionAid as a whole.

As the epidemic is at different stages of advance in the two countries, the study also offered the opportunity to meet one of ActionAid's priorities, that poor communities should learn from each other and, in particular, that Asia should learn from African experiences of HIV/AIDS.

The research aimed to answer the following questions:

- What is the expressed demand for HIV/AIDS education by young people, parents and their communities?
- What is thought to be the role of the school in meeting the above demand?
- How do students and parents perceive the way that HIV/AIDS is taught in school?

- What are the difficulties identified by teachers and students, and how might they be overcome?

Timing

Fieldwork was conducted during June 2002 in Kenya and July/August 2002 in India. Learning from the Kenya research was used to fine-tune the research tools and methodology used in India.

Setting

The research was conducted in Nyanza province, Kenya, and Tamil Nadu state, India. In both countries the selected areas have higher than average national HIV/AIDS prevalence rates. Also of importance for the research, each region has implemented a programme of HIV education in state schools.

Nyanza province, Kenya

Research took place in one rural setting (Homa Bay) and one urban setting (Kisumu) of Nyanza province in the western region of Kenya. The main industries are fishing and agriculture; the main ethnic group is the Luo, the third largest ethnic group in Kenya. About 90% of the population is Christian, although traditional beliefs are still common.

Nyanza province is one of the poorest provinces in Kenya. A substantial proportion (44%) of the population in Nyanza has no access to mass media, particularly women Demographic and Health Survey, (DHS) 1998. The median age of marriage in the province is 17.5 years for women with sexual debut averaging at 15.6 years (DHS, 1998).

HIV prevalence rates are amongst the highest in Kenya with about one in three pregnant women testing positive at antenatal clinics in the region – this is over double the national prevalence of 15% and the area is probably one of the highest seroprevalence regions in the world (UNAIDS, 2002; Volk, 2001). The main mode of HIV transmission is identified as being through heterosexual intercourse (UNAIDS, 2002; Okeyo, 1998).

A recent UNAIDS study which included Kisumu suggested that a number of factors increased vulnerability to HIV: reported behavioural factors included young age at first marriage for women, and a considerable age difference between spouses (UNAIDS, 2002).

Tamil Nadu, India

Tamil Nadu is one of India's southern states, with a population over 60 million. Tamils are the main ethnic group and the dominant religion is Hinduism. The main occupations are fishing and agriculture, and about 80% of the land is owned by the high caste. Inequalities in land ownership have led to mass migration of poor farmers to cities as Chennai or Mumbai in search of work.

At 73.5%, literacy is relatively high in the state though, as in other parts of India, female literacy (64.5%) is substantially lower than male (82%). Women in the state marry much younger than men, the median ages being 20.9 and 26.6 respectively (DHS, 2000). 24% of young women aged 15 to 19 years are married, with the number rising significantly in rural areas (DHS, 2000).

Urban areas have more access to communications – only 9% of people in urban areas have no access to mass media, compared to over 25% of those living in rural areas.

HIV prevalence among women visiting antenatal clinics in Tamil Nadu is around 1.1% (National AIDS Control Organisation, 2002), one of the highest in the country. India has a number of serious and different localised epidemics (UNAIDS, 2002). In Tamil Nadu, the main mode of transmission is thought to be through sexual intercourse (UNAIDS, 2002).

Survey methodology

Research tools were created by ActionAid researchers in collaboration with Dr Nicola Swainson and Dr Paul Bennell from the University of Sussex, drawing upon their own experiences in researching the impact of HIV/AIDS on education (Bennell, Hyde & Swainson, 2001).

A combination of quantitative and qualitative approaches was employed. The main research tools were:

- self-completion, structured questionnaires for parents and students
- interviewer-administered questionnaires amongst parents
- individual semi-structured interviews with headteachers and other key informants
- focus group discussions with students (India and Kenya) and teachers (India only)

Each of the interviews explored aspects of the HIV syllabus and asked respondents what they thought about HIV/AIDS education. Questions covered four main areas:

- demand for HIV/AIDS education
- the role of schools in meeting that demand
- policy and practice of HIV/AIDS education
- overcoming difficulties in teaching HIV/AIDS education.

Individual interviews and focus group discussions were designed to probe on specific issues emerging from the quantitative stage and to achieve deeper understanding of respondents' answers.

Interviewing was conducted by teams of researchers and supervisors in each country under the guidance of Amina Ibrahim in Kenya and Ranjin Adoss in India.

The following table (*overleaf*) summarises the composition of the survey sample.

Table 1 Summary of interviews achieved

Area	Schools	Student questionnaire (self-completion)	Teacher questionnaire (self-completion)	Parent questionnaire (interviewer administered)	Qualitative phase	Key informant interviews
Kenya (Nyanza province) Kisumu district <i>(urban)</i> Homa Bay district <i>(rural)</i>	20 primary 10 secondary	1,198	291	291	30 student focus group discussions 30 headteacher interviews	curriculum design AIDS control organisations teacher training education officers community leaders religious leaders NGOs 34 interviews in total
India (Tamil Nadu) Chenna <i>(urban)</i> Tuticorin <i>(rural)</i>	30 schools all secondary 10 High Schools (X) 10 Higher Secondary (XI) 10 Higher Secondary (XII)	1,201	299	299	42 student focus group discussions 30 headteacher interviews 20 teacher focus group discussions	

Sample

It was not intended that these findings would be representative of the total populations of the countries in question, more that they would be indicative of the views of communities experiencing relatively high levels of HIV (within their national context) and which have been exposed to some form of school-based education on the topic.

Overall, it was the purpose of the research to include sufficient interviews to produce significant results for key segments – that is gender, school stage and geographic location and to allow for comparisons between the groups of greatest interest in each country.

One urban and one rural area were chosen in each state and interviews were evenly split between these.

In Nyanza these included primary and secondary schools (as HIV/AIDS education is taught from Standard 1 of primary school). In Tamil Nadu, only high school and higher secondary schools were sampled because HIV/AIDS education is not introduced into the syllabus until Standard 8 of secondary school.

More purposive sampling was used in India, which included a mixture of state and private, Hindu, Christian and Muslim schools, to allow some comparison across schools. In Kenya, all were government schools. In India, students were evenly split between those studying science subjects and those studying arts subjects.

For each school:

- An interview was conducted with the school principal/headteacher.
- The teacher questionnaire was administered to a maximum of ten teachers in each school, including all those involved in HIV/AIDS education plus a selection teaching other subjects. A range of age and gender was included.

In India, all of the teachers directly involved in teaching about HIV & AIDS were also asked to participate in a focus group discussion. Alternatively, individual or paired depth interviews took place depending on individual school circumstances.

- Students from each year group were randomly chosen (gender-balanced) and asked to complete questionnaires.
- After completing the questionnaire, a group of five to eight students (of the same sex) from one of the age groups was randomly chosen (but balanced across the total sample) and asked to stay behind for a focus group discussion. Each group lasted for around one hour.

- Additionally, parents with children in the year groups being researched (though not necessarily parents of the actual student respondents) were invited to take part in an interviewer-administered questionnaire. A target was set of 12 parent interviews per school. Across the whole sample an even gender and student year group split was achieved.
- Key stakeholder interviews were conducted in the locale or in regional/national offices where appropriate.

Translation

Bilingual interviewers and moderators were used in both countries, though the Kenyan research team preferred to use materials in English whilst the Indian team opted for Tamil versions. All questionnaires and interview notes were transcribed into English in country, but were processed and analysed in the UK.

General

- Permission was obtained from Education Authorities to interview in the selected schools. Additional permission was sought from parents to speak with children. High levels of privacy were maintained whilst respondents were participating in the research and guarantees of anonymity were given.
 - Individual interviews and focus group discussions were tape recorded and transcribed where permission was given. Otherwise notes were taken.
 - Where possible moderators were the same sex as participants.
 - Small incentives were provided to all survey respondents.
 - Data analysis was carried out in the UK by Vital Statistics, a specialist data processing agency.
-

Results 1 Demand for HIV/AIDS education

One of the key aims of the research was to find out what level of support HIV/AIDS education has at the community level – this ties in strongly with ActionAid’s approach of working in partnership with communities. Research suggests that community resistance to young people being taught about HIV does exist – and can lead to teacher anxiety of potential criticism from parents (Malambo, 2000). In this section we examine respondents’ knowledge of, and attitude towards, HIV/AIDS education, as well as the factors affecting demand for such education – bearing in mind that, in theory, HIV education is mandatory in the local state syllabus.

It seems clear from both the quantitative and qualitative research that most parents, students and teachers view HIV/AIDS education as important and necessary: 69% of Indian teachers and 80% of Kenyan teachers said that it was very important to have HIV/AIDS education in schools. Attitudes vary according to the perceived extent of the problem and what should and should not be taught.

1.1 Parental knowledge of HIV/AIDS curriculum

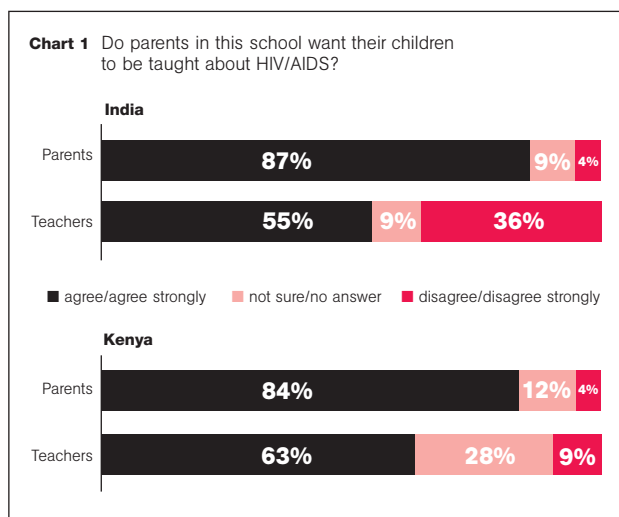
Parents were asked if they were aware that their children were being taught about HIV/AIDS in school: 68% of Kenyan parents said they were, compared to only 12% of Indian parents.

There were striking urban and rural differences in each country. Parents in rural areas reported having significantly less knowledge of HIV/AIDS education than their urban counterparts – 82% of Indian respondents in rural areas reported knowing ‘not much’ about HIV/AIDS education in schools, compared to 27% in urban areas. In Kenya, the comparative figures were 40% in rural areas and 21% in urban areas.

1.2 Parental attitudes towards HIV/AIDS education

In order to gauge what attitudes parents had towards their children learning about HIV/AIDS in school, parents and teachers were asked to state their level of agreement that: ‘on the whole, parents in this school want their children to be taught about HIV/AIDS.’

Overall, the vast majority of parents said that they did want their children to learn about HIV/AIDS. The interesting dynamic is that most teachers perceive parental support to be lower than it is.



Additional interviews with parents and teachers seem to support this finding. While teachers often feared a backlash from angry parents, the majority of parents in both countries said they were supportive of HIV/AIDS education.

“ Most of the teachers are afraid because teaching this (HIV) will get them into some problems in village. They are afraid that people will raise objections so parents must be involved, so there will not be any objections. ”

Priest, Chennai, India

Chart 1 also shows that the discordance between teacher and parent perceptions is larger in India than Kenya: teachers in India seem to be less confident of parental support than their Kenyan counterparts.

In India, interviews supported the idea that teachers’ fear of criticism was the result of parents directly making complaints to the school:

As we are interested in the wellbeing of the students, the parents are also deeply concerned about their future. Though a parent cannot talk freely with his/her child about HIV/AIDS, they are happy that we, as teachers, relieve them of this burden.

Female teacher, India



Howard Baker/ ActionAid

“ Teachers should not earn a bad name from the parents. When a teacher teaches HIV/AIDS, there is a slight restlessness in class. Students go home and tell this to their parents who say that the teacher is obscene. Then parents come to school to question the teacher, as to why the teacher has been teaching dirty things in class to students. We cannot keep explaining to the parent that it is a part of the syllabus.”

Female teacher, India

It is important, however, to keep in mind that the majority of teachers in both countries (55% in India; 63% in Kenya) thought that there was parental support for HIV/AIDS education:

“ Some parents really want their child to learn about AIDS but they are ashamed of it, whilst some don't want it and they claim it is bad manners.”

Headteacher, Kenya

Many students also claimed that their parents wanted them to learn about HIV.

“ My parents enquire whether we are taught about AIDS in school. If I say no, they do it themselves.”

Female student, Kenya

“ Some parents do not know about this [AIDS] much. Because of this they do not show any interest with their children in studying the subject. But definitely they feel in general that we should know about this to be safe in the future.”

Male student, Chennai, India

“ Some parents do not know about this [AIDS] much. Because of this they do not show any interest with their children in studying the subject. But definitely they feel in general that we should know about this to be safe in the future.”

Male student, Chennai, India

However, when opposition does exist it flares up strongly – especially in India, as the following quotes illustrate:

“ When I discussed with my mother about having AIDS education program she said you learn and come home and talk about it in the neighbourhood, they will kick you. She feels that we should not talk about it.”

Female student, Chennai, India

opinion

It is important that teachers can rely on the support of the parents and communities in teaching HIV/AIDS. Although this support does exist, it seems that a minority of parents with strong opposition to HIV/AIDS education have overly-influenced teachers' judgement.

Strengthening links between the school and the community is one way of increasing parental support of HIV/AIDS education. No school exists in a vacuum and, especially in the case of HIV/AIDS, education has the potential to extend out into the community and make a difference. These links could be created through parent-teacher associations, school-home liaison or through community-based organisations.

1.3 Perceived risk to HIV/AIDS

In trying to understand parental attitudes towards HIV/AIDS education, it is important to also understand general attitudes towards the size of the problem and the extent to which parents think their children are at risk.

Respondents were asked if they viewed HIV/AIDS as a problem that touches upon their personal lives, and what they perceived the level of risk behaviour to be in their school. One Indian student summed it up as follows:

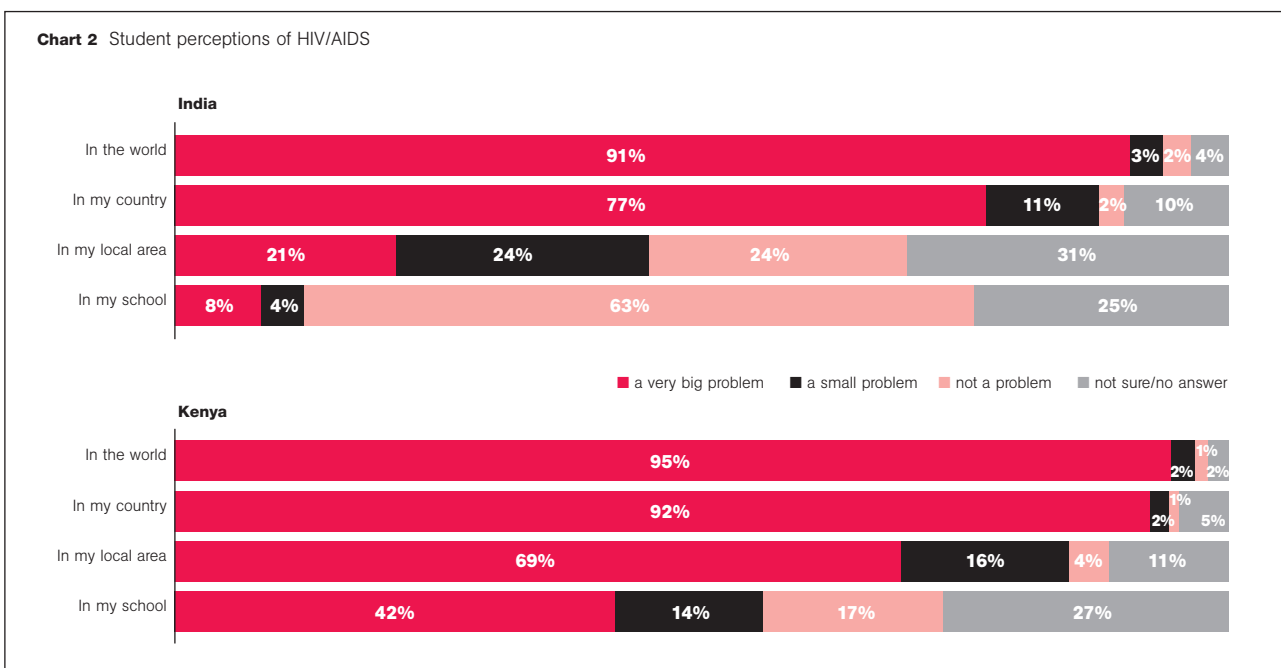
“ HIV is a small virus. But once it penetrates into the human body, it is a big problem. ”
Female student, India

Respondents were asked how serious a problem they viewed HIV/AIDS to be at different levels: in the world, their country, their local area and their school. There were strong levels of agreement between parents, teachers and students in both countries. The graph below depicts the responses from the students.

The epidemic in India is usually identified as being at an early stage (UNAIDS, 2001), and compared to many sub-Saharan countries, prevalence rates are relatively low. However, the majority of students, parents and teachers in both countries viewed HIV/AIDS to be a very big problem in their own country. In India, respondents reported that HIV/AIDS was not such a big problem in their local area – an interesting finding as prevalence rates in Tamil Nadu are among the highest in the country. Accordingly, we might have expected respondents in Tamil Nadu to perceive their own area as having a bigger problem than the rest of the country.

1.4 A ‘them, not us’ attitude

One explanation for this is that people do not personalise HIV/AIDS as a problem but see it as something that only happens to other people in other places. They do not therefore see themselves as personally at risk (Barnett & Whiteside, 2002). The Health Belief model, which is popularly used to explain risk behaviour, also holds central the idea that knowledge and awareness are not enough to reduce risk behaviour and that perceptions of personally being



Those who misbehave or have illegal contact or multiple sex partners must be punished, students must know what happens to them in the future. There must be an Act proposed that those who behave in a wrong manner will be punished before the law

Community leader, India

susceptible must also exist (Volk, 2001). Weinstein takes this idea further by suggesting that perceived threat involves two components: perceived risk and perceived severity (cited in Diclemente, 2002).

This idea is supported by some of the interviews in both countries, which show that having actual personal experience of HIV/AIDS is important in order to perceive risk. Many interviews show underlying assumptions of 'us' and 'them', with the blame for some 'morally deplorable behaviour' being firmly placed on 'them'.

“ So far, there is no pregnancy problem in this school. But in Kanya Kumari it is frequently heard, though it is not recorded officially. It is because of the influence of nearby state Kerala culture. There, boys and girls mingle freely. ”

Headteacher, Tuticorin, India

“ All the girls who left school this year due to pregnancies were all newcomers who transferred to this school recently. We believe they were already pregnant even as they came. ”

Female student, Homa Bay, Kenya

This second quote from a female student in Kenya suggests a similar phenomenon of 'them, not us' is occurring in Nyanza – but the boundary between 'us' and 'them' is much closer to home than in Tamil Nadu. Chart 2 clearly shows that the vast majority of respondents in Nyanza claimed HIV/AIDS to be a very big problem in their local area. This makes sense: adult prevalence is estimated to be over 30%. HIV in Nyanza is much more personal, and approximately three out of ten students reported the death of their fathers, compared to only 10% of Indian students. As most

of Kenyan parents in the sample were aged below 44 (61%), it can be assumed that this degree of adult mortality within these age ranges is caused by HIV/AIDS³. Clearly, HIV/AIDS has directly affected the lives of many of the Kenyan students who responded to the survey.

In Kenya, perceptions of the size of the problem in schools differ between respondents. 67% of teachers and 73% of parents view HIV/AIDS to be a very big problem in their school, while less than half of the students (42%) agree. This may explain a common theme in the interviews with teachers, who often complained that students viewed HIV as something that would not personally affect them, only 'others'. In this case, the personal boundary is being drawn around the school-place, as the following quote shows:

“ Peer influence is very disturbing – there is an assumption that young people may not be carriers of AIDS. ”

Headteacher, Kenya

opinion

If Kenyan students do not perceive HIV to be a local issue, but rather one that affects others, then one implication for HIV/AIDS education is that learning materials should be locally-driven. In addition to humanising HIV, it is important to incorporate local testimonies, case studies and statistics as well as material on international statistics. Even within the more scientific approach to HIV/AIDS education, local prevalence rates and statistics could be used so that young people perceive HIV to be a local and personally relevant issue. This of course raises new challenges in being able to collate accurate local data and in overcoming the stigma which may prevent people from offering testimonies.

³ In Sub-Saharan Africa, adult mortality under the age of 50 is now taken as a proxy for HIV/AIDS mortality.

1.5 Visibility of the disease

It is clear that an overly scientific approach to HIV/AIDS education risks being divorced from any reality which young people can relate to. The following quotes suggest that having some form of human connection is helpful in understanding HIV and personal risk:

“ So far there has been no such importance given to AIDS education in these surroundings. Now I am 46 years old and so far even I have not met or seen any infected person. ”

Headteacher, Tuticorin, India

“ Improvements [in behaviour] have been seen in some quarters as most pupils have seen the danger and have had relatives who were victims. ”

Kenyan headteacher, Homa Bay, Kenya

“ When it [AIDS] is just read from a book by a teacher we do not really relate to it, whereas when we see a live show about an AIDS victim we will feel for them and the consequences of AIDS can be really understood. ”

Student, Chennai, India

opinion

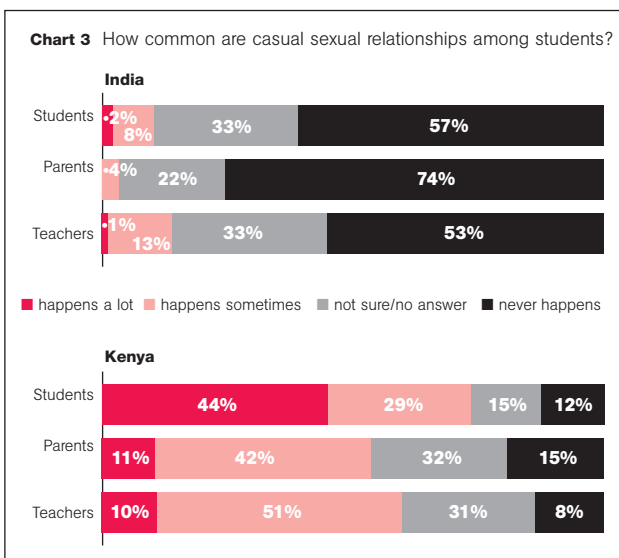
To communicate effectively with young people on a sensitive issue like HIV may require a different pedagogy to that associated with traditional learning in the classroom. Although teachers should be encouraged to broaden their own pedagogic base, there is also great potential in involving or developing external resource groups. Governments could encourage the formation or strengthening of mobile groups⁴, such as those that use theatre, song, dance or storytelling, which can be supported to tour around schools in each district. Specific incentives may be offered to such groups whether at national or district level for them to develop work on HIV/AIDS and make links with schools. The use of different forms of creative communication can humanise HIV/AIDS, bringing home key messages more powerfully than merely reading from textbooks.

Positive speakers (people living with HIV) may be invited to schools to talk about living positively with HIV. Not only will these speakers help to add that crucial human element, they will also help break down stigma and discrimination, as young people see that it is possible to live positively with HIV. It is also important for young people to see that people with HIV often look healthy as it is a common misconception that you can tell by looking at someone if they have HIV or not (UNAIDS, 2002).

⁴ 88% of Indian teachers and 85% of Kenyan teachers approved of the use of external resource teams to develop HIV/AIDS education in schools

1.6 Perceived risk behaviour in school

The questionnaire asked about the frequency of a small number of possible risk behaviours; casual sexual relationships; pregnancies (as proxy for unprotected sexual intercourse); and use of alcohol and drugs. Respondents in both countries were asked how frequently occurring they perceived each of these to be. Chart 3 compares the perceptions of Indian and Kenyan respondents on students in school having casual sexual relationships. Clearly in Kenya there is an acceptance that these relationships are taking place – quite opposite to the view from India.



Similar trends were found when respondents were asked about pregnancy, alcohol and drugs. Indian and Kenyan respondents showed opposite patterns of response, but there was generally strong agreement between students, parents and teachers within each country. For example, on the issue of pregnancy, 78% of Kenyan teachers and 70% of parents said it happens sometimes or a lot whilst in India, 80% of Indian students and parents and 77% of teachers said that it never happens.

In Nyanza, risk behaviours within the school – such as casual and unprotected sex – were reported by the majority of students, with only a minority reporting that these behaviours never happen.

“ Some girls still maintain multiple partners, one here in the school, another at home, another in another school and so on. ”
Female student, Kisumu, Kenya

In Tamil Nadu the opposite appears to be true, with the majority of all respondents saying these risk behaviours never happen. In interviews many of the teachers explained that there was a high level of control exerted over young people, both by the school and their parents.

“ Regarding students’ behaviour, they behave well. They know the basic elements to be safe...I do not know the peer group influence outside the campus. Inside we keep them under control. ”
Headteacher, India

“ Even if a teacher comes to know that a student talks with a boy, immediately the report will go to the assistant headmistress and then we call the parents and report. We have such strict discipline. ”
Female teacher, India

Many of the other interviews also suggested that male and female students in Tamil Nadu’s mixed-gender schools are segregated to the extent that they not only sit in separate parts of the classroom, but are forbidden to talk to each other.

opinion

Such gender segregation distorts human relations between boys and girls. Once young people enter sexual relationships, this type of segregation will only hamper any communication on HIV. Indeed, the less interaction there is between boys and girls in other spheres of life, the more difficult it may be for both to handle sensitive issues when they do come together in a relationship.

For perceived levels of risk behaviour to affect the demand for HIV/AIDS education, parents and teachers would need to view these behaviours as **i)** a problem **ii)** being related to HIV **iii)** influenced by education.

i) Kenyan teachers' perceptions of student behaviour

“ Deplorable! Student behaviour is bad, which I tend to think is a factor of environment. As you can see we are located in one of the less polished suburbs of Kisumu city. This has an effect. For example recently I sent pupils home. Five girls decided not to go home directly but to somebody’s house. Recently also a girl was caught having sex with a boy from the neighbouring secondary school during break time. This term another girl has gone home to give birth. Well, student behaviour is not good. Not good at all. ”
Headteacher, Kisumu, Kenya

Many teachers in Kenya clearly thought that student behaviour was a problem.

ii) Behaviour related to HIV vulnerability

Pregnancy is one of the clearest indications of unprotected sex. The following quote shows the underlying assumption that not only are student pregnancies linked to HIV but that they are also linked to low levels of HIV/AIDS education. The assumption is that if the students had more HIV/AIDS education there would be less unprotected sex and that education can and will lead to behaviour change.

“ High levels of pregnancies among school-going girls indicate high levels of unprotected sex among them. This indicates low levels of education on AIDS among pupils and communities. ”
NGO representative, Kenya

iii) Education for behaviour change

Most health education theories are founded on the belief that education is a necessary component to realising behaviour change. As mentioned earlier, the Health Belief model suggests that some element of knowledge and awareness is needed. Diclemente argues that behaviour change is determined by a myriad of factors, as the following quote illustrates:

“ HIV-protective behaviour represents the behaviour endpoint of a complex decision-making process that is influenced by a broad spectrum of cognitive, psychosocial and environmental factors. ”
(Diclemente, 2002)

Diclemente concludes that the empirical data, in particular the more behaviouralist interpretations of behaviour change, indicate that education is necessary but not sufficient to reduce risk behaviour.



Sven Torfimi/Panos Pictures/ActionAid

Our interviews reveal that some of the respondents also share this belief, as illustrated by the following quotes:

“ I may not be in a position to comment on behaviour change of students, as I do not interact with them directly. But the end in view and the whole point of the curriculum is behaviour change.”

Curriculum design official, Kenya

“ There has been a general decline in infection rates in reference to the previous years before the curriculum was introduced. I strongly feel that three-quarters of this decline was a contribution from the Ministry of Education through the introduction of the AIDS curriculum.”

AIDS control officer, Kenya

“ Earlier some students would have been doing so many bad things. Now that they have been taught about HIV virus, they will know that such things are wrong and if such bad things are done, HIV will be transmitted and so they will not do such things. Students have corrected their behaviour now.”

Female student, Tuticorin, India

In India, in the context of a more recently acknowledged epidemic, the findings from the interviews suggest there is a strong belief that educating students about the dangers of HIV will protect them in the future. In contrast, Kenyan respondents were more sceptical –

perhaps after having experienced a more severe epidemic, more HIV/AIDS education, and less observed behaviour change. There also appears to be more of a realisation in Kenya that other factors apart from knowledge of HIV are at play in making choices about sex:

“ There is a change of attitude realised, however, some students are still exploited – both pregnancies and early marriages are on the increase.”

Headteacher, Kisumu, Kenya

opinion

Young people need more than knowledge – they also need the skills to apply that knowledge to everyday situations which are far removed from the classroom (UNAIDS, 2002). In addition to skills, people need the power to leverage their sexual health rights. One critical element of ActionAid’s work in both the fields of education and HIV has been to challenge ingrained gender and power relations which contribute to the rapid spreading of the HIV/AIDS epidemic (Archer & Cottingham, 1996; Welbourn, 1995).

Examining gender inequality and its effect on communication in sexual relationships needs to be cardinal to any education approach which truly aims to change sexual behaviour. The challenge is to find constructive ways to work with men as well as women, and boys as well as girls, to address the wider gender and power issues that affect communication within sexual relationships⁵.

⁵ Adapted from Metcalf’s *Reflect: towards a gender and development approach*.

2 HIV/AIDS education: whose responsibility?

As discussed earlier, our research suggests that there is a demand for HIV/AIDS education in both Tamil Nadu and Nyanza. This section examines what role, if any, schools have in meeting this demand.

Bearing in mind that some parents might think that the formal education system should not be involved in the moral and religious upbringing of a child at all, we asked what role schools had in teaching young people about HIV and sex.

Apart from the question of whether or not schools have a place in teaching children about HIV or sex, there is also the question of whether or not children learn effectively about such issues from school. We therefore tried to establish the extent to which children are influenced by other sources of information, such as the media, family or peers.

To consider the question of responsibility, teachers were asked who should teach children about HIV. They were asked to tick as many categories as appropriate. The results are displayed in Chart 4.

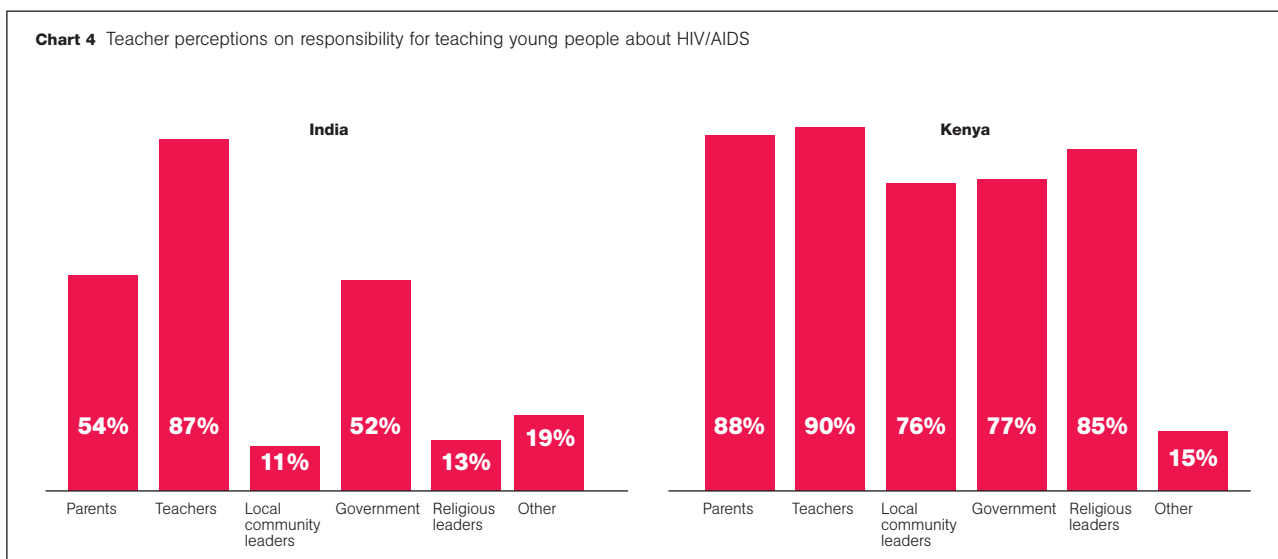
There are striking differences between responses in Kenya and India. Although the most common answer

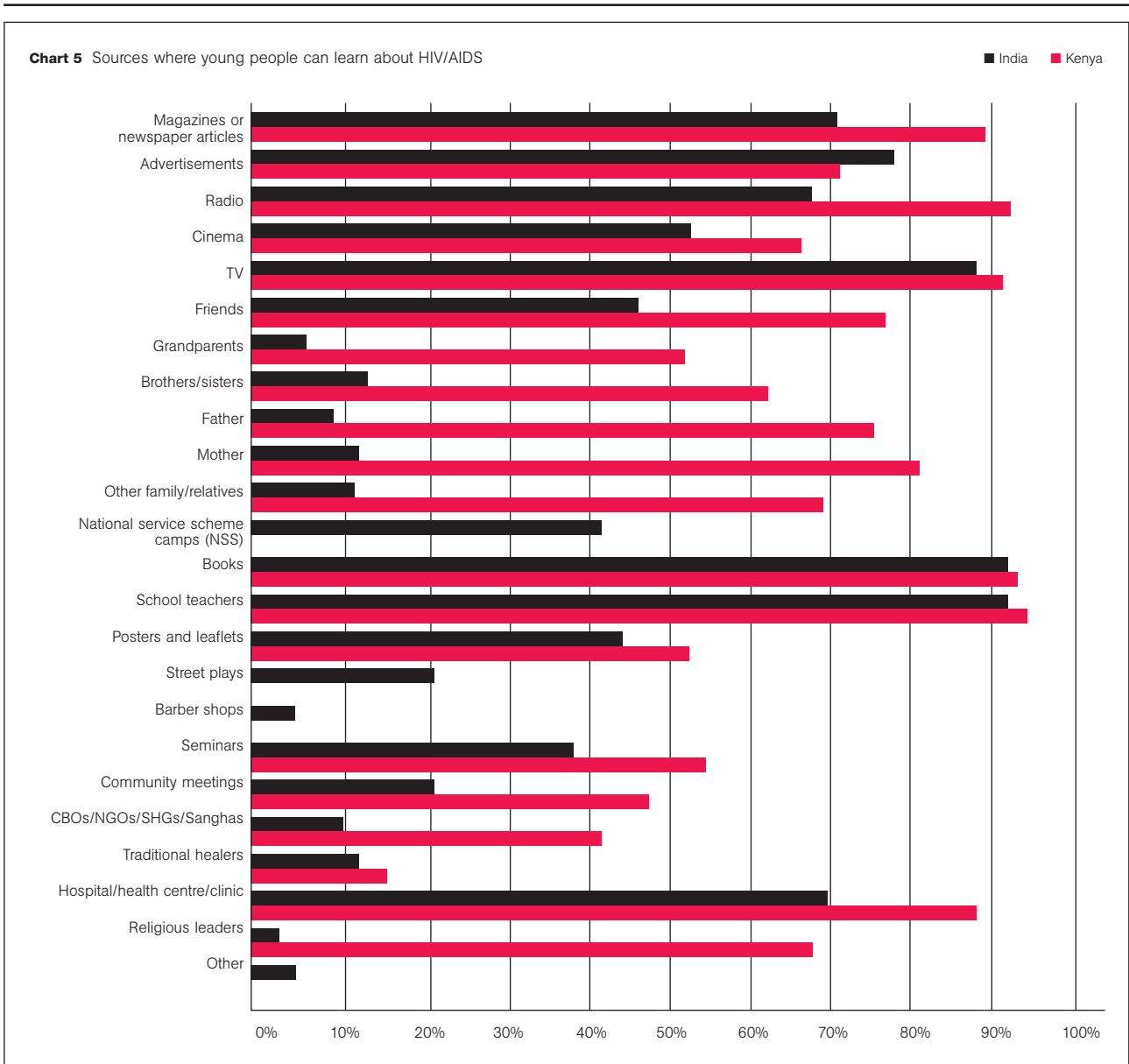
for both countries was teachers, in Kenya, responsibility is perceived to be much more spread out, and incorporates the whole spectrum from parents to religious leaders to government – perhaps out of recognition of the need for a multi-sectoral response. In India, most of the perceived responsibility lies with the teacher.

2.1 Where do young people learn about HIV/AIDS?

Parents, teachers and students were asked where they thought young people learnt about HIV/AIDS. The questionnaire included 20 possible categories, and respondents were asked to tick as many as appropriate and then list the three sources they considered to be most important.

There was a high level of consistency between respondents' answers in each country. Similar to other research (UNAIDS, 2002), the findings suggest that there are a number of social influences on young people. Chart 5 demonstrates student responses:





2.2 Mass media

In both Kenya and India, television was rated as one of the top three sources of information by all respondents.

However, although mass media is clearly an important source of information for young people, it may be less so for young women than it is for men.

“ Students get most of their information from school. This is especially true with girls, as we remain confined to the home outside school hours. Boys have the freedom to go out with their friends, to the movies, etc, so they have a better chance of getting additional information. As girls, after a certain age we stay at home and only go out to study. School is therefore the basic source of information for girls. ”

Female student, Chennai, India

In India television is often viewed as a negative influence. Some respondents expressed concern that the information is unsuitable and could lead to sexual experimentation.

The role of the school is therefore prioritised because of its potential to counterbalance ‘misinformation’ from television.

“ In schools, the subject is being taught as science and part of science. But outside through media and advertisements, students’ minds may be diverted. This can create temptations among students. ”

Female headteacher, India

2.3 The role of the family

“ When we receive information from outside it could be good and bad. But when we get information from our teachers, it is always correct information. ”

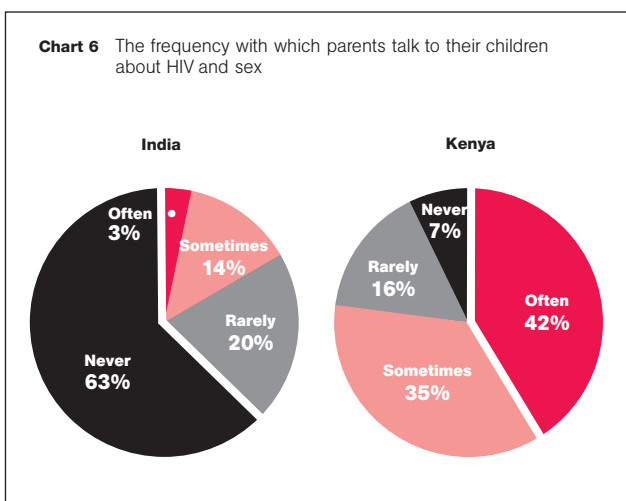
Female student, India

“ We fear that children get wrong information from outside. When the message is given by the teacher, it carries weight. Sometimes students are misled by information from outside sources. ”

Female teacher, India

The majority of Indian respondents did not cite any family member as a source of information. In contrast, the majority of Kenyan respondents listed all family members, especially the mother. Female students in both countries were more likely than their male counterparts to report learning about HIV/AIDS from their mothers: 17% of female Indian students as opposed to 6% of males; 78% of Kenyan females compared to 69% of males.

Parents were asked how often they talk to their children about sex and HIV. The pie charts below depicts the striking differences between countries.



In this country most of the parents leave their children to the school and the church for issues of discipline

Headteacher, Kenya

Kenyan parents appear to talk to their children about sex and HIV/AIDS far more than Indian parents. When asked why they did not talk to their children about such issues, 31% of Indian parents said because they did not like to talk about sex.

“ Few parents mind what their children learn in school... parents do not take part in advising their children on AIDS because of its involvement with sex. ”

Community leader, Homa Bay, Kenya

The role of the family in HIV/AIDS education seems to differ greatly between India and Kenya. The data indicates clearly that the family, particularly the mother, is more open in talking about HIV/AIDS and sex to their children in Nyanza compared to Tamil Nadu. Female students are also more likely to learn about HIV/AIDS from their mothers than male students.

In Tamil Nadu there were strong differences between urban and rural areas, with parents in rural areas much less likely to discuss sex or HIV/AIDS with their children: 82% of parents in Tuticorin claimed never to have talked to their child about sex or HIV/AIDS compared to 44% of respondents in Chennai.

In both countries, perceived difficulties for parents to talk to their children about HIV/AIDS was implicitly given as a rationale for the school to teach HIV/AIDS.

In India:

“ Any parent will show interest towards AIDS education because they want to protect us from AIDS. Also most of them feel embarrassed to discuss it with their children. So they like us learning about AIDS at school. ”

Female student, Chennai, India

In Kenya:

“ We get most of our information on AIDS from school because teachers tend to be more free than parents when it comes to this subject. ”

Female student, Kenya

In Kenya the extended family network also appears to play an important role in teaching young people about sensitive issues such as HIV.

“ There are customary arrangements which will make it difficult for a parent to talk to his or her child on certain issues. This was to be done by the other members of the extended family, and now we being in town the uncles and aunts are not here to speak to the children on behalf of their parents. ”

Headteacher, Homa Bay, Kenya

opinion

HIV/AIDS education should take advantage of pre-existing systems of knowledge transfer. If it is the custom for uncles or aunts to discuss sex with young people, then they could be encouraged and supported in discussing HIV with their nieces and nephews.

In addition, the findings suggest that the mother plays a key role in educating young people about sexual relations (including HIV/AIDS). They should also be the focus of adult learning programmes which will encourage them to communicate positively, openly and accurately on HIV/AIDS.

2.4 Religious leaders

Kenyan respondents were far more likely than Indian respondents to list religious leaders as a source of HIV/AIDS information. In addition, a significant percentage of Kenyan respondents listed religious leaders as one of the top three sources of information (14% of students, 17% of teachers and 11% of parents).

“ The religious influence is very high because they talk about AIDS frequently in all their functions.”

Headteacher, Kenya

The possible effects of religious involvement in school-based education are discussed in section 3.8.

2.5 Peer influence

A high percentage of respondents in both Kenya (70%) and India (43%) reported learning about HIV/AIDS from friends. Interestingly, there was also a strong gender dynamic in India, where 52% of male Indian students cited their friends as somewhere they get information on HIV, compared to 33% of female students. In addition, 20% of male students listed friends as one of their top three sources of information, compared to 8% of female students.

It is not clear from the research whether peer influence is either negative or positive. The interviews showed rather mixed responses on this issue. In Kenya there was significant reporting of negative peer influence which was not so apparent in India:

“ There are a lot of cases of peer influence, especially with drinking and taking drugs such as kober and bung.”

Headteacher, Kisumu, Kenya

“ We could not discuss this with elders. We feel free to talk with friends. We can clarify doubts. It is a good experience.”

Male student, Chennai, India

opinion

Peer influence should be used in a positive way. There is great potential for young people to teach each other about HIV/AIDS. Openness between peers is a strong theme in *Stepping Stones*, one of the central tenets of which is that communication is facilitated through same-age groups.

2.6 The problem of contradictory information

The large number of potential sources of information on HIV is problematic in that it increases the probability of young people receiving conflicting messages. Although teachers in Nyanza did not discuss any negative impact of mass media, 50% viewed contradictory information as a barrier to delivering HIV/AIDS education, compared to only 18% of Indian teachers.

However, conflicting information does not only come from the media. In Kenya, it is likely that contradictory messages also come from traditional healers or religious leaders: 29% of Kenyan teachers viewed religious teachings as barriers to HIV/AIDS education, compared to 7% of Indian teachers.

Silences in communicating on HIV/AIDS

3.1 The historical framework

Sexual and reproductive health education has been a contentious issue for some time, even before HIV and AIDS were discovered (Smith, 2000). Key issues concern whether or not teaching young people (who are not yet sexually active) about sex will lead to increased sexual experimentation, and how the subject should be taught: either 'fact based' (the scientific approach) and/or 'skill based' (the life skills approach) (Barnett, 1995).

When HIV and AIDS first became part of school curricula, emphasis was placed on topics such as the structure of the virus or what happens to the body after infection. Early approaches tried to instil as much scientific fact about HIV/AIDS as possible (Fiedrich, 2002). This approach was based on the assumption that increasing levels of knowledge and awareness would lead to the desired behaviour change. Having accurate information about how the virus is passed is undoubtedly a necessary part of protecting oneself against the virus, however, it is not sufficient.

Young people must also have the necessary skills to apply their knowledge. This realisation has led to a move to a more life skills approach, teaching a wide range of skills which go beyond HIV. The rather broad definition by World Health Organisation is as follows:

“ Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life.”
(WHO, 2002)

Three equally broad categories of skills that would apply to the life skills approach include:

- communication and interpersonal skills
- decision-making and critical thinking skills
- coping and self-management skills (UNICEF & WHO, 2002).

School curricula on HIV will differ according to the extent to which they tackle the issues from a scientific approach (most common), or a life skills approach (more recent). A combination of both approaches would reduce the limitations that arise in using one approach exclusively.

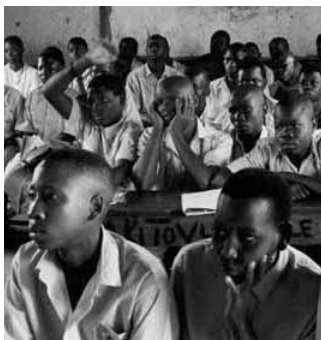
The shift to a life skills approach goes some way to meeting some of the criticisms that simply increasing awareness will not lead to behaviour change (UNICEF, 2002). However, as discussed in section 1.9, skills will be of limited use unless they are accompanied by the necessary power to use those skills.

3.2 Policy framework in Kenya and India

The HIV/AIDS curricula in Kenya and India differ greatly. The curriculum was introduced in Kenya in 2000 – one year after HIV/AIDS was officially declared a national disaster. HIV/AIDS education was added to the curriculum as a separate subject which took the place of a physical education (PE) class, and is typically taught by PE teachers for half an hour a week⁶. The syllabus starts from Standard 1 of primary school. The curriculum is broad and deals with both scientific aspects of the disease and the more social and cultural factors.

⁶ Although the choice of PE teachers as HIV/AIDS educators was not examined in the research, the emphasis of physical education in the physical realm could lead to a physical or physiological focus in HIV/AIDS lessons

Gideon Mendel / ActionAid



The curriculum, I think is relevant since it tries to strike a balance between life skills and the scientific facts regarding AIDS and the process of growing up in general

Headteacher, Kenya

The government provides facilitators' handbooks for teachers. As of yet, there is no official training on how to implement the curriculum, although Nyanza has participated in a pilot training study run jointly by DFID and the Kenyan Government. In addition to this separate subject, HIV/AIDS is integrated and infused across the curriculum.

In Tamil Nadu, lessons on HIV/AIDS have been included in the syllabus for Tamil, English, botany, zoology and science. The lessons are more scientific than in Kenya, covering issues such as the structure of the HIV virus or disease progression. In addition, these lessons are only available to science students after Standard 10.

More recently there has been the introduction of the Total Health Programme, funded by UNICEF, which has a much wider scope, but does include HIV. This training manual includes more of a life skills approach.

opinion

School-based HIV/AIDS education is limited in scope because of its failure to reach the millions of children who are not currently in the formal education system.

There are estimated to be more than 115 million children out of school worldwide (EFA, 2002). These children are likely to come from more vulnerable sectors of society and are potentially more at risk of HIV infection than young people who are in the formal education system (Bundy, 2002).

Moreover, if school-based HIV/AIDS education does not start until secondary school, then even more children will be excluded. This is the case in India, where more than half of young people never even enrol in secondary school and therefore have limited access to HIV/AIDS information compared to their counterparts who are in school. In Kenya, over 70% of children never reach secondary school⁷.

To ensure that all young people are reached by HIV/AIDS education, there must be either a massive increase in the percentage of youth participating in the formal education system or else, schools should seriously consider how HIV/AIDS learning in the classroom could extend back into the community.

Table 2 (right) summarises the main points on HIV/AIDS covered in the both countries. The Kenyan syllabus is so detailed that only the key points have been included. It is important to note that this is the syllabus as laid out by the relevant government bodies – it does not indicate how the syllabus is being implemented in the classroom.

⁷ Gross enrolment rates for secondary schools in India (49.92%); Kenya (29.85%) (UNESCO)

Table 2 Main points of HIV/AIDS included in school curricula

Kenya (Nyanza)					
Coverage HIV/AIDS classes		Emphasis	Time commitment	Learning materials	Responsible government body
Myself and others	Physical and emotional changes that take place during adolescence	Scientific and life skills	Half an hour per week Integrated across the curriculum	Teachers	NACC and KIE
Facts about HIV/AIDS	Stages of HIV infection and symptoms of AIDS				
Transmission of HIV/AIDS	How HIV is transmitted and not transmitted				
Transmission and prevention of STDs	How sexually transmitted diseases are transmitted can be prevented				
Responsible behaviour	Things you can do to avoid getting HIV				
Effects of HIV/AIDS on the nation	How HIV/AIDS affects Kenya				
Beliefs and practices that affect the spread of AIDS	Includes traditional cultural practices and myths				
Care and support for people infected and affected by HIV/AIDS	Ways in which care and support can be given				
India (Tamil Nadu)					
Coverage HIV/AIDS classes		Emphasis	Time commitment	Learning materials	Responsible government body
Tamil/English (Standard 8 & 10)	One page dialogue on "AIDS the killer disease"	Scientific	Variable – depends if Total Health Programme has been implemented Several lessons per year – mostly for science students	Teachers: Training manual: "Learning for life" (UNESCO, UNICEF, NACO, NCERT) Schools Total Health Programme (Health Education and Promotion International)	TANSCAC and DIET
Science (Standard 10)	Lesson on viruses, includes HIV symptoms, transmission and prevention				
Botany (Standard 11)	Lesson on viruses, includes structure of HIV, symptoms, mode of transmission and prevention				
Zoology (Standard 12)	Lesson on contact disease, includes structure of HIV, symptoms, mode of transmission, diagnosis, control and preventive measures				

3.3 From policy to practice

Very limited research has been devoted to the implementation of HIV/AIDS education in the classroom. A qualitative study in Uganda suggested that teachers were reluctant to teach about condoms and also avoided the more 'participatory' elements of the curriculum (Kinsman, 1999). Similarly, some anecdotal evidence suggests that teachers actively shy away from teaching HIV/AIDS (Kelly, 2000). The difficulty of implementation is also acknowledged by UNAIDS:

“ In theory, health education, which could embrace AIDS education, is supposed to be taught in schools, but in practice it is often neglected. ”
(UNAIDS, 1997)

Clearly, it is important to know how HIV/AIDS is being taught in the classroom and what messages are being given out to young people. In order to gain some rough indication of how HIV/AIDS was being taught in the classroom, the questionnaires asked students to list topics on the curriculum that had been taught. One of the limitations of the research was that it was carried out in the middle of the school year, therefore, for some either the curriculum hadn't been covered yet or else students had forgotten because it was covered some time ago. However, we are given some insight across the samples on the extent of HIV teaching, particularly because the older students were asked to refer back to subjects taught in the last one/two academic years. Teachers were also asked what topics had been covered, and how important they considered each topic to be.

3.4 Selective teaching

Some students claimed that the lessons as laid out in the syllabus were simply not being taught at all. In

Tamil Nadu, 95% of teachers claimed the Total Health Programme was being taught, but only 53% of students agreed:

“ Though we have one period per week [Total Health Programme], they never teach about health or AIDS, but use it to teach other lessons. They teach us about AIDS only when somebody comes for inspection. ”
Male student, Chennai, India

If the Total Health Programme is not being taught in Tamil Nadu, this is not a case of omitting certain topics, but an entire curricular subject.

In Nyanza, all schools are supposed to have started HIV/AIDS education:

“ As the DIS [District Inspector of Schools] of this area, I can say that the [AIDS] curriculum has reached all schools, and in those where it is not being taught it's because of lack of teaching materials. ”
District Inspector of Schools, Kisumu, Kenya

However, 8% of the Kenyan students said that they had never been taught about HIV in school:

“ There is an HIV/AIDS lesson indicated in the timetable but no teacher comes to class for it – sometimes we are left free during the lesson, at other times we are taught other subjects. ”
Male student, Kisumu, Kenya

“ HIV/AIDS is in the timetable but no teacher comes to class at that time. Students are left on their own to discuss HIV/AIDS, they joke a lot about the sexual parts. ”

Male student, Homa Bay, Kenya

“ If we ask the teachers to teach clearly and promptly in the class, the teachers feel shy and uneasy. We do not know the reason for that.”

Female student, Tuticorin, India

In both Kenya and India, reports of selective teaching was higher in rural than urban areas. For instance, in India, only 46% of students in rural areas reported having been taught the Total Health Programme compared to 60% in urban areas.

Possible reasons why some of these classes were not being taught are discussed below, and include a lack of training, leading to lack of confidence and responsibility; gender issues; low priority given to such lessons; and the wider crisis in education.

From the questionnaires it is not possible to state exactly what has and has not been covered in the syllabus. The quantitative analysis shows some level of selective teaching: there are several strong links between what teachers consider to be important to teach and how much students say they have been taught.

For example, in Kenya, ‘beliefs and practices which affect the spread of HIV/AIDS’ was rated as the least important topic to teach by teachers. Students claimed that this was the least taught topic on the syllabus: 59% of students claimed it was being taught, compared to 91% for responsible behaviour and 93% for transmission of HIV.

These findings suggest that the syllabus is being taught selectively, a conclusion that was reinforced in some of the focus group discussions with students. Some teachers seem to avoid teaching lessons which are sensitive and, perhaps, embarrassing. This would also explain why the topic on cultural practices and beliefs is being missed out, as it is less straightforward and more sensitive than other more scientific topics.

“ The teachers seem to fear teaching on the subject of HIV/AIDS. ”

Female student, Kisumu, Kenya

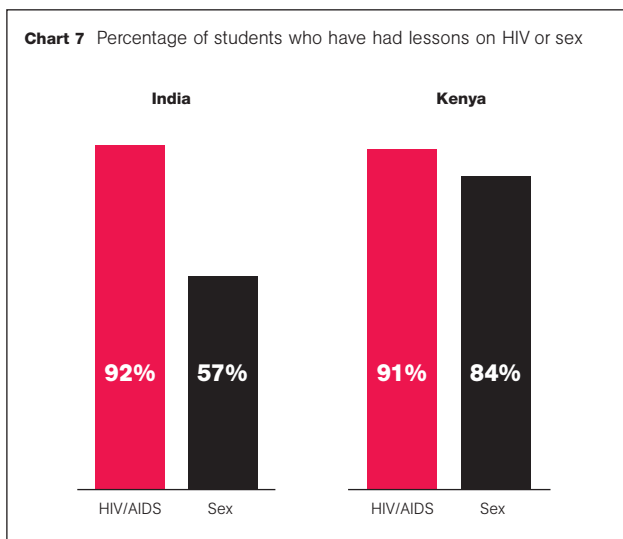
Teachers appear to be teaching some lessons on HIV, but exercising their own judgement in which messages should be taught and which not. There are likely to be two reasons for this:

- difficulties in discussing sex, leading to discussions of HIV without talking about sex
- societal and religious pressures that forbid the discussion of safer sex, leading to HIV/AIDS lessons which emphasise abstinence without raising issues on safe sex.

3.5 Selective teaching of HIV/AIDS without direct reference to sex

In the context of AIDS epidemics which are being spread mostly through heterosexual intercourse in both Tamil Nadu and Nyanza (UNAIDS, 2002), a discussion on HIV/AIDS without talking about sex will be inherently limited. Most models which relate education to behaviour change rely on some premise of awareness of risk (see section 1.8). It is impossible to have a clear idea of personal levels of risk to the virus without knowledge of how HIV is, and is not, transmitted.

Despite this, sex is such a taboo subject in many countries that there is high resistance to opening such a discussion. We asked students if they had ever had any lessons on HIV or sex. Chart 7 shows that in both countries a significant percentage of students had had HIV/AIDS education without ever having had any lessons on sex.



HIV/AIDS education without direct reference to sex appears to be much more common in Tamil Nadu than Nyanza: approximately one third of the Indian students reported having had lessons on HIV/AIDS but not sex, compared to only 7% of the Kenyan students.

The reason for this is probably the emphasis in Tamil Nadu on teaching HIV/AIDS as a scientific subject, extracting sex and human relations from the equation. A common thread running through the Indian interviews was the underlying belief that HIV/AIDS consisted of scientific fact and should be taught accordingly, and any other way of teaching could lead to sexual experimentation and raise passions.

“ Once one teacher who was a little eccentric taught vulgarly. When this news reached the parents there was big commotion and they protested. And the teacher was taken to task. He tried to explain it away saying it was in the text but he overdid it. Parents react. I told him not to repeat and warned him to teach carefully without arousing passion. ”

Headteacher, Tuticorin, India

“ They teach whatever is printed in the textbook. They confine themselves only to textbooks. They teach us only about origination and the spread of the disease. They do not speak to us about how and why it spreads. ”

Male student, Tuticorin, India

More female students reported having had lessons on HIV/AIDS and sex in rural and urban areas of both countries. For instance, 60% of female Indian students claimed to have had lessons on sex, compared to 54% of their male counterparts. The reason for this trend is not clear. It is possible that, for gender-specific reasons, female students are actually receiving more sex education. Alternatively, there may be a gender bias in the reporting, with female respondents perhaps being more open about having received sex education.

Teachers also expressed concern that parents would disapprove if they knew that the students were being taught about sex.

“ Most of the parents will think that we are introducing their children to sex, and will not like this education about HIV/AIDS. All students come to school with an objective, to get good grades in their exams, but through sex education we may be diverting them. They will feel that there will be a disturbance in their education. ”

Female teacher, Chennai, India

“ They feel that we spoil the students by teaching them about AIDS. That is the fear in the parents’ minds. They will be ignorant of the field of sex. If we teach them about AIDS, we have to teach them about sex too. ”

Headteacher, Chennai, India

3.6 Selective messages on acceptable sexual relations

In Kenya, something different appears to be happening. HIV/AIDS education involves more lessons which include sex education than India, but the messages on sex are highly selective.

HIV/AIDS education gives people strong messages on appropriate and safe sexual behaviour. The three key messages used around the world are:

- A** Abstain
- B** Be faithful
- C** use Condoms.

(Welbourn, 1995)

However, there is controversy over whether or not the ‘C’ component should be taught at all. Roth (2001) examined condom use in India and concluded that the cultural and social climate renders “the existing educational and disease prevention strategies inappropriate and ineffective” (p65). In this quote he is referring specifically to the promotion of condoms and safe sex.

Certain religious institutions are also against the teaching of the ‘C’ component with the Vatican probably being the most vocal in its stance against condoms. Although it has not been shown empirically, it has been suggested that religious barriers that oppose the promotion of condoms lead to ineffective prevention strategies (Amuyunzu–Nyamongo et al 1999). In his study in the Masaka district of Uganda, Kinsman suggested that there were four interrelated factors which deterred teachers from discussing condoms in the classroom: **i)** the belief that condoms will encourage promiscuity, **ii)** the influence of the Roman Catholic church, **iii)** fear that the headteacher will fire the teacher, and **iv)** personal beliefs of teachers.

The current research aimed to examine how teachers in the two countries view condoms and what messages about sex are being given out in school–based HIV/AIDS education.

In both countries, there was a strong belief that refraining from any sexual relationship is the best, and the only way to stop the further spread of HIV. There was also the belief that educating young people about methods of safer sex will lead to sexual experimentation. The following quotes exemplify some of these points:

“ My parents are always warning me against sexual intercourse which is also a basic message of AIDS education here in school. ”

Female student, Kisumu, Kenya

There is plant reproduction and animal reproduction in the syllabus. We are able to take classes and explain elaborately about plant and animal reproduction with purpose. When it comes to human beings we are not able to conduct the classes. We do not know how to overcome this

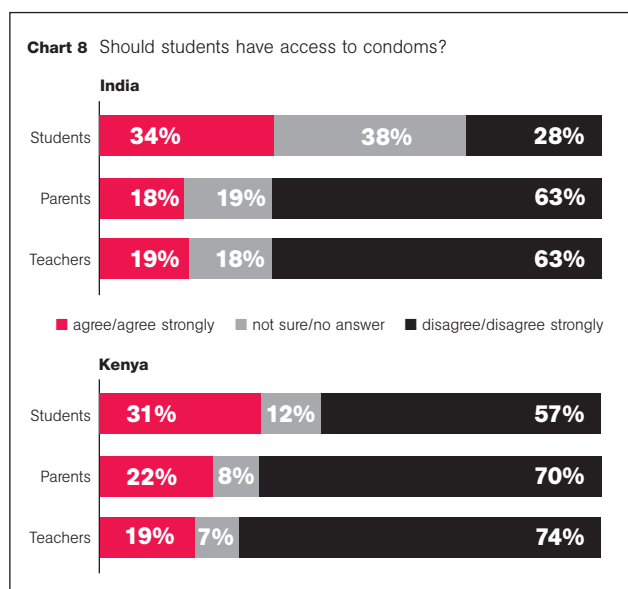
Female teacher, India.

“ The teachers know only about reusing syringes and about illegal sex. They only teach us about cleaning syringes before using them, and also that it [HIV] spreads through immoral sex. We too know only about these things. But they do not tell us anything about using condoms and other things related to sexual intercourse. They never teach us about preventative methods. ”

Male student, Chennai, India

3.6.1 Attitudes towards condoms

In the questionnaire respondents were asked whether or not they thought students should have access to condoms, as a way to gauge their opinions towards safer sex and condoms. There was strong resistance towards condoms in both countries and amongst all categories of respondents, as illustrated in Chart 8.



Students in both countries were more likely to agree to access to condoms than their parents and teachers. The findings also show that there was less disagreement towards access in Tamil Nadu than Nyanza. In Kenya, respondents were more certain of their negative stance towards condoms: 57% of Kenyan respondents disagreed strongly, compared to 28% in India. One likely reason is the strong influence of the Roman Catholic church in Nyanza and its stance against condoms.

“ Being a Catholic-sponsored school, the use of condoms is definitely totally disapproved and abstinence is taught to the girls...there is a motto of ‘close your thighs and open your books ’”

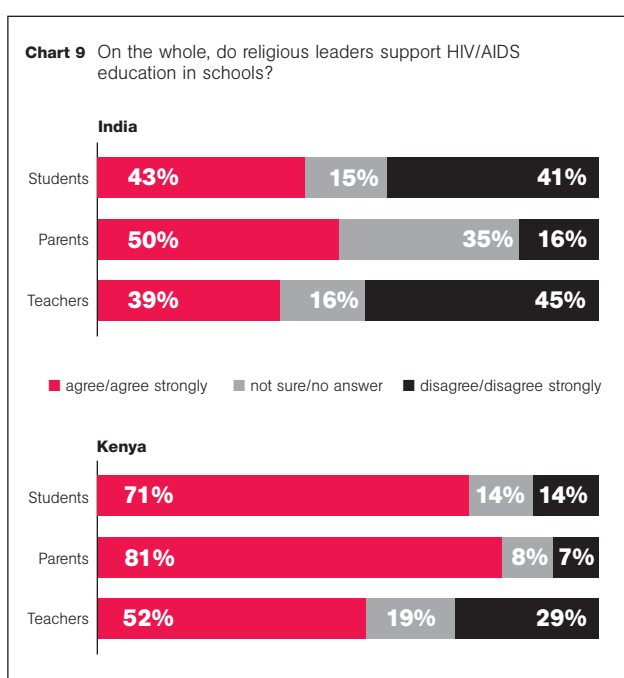
Headteacher, Homa Bay, Kenya

“ Religious leaders have positive effects except for use of condoms among youths. ”

Headteacher, Kisumu, Kenya

3.6.2 Religious influence on selective teaching

The Catholic Church appears to exert a strong influence on HIV/AIDS education in Nyanza. Religious influence in Tamil Nadu doesn't appear to be as strong, certainly in the state sector. 22% of students in Nyanza reported having learnt about HIV during religious teachings. Also, more Kenyan students, teachers and parents said that religious leaders supported HIV/AIDS education in school than their Indian counterparts, as illustrated in Chart 9.



Although the results suggest stronger religious support of in HIV/AIDS education in Kenya than India, a significant proportion of teachers in both countries viewed religious leaders not to be supportive: a significant proportion of teachers in both countries viewed religious teachings to act as a barrier to HIV/AIDS education - particularly in Kenya.

“ Religious leaders are negative on the facts delivered and on ages to be taught about AIDS. ”

headteacher, Kisumu, Kenya

“ When religion comes in the picture, science goes backstage. Religion spreads superstitious belief on the whole, be it any religion. ”

Male teacher, Chennai, India

“ Use of condoms is a way of spreading AIDS, the virus is very minute and can move freely in and out of a condom. ”

Male student, Homa Bay, Kenya

opinion

HIV/AIDS education should acknowledge the influence of the religious institutions and look at how to involve and include local spiritual leaders. It is important that there is consistency in the messages given on HIV/AIDS between schools and church. Religious leaders need to be brought together and asked how they will respond to the human crisis which has arisen because of HIV. Their role in educating young people about HIV and condoms must be used positively. However, religious leaders cannot be expected to have the knowledge and skills needed to discuss HIV openly, accurately and positively.

If not, there will be contradictions between the messages received by young people at school and in church. As already discussed in section 2.6, contradictions lead to confusion and can propagate potentially negative myths.

Myths and misconceptions about condoms, such as the one above, are potentially very damaging. It is important to know what myths are being circulated among young people and then to challenge them.

3.7 Understanding selective teaching: the paradox of safer sex ¹¹

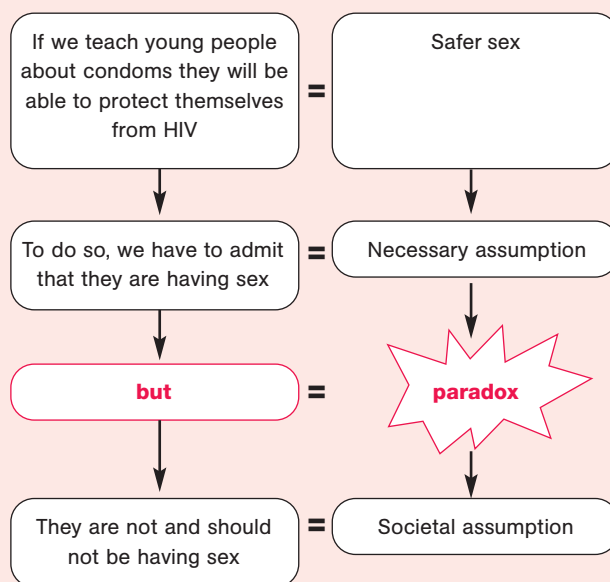
It is worrying that safer sex is not being taught to students, precisely because the findings show that risky sexual behaviour is perceived to be fairly common in Kenyan schools. Evidence from a recent study in Kisumu showed that reported condom use was highest amongst those with the most knowledge of HIV (Volk, 2001). HIV/AIDS education which addresses the issue of condoms can lead to safer sexual practices. On the other hand, messages on abstinence may delay sexual debut but will not be effective in protecting those who are already sexually active:

“ Not enough choices are given to students. The Ministry just approves teaching abstinence which is quite impossible, especially to the sexually active youths. When they preach abstinence they don’t give appropriate life skills to say no to sexual advances. ”

NGO representative, Kenya

The paradox of safer sex

We have already seen the tension which exists in educating young people about safer sexual habits. The logic is as follows:



The paradox of safer sex arises from a tension between two assumptions that fit ill with one another. One is an assumption that students might be having sex, and therefore HIV is a genuine risk; the necessary assumption to discuss condoms. The other is what we might call a 'societal assumption', which results from deep-seated social pressures (which have their origin outside the classroom). In this case the societal assumption is 'we do not and will not have pre-marital sex'.

Clearly they are contradictory, and the paradox of safer sex arises precisely because both find themselves thrust upon the educational agenda, the first by the HIV/AIDS curriculum and the second by deeply entrenched societal pressures.

¹¹ This analytic framework has been applied to young people but could equally be applied to situations where the societal assumption is no extra-marital sex, or no homosexual relationships

3.8 Resolving the paradox (in the context of young people)

Accepting condoms as a method of reducing the risk of HIV must assume that young people are having, or might have, pre-marital sex. However, this can contradict deeply ingrained societal assumptions that pre-marital sex doesn't happen. It therefore becomes rationally impossible to discuss safer sex.

Resolving the tension in this paradox means dropping one of the above assumptions. Assuming that students will not have pre-marital sex is a familiar response: 'HIV isn't our problem – it happens to others, to immoral sorts'. This assumption leads to stigma and discrimination, and in refusing to acknowledge the problem, there is little hope of solving it.

Only an effort to challenge the 'societal assumption', in this case that sex before marriage does not happen, is likely to bring about any real change. This means challenging the cultural assumptions of the societies in which HIV is prevalent. It is hard, but not impossible.

However, challenging a country's social norms carries the threat of cultural imperialism – especially if outsiders are perceived to be challenging or, more often than not, criticising. Moreover, it is paramount that positive social norms are not undermined.

Education which challenges harmful social and cultural norms is possible – in *Reflect* circles knowledge is not provided in a hierarchical unilateral way but through a process which encourages the participant's self-analysis and discussion.

Results **4** Obstacles to teaching HIV/AIDS – a wider crisis in education

Recent research suggests that teachers are hampered in their efforts to teach HIV/AIDS in the classroom for a number of reasons, including low prioritisation of HIV/AIDS education, and material factors such as insufficient learning materials (Bennell, et al. 2002; Malambo, 2000).

Qualitative research using focus group discussions suggested that teachers found it difficult to teach about HIV in Zambia, because of a lack of training and insufficient learning materials (Malambo, 2000). UNAIDS suggest that an overcrowded curriculum leads to a low priority status for lessons on HIV/AIDS:

“ It is often difficult to find a slot for AIDS education in an already full and overcrowded school curriculum, especially when there are many issues competing for space. ”
(UNAIDS, 1997)

4.1 A wider crisis in education

Despite huge international mobilisation to provide universal primary education, in many countries formal education systems are under duress. Although there have been commendable increases in enrolment in many countries, these increases have unfortunately been accompanied by decreases in quality (Fuller, 1989; ActionAid, 2003).

ActionAid recently completed a survey of its grassroots education work over the last 30 years up to 2002. In contrast to official UN statistics, the survey gauged the perspectives of education from the communities themselves and found that:

“ The education system in most areas of the countries where ActionAid works is in a terrible state of crisis – much more acute than is generally realised. ”
(ActionAid, 2003)

The quality of formal education systems in resource-poor settings has been eroded over the years through chronic under-financing (Filmer, 2002). The resource gap for providing universal primary education currently stands at \$5.6 billion per year (UNESCO, 2002).

Moreover, The large number of out-of-school children, which is symptomatic of the wider crisis in education¹⁴, also has huge implications for school-based HIV/AIDS education by significantly limiting its scope.

Quality of education

Systematic progress towards quality education for all is generally measured using two proxies: 1) educational expenditures 2) pupil-teacher ratios (UNESCO, 2002).

4.1.1 Educational expenditure

The EFA monitoring report estimates India to have resource gaps of between 1 to 4 billion dollars per year – this is the level of additional investment needed to reach international targets of universal primary education by 2015. In Kenya, estimates are between 70 and 172 million dollars per year.

“ In sub-Saharan Africa and south and west Asia, expenditure has not kept pace with the growth of population and of the enrolment rate. In consequence, spending per pupil has declined in these regions. ”
(EFA, 2002)

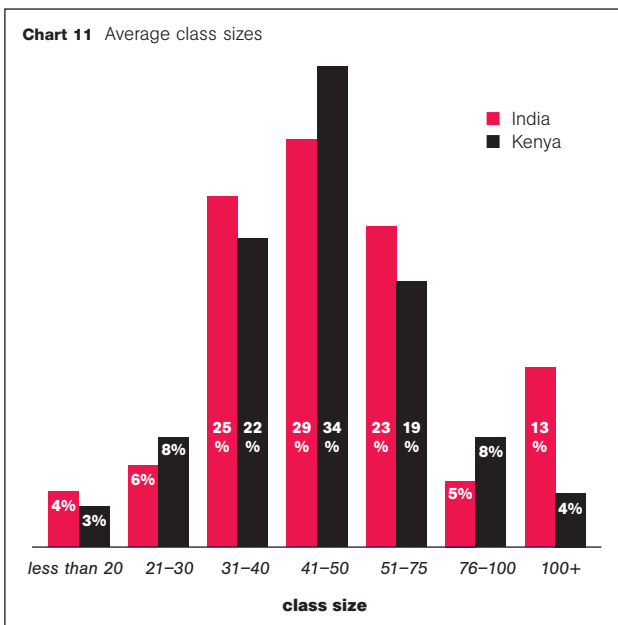
4.1.2 Pupil-teacher ratios

As a general indicator of the underlying quality of education in Tamil Nadu and Nyanza, we asked teachers to indicate average class sizes. The results are shown in Chart 10:

¹⁴ See section 3.2 on out-of-school children.



Howard Baker/ActionAid



Over 40% of classes in the Indian sample averaged at over 50 students. With classes this large, it is questionable how much learning can take place, and the quality of education each student receives is seriously undermined.

In Kenya, teacher shortages are being compounded by the HIV/AIDS epidemic.

“None of the teachers have gone for AIDS tests, although the school has lost five teachers in two years.”
Headteacher, Homa Bay, Kenya

Although it was beyond the scope of this study to examine the impact of HIV/AIDS on teacher shortages, there is evidence that the quality of education is further undermined through teacher morbidity and mortality (Bennell et al, 2002; Badcock-Walters, 2002).

4.2 HIV/AIDS education in the context of a wider crisis in education

“In my area, some schools have started on this AIDS curriculum and some haven’t because of lack of materials and teachers for this subject...[the] main obstacle is poverty in the community and its schools. For schools to watch [video] tapes, for instance, there has to be electricity, and most schools lack electricity.”
Community leader, Kisumu, Kenya

Teachers were asked what difficulties they faced in teaching HIV/AIDS. Some of these issues have already been discussed and relate to the specific nature of HIV/AIDS education (social and cultural barriers). Other difficulties relate to an underlying crisis in education – these constraints are faced every day by the majority of teachers in resource-poor settings.

On the whole, Kenyan teachers cited a much larger number of obstacles than their Indian counterparts. However, the three obstacles most commonly cited in both countries were the same, as shown in Table 3:

Table 3 Most commonly cited obstacles in teaching HIV/AIDS

Most commonly cited obstacles	India	Kenya
1	lack of resources	lack of resources
2	cultural barriers	lack of training
3	lack of training	cultural barriers
4	parental resistance	contradictory information

4.2.1 Learning resources

Lack of learning materials was one of the most commonly cited barriers to HIV/AIDS education by

teachers in both countries. 62 % of students in Kenya said their schools did not have enough teaching materials to teach about HIV/AIDS, compared to 67% of Indian students.

“ These learning materials are seriously lacking as one book contains materials from Standard 1 to 8.”
Headteacher, Homa Bay, Kenya

opinion

A massive injection of resources is needed in order to support teachers – not just for teaching about HIV/AIDS, but to ensure some modicum of quality education for all.

4.2.2 Teachers’ levels of knowledge

All respondents were asked if they thought teachers had enough knowledge to teach HIV/AIDS. Table 4 shows the percentage of respondents who perceived that teachers do not have enough knowledge on HIV.

Table 4 Percentage of respondents who thought teachers did not have the necessary knowledge to teach HIV

	India %	Kenya %
Parents	5	21
Teachers	20	45
Students	8	14

Although the majority of respondents in both countries perceived teachers to have enough knowledge to teach HIV/AIDS, overall confidence in teachers’ competence appears lower in Kenya than India. The pattern of differences between respondents was similar for the two countries – both parents and students reported having more confidence in teachers’ levels of knowledge than the teachers themselves.

This interpretation is consistent with the idea that both students and parents were shifting responsibility for HIV/AIDS education onto the teachers and that this might be a leap of faith, as the teachers themselves are not as confident about their abilities.

Some headteachers also reported that teachers did not have sufficient knowledge to teach about HIV:

“ I can’t say that they [teachers] have enough knowledge. There must be enough knowledge given on HIV to teachers. I came to know in detail about HIV only after attending the seminar in Vanarampatti organised by DIET...the headteacher must be sensitised first, and thereby the information will be disseminated to the teachers. ”
Headteacher, Tuticorin, India

This quote highlights the importance of working with headteachers on HIV/AIDS education. Many of the interviewees from both countries suggested that headteachers either implicitly or explicitly supported open discussions of HIV/AIDS in the school.

opinion

One way of increasing levels of knowledge is to provide distance-learning materials for teachers. These could include training manuals, videos or interactive learning modules. However, as discussed above, learning materials are already in short supply. Many schools would not have the facilities to use electronic materials, even if they were easily available. Moreover, learning materials alone will not equip teachers with the skills to teach confidently about HIV/AIDS and sex – they also need practical training.

The way they teach it (HIV/AIDS) reflects that they are not happy. The facial expression show their feelings: because the face is the index of the mind. They are thinking: why should we teach on HIV to students?

Male student, India



Jenny Matthews/ Network/ ActionAid

4.2.3 Levels of training

“ Training has to be provided. There is a hesitation to teach certain areas. The training has to focus on demolishing such hesitation in the minds of teachers. ”
Female teacher, Chennai, India

Training is obviously the most straightforward way of equipping teachers with the knowledge to teach about HIV. However, as a Kenyan HIV/AIDS control officer admits, this is a formidable task:

“ There are approximately 240,000 teachers on the government payroll. The Ministry admits that the teachers have not been successful in delivering the [AIDS] curriculum as required... they need sensitisation and more facts. ”
AIDS control officer, Kenya

Over half of the Kenyan teachers reported not having received any training on HIV/AIDS. This figure is likely to be lower nationally because Nyanza has been the focus of an intensive teacher training programme on HIV (CfBT, 2002). Training on HIV/AIDS in India appears to

be even less common – 70% of teachers said they had never received any training on HIV.

opinion

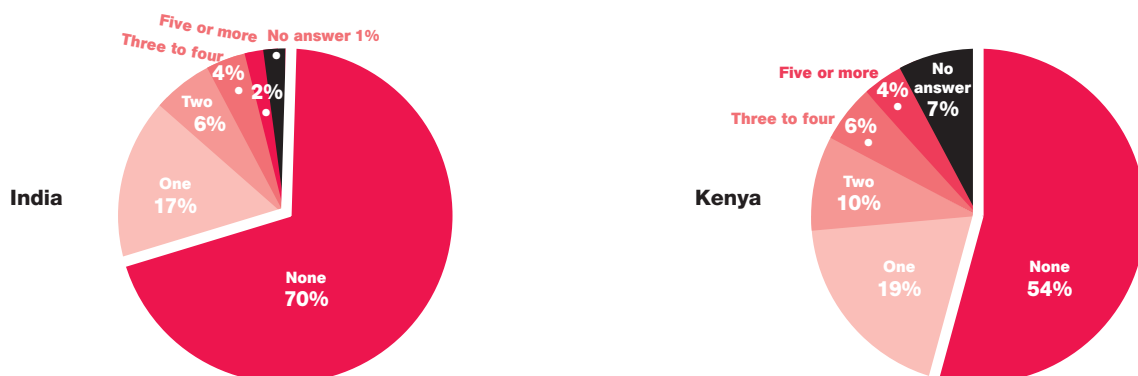
It takes special skills to talk about sex and a life-threatening disease, especially in countries where sex, and consequently HIV, are linked to immorality. These are big obstacles, but they can be overcome. However, these are not talents one can gain from a book: it will take a very different type of training and learning process to gain the necessary skills. More than anything, it is about communication.

4.2.4 Over-burdened timetable

Linked to the issue of staff shortages, teachers were asked whether or not they had enough time to teach HIV/AIDS: 52% of Indian teachers and 55% of Kenyan teachers said they did not. Interviewees also suggested that some teachers viewed HIV/AIDS education to be an extra burden on an already packed syllabus:

“ It is an additional subject to be taught in schools (HIV/AIDS). While the number of teachers is small, it therefore has created a heavy workload which becomes unbearable. ”
Headteacher, Homa Bay, Kenya

Chart 10 Number of HIV/AIDS training courses teachers have attended



“ We do not have enough time to teach about HIV/AIDS, as we are already burdened with enough workload. ...We don't have sufficient time for this [AIDS education]. We are always in a rush to complete the syllabus. ”

Female teacher, Chennai, India.

opinion

In many countries there needs to be a fundamental review of the school curriculum to determine which topics are fundamental and relevant to school education. In many cases the national curriculum is already over-burdened, with new subjects or curriculum areas frequently added without anything ever being taken away. Over the years this has led to saturation – there simply isn't the space or the time for yet another new curriculum area on HIV/AIDS. It can exist on paper in Ministry of Education documents, but it will not appear in practice. Only by doing a more fundamental review of the entire curriculum can new space be found which will make it possible for HIV/AIDS education to be seriously addressed.

Some of the interviews with teachers in both countries also suggested that exam-focused education acted as an additional barrier to HIV/AIDS education:

“ If AIDS is not an examinable subject then teachers may give it a very low cover or no teaching at all. ”

Community leader, Kisumu, Kenya

“ We do not have any special timetable for AIDS. It is taught along with the usual syllabus and timetable. We teach it with examination point of view to score high marks. ”

Headteacher, India

opinion

In the era of free choice, and a belief in the benefits of competition, schools around the world are becoming increasingly results-orientated. This poses problems for any type of learning which is not easily examinable. There may be merit in testing young people on the scientific facts they know about HIV, but it will be detrimental to attempt to examine life skills or some of the more innovative learning approaches we discussed in Part 2.

4.2.5 Gender

A recurring theme in the interviews was the reported shyness felt by teachers in talking about HIV/AIDS with members of the opposite sex. This gender dimension appeared to be stronger in India than Kenya.

“ According to me teachers are not happy about teaching this [HIV/AIDS]. We are female teachers, it is impossible for us to teach it openly to male students. I like to inform you that we can teach about this to girls happily. ”

Female teacher, Chennai, India

“ When male teachers explain about AIDS to female students, there may be some uneasiness. ”

Female teacher, Chennai, India

Training has to be provided. There is a hesitation to teach certain areas. The training has to focus on demolishing such hesitation in the minds of teachers. Our society and the culture are getting destroyed slowly. When there is a war we prepare ourselves. Likewise our houses and the individuals have to be prepared to fight the war against AIDS. This has to reach all teachers.

Teacher, India

opinion

This gender issue has two implications for teaching HIV/AIDS. If possible, training should be designed to overcome inhibitions that teachers have in discussing sex with students of the opposite gender.

Alternatively, if inhibitions about having a frank discussion about sex with the opposite gender are too ingrained, then there is merit in having single sex lessons.

This approach has been used by Stepping Stones, allowing peer groups of the same gender to discuss personal issues in-depth without the constraints that normally exist between mixed-gender groups.

4.2.6 Role models

There has been concern that teachers do not act as positive role models for young people, and that their own sexual behaviour is in direct contradiction to the behaviour they advocate in HIV/AIDS education (Bennell et al, 2002). In order to investigate this claim, we asked all respondents whether, on the whole, teachers in their school set a good example to pupils when it came to safe sexual behaviour.

In Kenya, 23% of students said that teachers did not set a good example with regards to sexual behaviour. A much smaller percentage (9%) of teachers reported the same. Among parents the figure was 17%.

In India, teachers were regarded as better role models for sexual behaviour than in Kenya, with 13% of students, 4% of teachers and only 3% of parents saying they thought teachers did not set a good example.

Examples teach better than actual preaching.

“ They [teachers] set really good examples. They can teach us well only when they are morally good...we have mother, God, and Guru system. Guru means teacher. ”

Female student, Tuticorin, India

One of the main concerns surrounding inappropriate role model behaviour among teachers is the level of hypocrisy which arises in the messages they give out:

“ The attitude of the teachers must change because, though they are the ones delivering the AIDS education, they are still maintaining ways of living that are not in consonance with the messages of AIDS education. ”

Male Kenyan government official

Some of the interviews in Kenya indicated that teacher-pupil sexual relationships were occurring.

“ The same teachers who are supposed to pass information to children, seduce them and therefore face the challenge of being good role models. They are not good examples, which is a great threat for children who may take after the behaviour of their teachers. ”

Government teacher training representative (Kenya)

opinion

For teachers to have sexual relationships with students is both illegal and a gross infringement of the power a teacher holds over a student. The education and legal systems have the responsibility to ensure that teachers who are found to be having sexual relations with students are prosecuted. In addition, teachers' unions should be encouraged to show zero tolerance towards sexual harassment in schools.

5 Conclusions and recommendations

There are a number of silences in communication around HIV/AIDS in schools. In both India and Kenya, lessons on HIV/AIDS are incorporated in the school syllabus, however it appears that selective teaching is often taking place in which either:

- entire lessons on HIV/AIDS are omitted
- HIV/AIDS is taught without any direct reference to sex or human relations
- selective messages are given on 'appropriate sexual behaviour.'

The difficulties which teachers face in communicating on HIV/AIDS appear to be affected by perceived parental disapproval, religious barriers (particularly in Kenya), cultural and social assumptions. A wider crisis in education compounds these issues through chronic under-financing of the education system in both these and many other countries.

A number of approaches for potentially overcoming these obstacles are discussed below including:

- taking advantage of pre-existing systems of knowledge transfer by working with all sectors of society to ensure that communication on HIV/AIDS is accurate, open and positive
- locally relevant HIV/AIDS education
- extending beyond the classroom so that out-of-school youth also have access to HIV/AIDS education
- challenging entrenched power inequalities through HIV/AIDS education
- prioritising school-based HIV/AIDS education, and education as a whole.

5.1 Placing HIV/AIDS education in the context of the community

Parental support for school-based HIV/AIDS education

On the whole, parents appear to support HIV/AIDS education in schools – although parents in India appear

to be far less informed than their Kenyan counterparts. A minority strongly oppose any communication on HIV/AIDS at all and have probably overly-influenced teacher perceptions, leading to fear of a backlash against teachers. It is important that teachers are confident that the majority of parents are supportive of school-based HIV/AIDS education.

One implication is that school-community links should be strengthened so that teachers are in contact with a wide range of parents (and therefore aware of parental support). An added benefit of this approach is that it allows an increased flow of information from the school to the parents so that parents themselves would learn more about HIV.

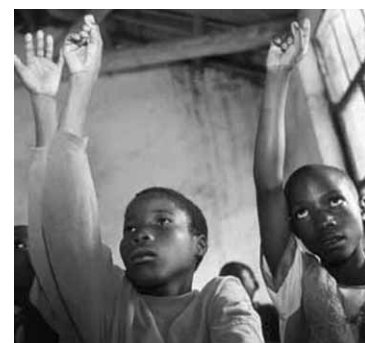
Diffused responsibility for communicating on HIV/AIDS

Young people learn about HIV from a plethora of sources which can lead to contradictory messages and hence confusion. In both countries, the role of the mass media and the school appear to be paramount and teachers are aware of this responsibility (although responsibility is more diffused in Kenya than India).

In Kenya, religious institutions and families exert more influence than in India over communications on HIV/AIDS. The influence of the religious institutions is sometimes perceived as negative and seems to contribute to the occurrence of selective teaching.

The diffused responsibility for communicating on HIV/AIDS should be seen as a positive force; however, it runs the risk of contradictory messages being received by young people. Collaboration and consistency must be fostered between schools, religious leaders and communities to overcome contradictory messages.

Participatory learning processes such as *Reflect* can help create a space so that these different stakeholders have the opportunity to share their opinions with others. Adult learning programmes can improve the meaningful participation of people in decisions about HIV/AIDS education in schools.



Stuart Freedman/ Network/ ActionAid

Personalising risk to HIV/AIDS

Despite acknowledging the severity of the problem, perceptions of risk to HIV/AIDS were not personalised, with strong sentiments expressed in both countries that HIV only affects 'them' and not 'us'. Boundaries of risk were drawn closer in Kenya and perhaps stronger for parents and teachers than young people.

Attitudes of 'otherness' lead to silence, stigma and denial. It is crucial that HIV/AIDS education works to increase people's awareness of HIV as a real and

personal risk by making learning resources locally relevant and 'humanising' HIV.

There needs to be a move away from an overly scientific approach to HIV/AIDS education. Learning materials should stimulate children to understand the human side of HIV so they can connect the issue to real life. Innovative and more participatory forms of learning are important for helping to achieve this – and efforts are needed to ensure that exam-focussed systems allow sufficient space and give recognition to such approaches.

Key recommendations

- Myths and misconceptions about HIV are potentially very harmful and need to be challenged in schools. Teachers must be able to explain clearly to young people why they are false.
- There is a need to have public fora discussing HIV/AIDS and the role the school plays in educating young people about HIV and sex. Communication between parents and educational personnel will mean that parental expectations of the school will match the teachers' perceived responsibilities.
- Ownership of the curriculum must be broadened to involve parents, teachers and religious leaders as stakeholders. However, these stakeholders must first go through an educational process themselves in which they can begin to discuss sensitive issues such as sexual and gender relations. During this process, they will be able to identify the positive role they can play in HIV/AIDS education, and start to take responsibility for it.
- Taking advantage of pre-existing systems of knowledge transfer – mothers, peers and, where appropriate, the extended family system should be targeted and encouraged to communicate on HIV/AIDS in positive, open and accurate ways.
- To ensure clear and consistent messages, HIV/AIDS education must target all sectors of society including religious leaders, the media, and families. It must look to provide the necessary knowledge about HIV, and learning must be participatory and locally relevant.
- Learning resources on HIV/AIDS should be locally driven – drawing upon local statistics of prevalence and case studies. This will make it easier for students to view HIV as a problem which is relevant to their own lives – an issue which can affect 'us', not just 'them'. Close links must also be made with other agencies collecting and collating local data – to ensure it can inform discussions in local schools.
- HIV/AIDS education needs to draw upon a wide range of creative pedagogic tools and in doing so can contribute to wider change in schools. Rote learning or learning passively from textbooks is not a useful approach when it comes to HIV/AIDS. In order to really engage children and change their attitudes or behaviour a different model of learning is needed. The use of song, dance, visualisation, story telling, role play and drama are just a few of the approaches that can help children to connect more deeply.
- Governments should encourage the development of mobile external resource teams within every district. External resource teams have the advantage of being able to more easily raise sensitive issues such as sex and HIV. Teachers will then be in a better position to follow up on these issues as there will be a precedent of openness. If such groups are promoted, not just at a national level, but also at a district level, then they can realistically reach all schools and can also contribute to wider education for parents, religious leaders etc.

5.2 Silences in communicating on HIV/AIDS

Selective teaching of HIV/AIDS

Curriculum for school-based HIV/AIDS education tends to either have a scientific emphasis or a life skills emphasis. The former is characteristic of the curriculum in Tamil Nadu, whilst a more life skills approach is apparent in Kenya. However, difficulties in communicating on HIV/AIDS exist for both countries and the life skills approach depends on a different pedagogy to traditional learning methodologies.

One of the key issues highlighted in the research is the practice of selective teaching. This is manifested either in **i)** entire lessons from the syllabus not being taught (both India and Kenya); **ii)** HIV/AIDS lessons without any direct reference to sex (more common in India) or finally **iii)** communication on HIV and sexual relations relying solely on messages on abstinence.

Each of these three types of selective teaching has created silences in communication which limits promotion of safer sexual practice. As discussed earlier, messages on HIV/AIDS without direct reference to sex act to dehumanise HIV/AIDS.

Messages on abstinence have a part to play in HIV/AIDS prevention strategies although perhaps 'sexual delay' is more achievable. However, HIV/AIDS education, which fails to communicate other methods of prevention, fails to reach those many young people who are already sexually active. HIV/AIDS education should reach all young people. Sexually active youths will not only feel excluded from messages forbidding pre-marital sex, but will also have limited access to potentially life-saving information. They have as much right to this information as any other young person. HIV/AIDS education must therefore also target sexually active youths whether they are in school or not.

Silences in communication over the issue of condoms, or messages other than abstinence arise out of a paradox of safer sex. In the context of young people, the paradox or tension can occur between two assumptions: a societal assumption that young people do not, and will not, have pre-marital sex and the necessary assumption needed to discuss condoms: that young people might have pre-marital sex.

Education that leads to positive behaviour or social change needs to look beyond skills and, in this particular context, challenge social, gender and power inequalities.

Challenging social and power inequalities

By focusing on power and communication issues in wider human relationships, some of the power issues involved in sexual relationships can be addressed. This is often key in promoting the practice of safer sex. A gender approach is needed that starts with an analysis of boys and girl's reality in order to promote understanding of the wider processes and structures that contribute to subordination and powerlessness.

Exploring how gender interacts with other forms of subordination (class, race etc,) can help boys and girls develop a wider awareness of power dynamics in human relationships. The more boys and girls (men and women) feel comfortable communicating on these issues, the more prepared they will be for communication at pivotal in sexual relationships.

Within the environment of globalisation, privatisation and liberalisation, schools around the world are becoming increasingly 'mainlined', results-oriented and competitive. This does not create the most conducive environment for learning, and for subjects such as HIV/AIDS, a radically different type of learning experience is needed.

Key recommendations

- HIV/AIDS education should challenge ingrained gender and power relations by giving space to boys and girls to discuss gender issues and to examine the power dynamics involved in intimate relationships.
- Discussing gender and power should be part of the wider school curriculum, and not focus only on sex and HIV.
- There needs to be space within schools to have single-gender groups so that young people can openly discuss gender and sexual rights.
- Once young people feel safe and comfortable raising these issues in single-gender groups, it will be important to have mixed-gender groups so that they can learn to openly and positively communicate with the opposite gender.
- A life skills approach is also necessary to equip young people, particularly women, with the skills they need to fulfil their sexual and reproductive rights.

5.3 A wider crisis in education

If the education system is to be a powerful vehicle to prevent the further spread of HIV/AIDS, then improving the basic functioning of the system is a prerequisite.

For too long now, teachers have been struggling under duress. Wider issues need to be addressed about the present crisis in education. No teaching of HIV will be successful when there are more than 50, and in some cases up to 100, children in each class. It is impossible for teachers to communicate effectively with their students in such circumstances.

It is clearly impossible for teachers to approach HIV/AIDS professionally when the curriculum is already over-burdened with the dozens of other priorities they are expected to address. The pressure to focus on exams also squeezes out teaching on HIV/AIDS. The obvious solution of making HIV/AIDS an examinable subject is also flawed, as this tends to encourage a

scientific rather than a human approach. Fundamental reviews of the curriculum as a whole, and more public debate on the role of education in society are required to focus on this dilemma.

Many teachers reported that they lacked the knowledge and confidence they needed to teach HIV/AIDS. Additional obstacles included a lack of training, gender dynamics, and paucity of resources and support.

It is difficult to respond to these obstacles with in-service training when the whole provision of in-service training is failing in many resource-poor countries. It is equally hard to argue for new learning resources on HIV/AIDS when so many schools lack even basic resources. To deal effectively with HIV/AIDS education, there needs to be an investment in in-service training as a whole and learning materials as a whole.

Deeply ingrained social constraints concerning sex compound these obstacles, manifested in the phenomenon of selective teaching (see above). Moreover, in Kenya, the suitability of teachers as positive sexual role models was questioned, especially with respect to sexual relationships between teachers and students.

Increased resources

A massive injection of financial resources is needed at every level: internationally, nationally, in communities and in schools themselves to ensure that HIV/AIDS is adequately addressed in schools. The education sector must take responsibility for facing the challenge of HIV, working in unison with national AIDS control organisations instead of shifting responsibility. A truly multisectoral response is needed.

Governments in both the South and North must live up to the commitments made at the World Education Forum in Dakar. Specifically, the resource gap must be taken seriously. The latest calculation suggests that an extra \$5.6 billion a year are needed to get all children into school (EFA Monitoring Report 2002). Of this, nearly \$1 billion is needed to respond to the impact of HIV/AIDS. This is probably an under-estimate but it gives a sense of the scale of the challenge.

Too many children out of school

There are estimated to be more than 115 million children out of school worldwide. Of these young people, 56% are girls and more vulnerable to HIV infection (EFA, 2002; UNAIDS, 2002).

The large number of out-of-school children poses difficulties for inclusive HIV/AIDS education simply because significant percentages of young people won't be reached by school-based HIV/AIDS education.

In countries where only a minority of children reach secondary school, school-based HIV/AIDS education will need to start earlier so that most young people are reached. The challenge will be to create age-appropriate learning materials.

Although a truly multisectoral response to HIV/AIDS should reach these out-of-school children through different mediums other than school, this approach also runs the risk of no institution taking adequate responsibility for these more vulnerable youth.

To ensure that all young people are reached by HIV/AIDS education, there must either be a massive increase in the percentage of youth participating in the formal education system and/or schools should seriously consider how HIV/AIDS learning in the classroom could extend back into the community.

Key recommendations

- School-based HIV/AIDS education should start in primary school so as to reach the large percentage of youth who never enter secondary school. Care should be taken to ensure that lessons on HIV/AIDS for primary school students are age appropriate.
- Strategies for feeding school-based HIV/AIDS education back into the community must also target out-of-school youth.
- Headteachers should be targeted, and they themselves be the focus on an educational process, so that they are in a better position to support HIV/AIDS education in schools.
- School must be a safe place for all students, and teachers who sexually harass students, or enter into sexual relations with students, must be openly prosecuted. In order to encourage more open discussion of these issues, students must be guaranteed independent and confidential appeal procedures.
- There needs to be an immediate and significant increase in training for teachers on HIV/AIDS. This training must reach all teachers and must be inserted into all pre-service and in-service training.
- If used in an innovative way, participatory training methodologies can be used to assist teachers in developing the skills necessary to protect themselves from HIV, and act as appropriate role models for young people.
- Teachers should be acknowledged for the non-traditional skills which they gain in training. This could include some form of certification which can be built upon and viewed as a positive career move.
- The potential of national civil society networks to advocate for national prioritisation of HIV/AIDS education must be capitalised upon. These networks must take responsibility to put HIV/AIDS education on the national agenda and provoke open debate, media coverage and public forums.

Appendices

The Stepping Stones approach

The all too common 'ABC' approach to HIV and AIDS consists of instructing people to Abstain, Be faithful and use Condoms. Usually this is accompanied by vigorous dissemination of information about how HIV is transmitted and how it can be prevented, on the false assumption that information leads automatically to behaviour change. Of course access to information and to sexual health commodities such as condoms is important. The mistake is to assume that they are sufficient on their own to bring about change.

What is Stepping Stones and how is it different?

It was from ActionAid's recognition of the drawbacks of the ABC and the information = behaviour change recipes that the Stepping Stones approach was born. First developed in Uganda in 1995, it has since spread to over 2,000 organisations in 104 countries. It is based on the following principles:

The best solutions are those developed by people themselves.

Men and women each need private time and space with their peers to explore their own needs and concerns about relationships and sexual health.

Behaviour change is much more likely to be effective and sustained if the whole community is involved.

The Stepping Stones training manual (A Welbourn, ActionAid, 1995) sets out a series of participatory activities for use in parallel men's and women's workshops, as described later.

How does the Stepping Stones process work?

Rather than concentrating on individuals or segregated 'risk groups', Stepping Stones works in groups of peers of the same gender and similar age (younger women, younger men, older women and older men) drawn from the whole community. The groups work separately much of the time so they have a safe, supportive space for talking about intimate issues, then periodically meet together to share insights. Throughout, they use participatory methods such as songs, games and role plays which are enjoyable and empowering. The process builds on people's own experiences, needs and priorities. It enables the exploration and negotiation which is essential for sustained behaviour change by individuals and communities.

Progression of themes

In order to provide the necessary time and skills to create this ideal brew, the Stepping Stones process goes through a progression of themes. First, time is devoted to developing skills of co-operation and communication. This helps each peer group to bond together and creates a safe, friendly atmosphere in which to explore sensitive issues. The facilitator or trainer of each group should also be of the same gender and age as the members, so that everyone can feel comfortable together as peers. Ideally facilitators come from the same community as the participants. No special expertise is needed, and all activities are designed to be used without the need to read or write.

Next, participants explore facts and feelings about relationships, HIV and safer sex (including but by no means limited to condoms). The men's and women's groups each have a chance to assess their own priorities in sexual

health and family life, in the context of a greater understanding of their potential vulnerability to HIV.

The third set of activities enables participants to understand what influences us to behave the way we do – including, crucially, society's expectations of us as men and women (gender roles), which are often closely tied up with cultural traditions. Involving men in this sort of reflection is key to transforming gender relations and harmful practices. But it is not a directive 'thou shalt not' approach. Participants – male and female – evaluate for themselves the advantages and disadvantages of the factors influencing them. For example, it is not up to facilitators to judge cultural traditions such as wife inheritance, polygamy, initiation and cleansing rites, and so on. Rather, community members are encouraged to question for themselves: what are the benefits of this practice that we want to retain? what are the risks we want to avoid? what alternatives can we devise? Other influences on behaviour, such as the pressures on us to make a living, the use and abuse of alcohol or drugs, and so on, are also taken into account.

Finally, participants explore how to practise and sustain change. The culmination of the process is a special request from each peer group to the whole community, presented in the form of a role play which illustrates the change each group sees as its top priority. The fact that these requests are collectively made, and collectively heard, makes them far more effective than a request by a single individual could possibly be. Men's groups appealing to other men in their community for change – such as reducing alcohol abuse or wife-beating – can have a powerful impact on changing collective norms of behaviour.

Tania Boler/ActionAid



Do the religious leaders oppose AIDS education, giving culture as an excuse? Actually, we teach AIDS education in order to protect our culture only. We have to accept the changing world and accept the changing needs too.

Headteacher, India

The Reflect Approach

Reflect is an innovative approach to adult learning and social change, conceived by ActionAid and piloted in El Salvador, Bangladesh and Uganda in 1993–95.

Groups develop their own learning materials by constructing graphics (maps, calendars, matrices, diagrams) or using forms of drama, story-telling and songs, which can capture social, economic, cultural and political issues from their own environment. The development of literacy and other communication skills becomes closely linked to the engagement of people in wider processes of development and social change.

Today over 350 organisations are working with *Reflect* in 60 countries. ActionAid plays a facilitating role within the International Reflect Circle (CIRAC) which comprises of leading practitioners from diverse organisations around the world. CIRAC promotes the continued evolution of *Reflect* to consolidate learning and develop international publications based on practice.

HIV/AIDS is often a significant issue for analysis in *Reflect* circles, especially in areas where prevalence rates are high. Some *Reflect* practitioners (e.g. in Burundi and Mozambique) have developed special modules to help participants

discuss HIV/AIDS. In Uganda almost any graphic includes reference to the impact of HIV/AIDS, whether participants are discussing an economic, social, political or economic problem. This crosscutting analysis is important as it prevents HIV from being pigeonholed as just a health issue or just a social issue. However, it does depend on facilitators who are confident enough to discuss such issues with their peers. Increasingly it is recognised that facilitator training needs to start with facilitators going through their own intensive learning process.

There has been active interest in developing a fusion of *Reflect* and Stepping Stones (see page XX) for several years. Some initiatives have started to work on this in practice (e.g. in Zimbabwe and India). However, a much larger momentum is now building following a regional workshop in January 2003 hosted by Kenya. A systematic capacity building programme is now planned by Pamoja (the Africa *Reflect* network), bringing Stepping Stones and *Reflect* practitioners closer together.

There are many other developments with *Reflect* from which relevant learning can be drawn for teaching on HIV/AIDS. In Burundi for example, *Reflect* has been used as an approach in mixed circles with both Hutu and Tutsi participants – helping

them to work towards peace and reconciliation. After years of violence the capacity to create a sustained space for people to come together is crucial. Whilst some sensitive issues cannot be addressed head on, for example in the first week or month, the growing trust and confidence within the group enables them to work towards addressing even the most difficult of issues over a one or two year period.

Another relevant example is in Peru where CADEP organised an intensive *Reflect* process with indigenous communities in the Andes, focused on breaking the taboos around domestic violence. Mixed groups of men and women used a range of visualisation processes to break the silence, almost invariably speaking for the first time in public on domestic and sexual violence. An integral part of the process involved the participants producing materials based on their analysis for publication in the local media (local radio and TV adverts, newspaper articles and posters). By creating new private and public spaces for communication between people around domestic violence, other boundaries were also broken, with much more open discussion then developing around gender and power relationships.

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"Training has to be provided. There is a hesitation to teach certain areas. The training has to focus on demolishing such hesitation in the minds of teachers. Our society and the culture are getting destroyed slowly. When there is a war we prepare ourselves. Likewise our houses and the individuals have to be prepared to fight the war against AIDS. This has to reach all teachers."

Cover photographs left to right:

Stuart Freedman/Network/ActionAid
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ActionAid is a unique partnership of people who are fighting for a better world – a world without poverty.

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