HIV and AIDS Preventive Education

A Training Programme for Teacher Educators in Sub-Saharan Africa

Gamsberg Macmillan

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Among the most fundamental of all moral principles is the principle of shared humanity; that every human life has a distinct and equal inherent value. This principle is the indispensable premise of the idea of human rights, that is, the rights people have just in virtue of being human...

Ronald Dworkin *"Terror and the attack on civil liberties"* in the New York Review of Books Vol L No 17 – 6 November 2003, page 38

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PART III

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We also express a word of thanks to the Section for Teacher Education, UNESCO, Paris, for the support extended to our office in building the capacities of teacher educators in our cluster country.

FOREWORD

Education has been identified as a key element in the fight against HIV and AIDS. Without education, people's knowledge about the disease will remain limited, attitudes towards current sexual practices will remain unchanged and the disease will continue to spread unchecked, with increasingly serious consequences for present and future generations.

This Training Manual for Teacher Educators is a response to the challenge of controlling the spread of HIV and AIDS in sub-Saharan Africa.

Teachers are respected members of the community and important role models, especially for young people. They are also, potentially, among the most effective disseminators of information to large numbers of people in a community. Educating teachers, therefore, is a vital step in the attempt to combat HIV and AIDS through changing attitudes and behavioural practices.

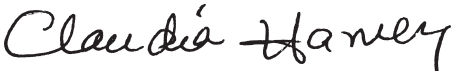
The goal of the training programme offered in this manual is to equip Teacher Educators for their difficult task. It aims to broaden their knowledge about HIV and AIDS, and to help them develop positive attitudes, values, skills and practices related to its prevention and control, which will influence their own lives, and through which they, in turn, will influence the teachers they educate.

In addition to broad coverage of all aspects of HIV and AIDS, this manual offers vital advice and support to programme facilitators, to enable them to achieve the best possible response from participants, thereby increasing the likelihood that what is learnt and experienced will be adopted and passed on.

Peter Piot, Executive Director of the Joint United Nations Programme on AIDS, stated in the Foreword of *HIV/AIDS & education* (UNESCO, May 2003), '...the world's goals in promoting education for all and in turning back the AIDS epidemic are mutually dependent. Without eduation, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach.'

Let this manual be part of a wave of action to '... (turn) back the AIDS epidemic' and ensure that education does not become out of reach for the children of sub-Saharan Africa.

Herewith our gratitude to the participants from sub-Saharan countries at the Windhoek Conference and a special word of thanks to Professor Wally Morrow and the staff of Gamsberg Macmillan Publishers, for their contribution in creating this Manual.



Dr Claudia Harvey

Director: UNESCO, Windhoek

ABBREVIATIONS USED

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (medicine)
BCC	Behaviour Change Communication
EFA	Education for All
HIV	Human Immunodeficiency Virus
HIV-postive	A person who is infected with the Human Immunodeficiency Virus
HIV-negative	A person who is **not** infected with the Human Immunodeficiency Virus
IDU	Injecting Drug User
ILO	International Labour Organisation
LSE	Life Skills Education
MSM	Men having sex with men
NGO	Non-governmental Organisation
OVC	Orphans and Vulnerable Children
PLWA	Person Living with AIDS
S & RH	Sexual & Reproductive Health
SADC	Southern African Development Community
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
SUPs	Standard Universal Precautions
TB	Tuberculosis
TTI	Teachers' Training Institutions
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VTC	Voluntary Testing and Counselling
WHO	World Health Organisation

TERMINOLOGY USED

Condom: A rubber latex sheath worn on the penis during sexual intercourse as contraceptive or to avoid infection. Femidom is the term for a female condom.
Facilitator: The trainer responsible for conducting face-to-face implementation of the training programme.
HIV and AIDS Preventive Education: Education that teaches people how to prevent the spread of the disease by learning about how it is transmitted.
Learning activity: An activity to be engaged in by participants in the programme.
Module: Each consolidated unit of learning (there are eight modules in this programme).
Pandemic: A disease prevalent across an entire country or continent, or over the whole world, as opposed to 'epidemic' which implies limitation to a smaller area. In this programme "the pandemic" refers to HIV and AIDS.
Participants: Learners or trainees in the programme.
Participatory teaching: A mode of teaching which emphasises active learner participation.
Plenary session: A training session during which all participants are together.
Small groups: The different-sized small groups into which participants are divided for various learning activities during the programme.
Task groups: The eight groups of between two and four members each into which participants will be divided, for the purposes of presenting and critiquing the modules.
Teacher education: Both pre- and in-service education of school teachers.
Teacher educator: A lecturer in a College of Education or some other teacher education institution whose main professional responsibilities are the training and education of school teachers.
Training programme: The full five-day course of training.
Training session: Each particular session of the training programme.
Universal Precautions: *Det p 4 ILO booklet*

GENERAL COMMENTS ABOUT THIS PROGRAMME

A. Introduction

The success of any HIV and AIDS Preventive Education programme depends largely on the knowledge, attitudes, values, skills and commitment of its major implementers – classroom teachers. And such capacities can be developed in teacher education courses. But then, teacher educators themselves need to be competent HIV and AIDS Preventive Education teachers.

This training programme has been prepared for use by facilitators in the training of teacher educators in Sub-Saharan Africa, specifically in relation to the profound impact of the HIV and AIDS pandemic on education in this region.

This programme assumes that teacher educators are themselves competent teachers, and this explains the key role assigned to participants in the programme; the facilitator is not seen as the sole "teacher" involved. In addition, this programme is designed in such a way that, apart from stationery and pens, all the material needed for its successful implementation is contained in this manual. Implementing the programme does not require additional equipment or facilities.

This programme is designed specifically for use in the training of teacher educators so that they are better able to train school teachers. However, it can be adapted for use with other target audiences. The optimum number of participants per training session is 25-30.

B. Goals

The goals of this programme are to:

- Train teacher educators in HIV and AIDS prevention and care.
- Help teacher educators analyse basic information, core messages, values and practices related to HIV and AIDS Preventive Education.
- Inculcate a caring and supportive attitude towards those living with HIV and AIDS.
- Encourage the integration of HIV and AIDS Preventive Education in teacher education courses.
- Sharpen the skills of teacher educators in using life skills techniques and participatory teaching strategies.

C. Content

This manual contains the basic facts and information needed in the acquisition of knowledge and the development of attitudes, values, skills and practices related to the prevention and control of the HIV and AIDS pandemic.

The content is presented in terms of modules designed to engage the participants in intellectual activity that makes them try out ideas, express their own feelings and opinions, reflect, and apply critical judgement to what is being studied. The modules aim to provide teacher educators with an experience of engaging in a participatory teaching HIV and AIDS Preventive Education: a Training Programme for Teacher Educators in Sub-Saharan Africa, including the need to discover their own feelings and how to make justifiable professional decisions in the light of the best information available. In addition participants are encouraged, throughout, to consider how what they learn in this programme can be applied in the teacher education programmes for which they themselves are professionally responsible.

The following modules are the spine of this programme:

Module 1 - The global, regional and local impact of HIV and AIDS

Module 2 - Halting the rampant advance of the pandemic

Module 3 - Protecting oneself from HIV infection

Module 4 - The impact of HIV and AIDS and living positively

Module 5 - Working together with the community

Module 6 - Care and safety in institutions such as schools and colleges

Module 7 - HIV and AIDS Preventive Education as part of the curriculum for teacher education

Module 8 - The use of participatory teaching strategies and assessment in HIV and AIDS Preventive Education

Each module is designed as a two-hour contact session to be presented by teams of participants (called Task Groups). The facilitator has an important organising role, but it does not include presenting the modules.

D. Point of View

All teacher educators will know that the content and the methods used in any teaching programme are closely related to each other – they are inseparable. This is a crucial consideration in relation to HIV and AIDS Preventive Education. Content is important but it cannot stand alone; teaching methods are important, but unless they reflect good content, they cannot achieve what they set out to. Content and methods are connected in the point of view from which teaching takes place.

Learning and teaching by doing is the overriding point of view that guided the development of this programme. Silberman (1996) expresses this as the Active Learning Credo:

What I hear, I forget.

What I hear and see, I remember a little.

What I hear, see and discuss, I begin to understand.

What I hear, see, discuss and do, I acquire knowledge and skill.

What I teach to another, I master.

E. Participatory Methods

Thus, this training programme is designed in such a way that it will require a variety of activities from the participants. It sets out to promote learning that reaches beyond the mere accumulation of information, and engages learners at a more than intellectual level.

One word to describe the methods used in this programme is that they are participatory methods.

Teaching is not pouring information into learners' heads, and learning involves a lot more than the mere accumulation of information. But at the same time teaching is not merely trying to elicit the current views of the learners and learning involves more than learners merely expressing their own opinions. Learning that is going to reach forward into the future and influence subsequent attitudes and behaviour is that kind of learning that engages the learners' emotions and background beliefs with well-founded knowledge which is already available.

In addition we have a tendency to understand learning in an excessively individualistic way. Participatory teaching and learning emphasises co-operative learning in which groups of learners approach learning with common objectives and shared resources. They work collaboratively, complementing each other's efforts and encouraging each other.

This training programme should be understood as an example of a participatory approach to teaching and learning. It consists of a sequence of suggestions about co-operative learning activities, related to appropriate resource material. It recommends a variety of activities and a range of resource material, arranged in a sequence that is designed to develop the learners' understanding of the issues of HIV and AIDS Preventive Education in such a way that it has an impact on their contribution, as teacher educators, on the war against the pandemic.

F. Assessment and Feedback

"Assessment" refers to measuring the learning achieved by learners in a programme or course of study; "feedback" refers to a response to something that has been done by someone. In order to progress in their learning, learners need feedback about how successful they have been. In a programme such as the current one feedback has a much more significant role than assessment as such.

Some standard forms of assessment are:

- Knowledge tests, that can be administered before and after instruction to identify an increase in knowledge.
- Attitude scales or inventories that can be used to measure changes in attitude.
- Tests of skills that can be used to determine the effects of instruction on the ability to perform certain behaviour.
- Self-report inventories that can be used to ascertain whether learners regard their views as having changed.

Some standard forms of feedback are:

- The reactions of a person or a group of people to something that has been said or done (often this is no more than facial expression or bodily gestures).
- Verbal responses to something that has been said, done or written. In the context of this programme this will be the principle mode of feedback – and facilitators should themselves provide constant critical feedback and encourage all participants to provide such feedback to their fellow participants.
- Written responses to something that has been said, done or written. This is frequently the most fruitful kind of feedback, as the learner has the opportunity to consider it out of the actual context.

"Critical feedback" is not "negative". It is a well-informed response that enables learners to understand clearly the strengths and weakness of their current understanding and thus to know in which respects they can try to improve.

G. Evaluation of the Programme

There are various kinds of evaluation of the programme which can be used to revise the programme either during the process of implementation or for the next group of participants:

- Process evaluation involves questionnaires or interviews to get feedback from the learners about their responses to the programme and its various components. In this way problems with the objectives, content, strategies or materials can be identified. Process evaluation is evaluation of the educational process.
- Formative evaluation is evaluation that takes place during the implementation of the programme, and can be used to modify the programme to make it more responsive to the prior knowledge, needs and expectations of a particular group of participants.
- Summative evaluation is evaluation conducted at the completion of the programme to determine its effectiveness in achieving its objectives. This form of evaluation is important in revising the programme for subsequent groups of participants.

H. Adaptation of the Programme

The Resource Materials and Activities outlined in this programme might need to be modified if considered inappropriate in particular contexts or in conflict with currently accepted norms in particular countries, areas, or groups of people. In such cases, facilitators should substitute alternative, but relevant, materials and activities.

In considering the adaptation of this programme, it is important to take into view the country's socioeconomic and political environment; culture and tradition; and legislation and policy for the training of teacher educators.

The following factors should specifically be considered:

- The translation of the manual into the appropriate local language.
- Needs assessment.
- Linking and networking with co-operating agencies.
- Planning for continuity and sustainability of the programme.
- Budgetary requirements.

PART I

ADVICE TO FACILITATORS ABOUT CONDUCTING THE PROGRAMME

This part of the manual provides advice to facilitators about how to conduct the programme, Part II contains the modules that form the programme's core, and Part III contains the Resource material.

Part I has five sections:

A. The roles and responsibilities of the facilitator
B. The skills and capacities of facilitators
C. Some advice about the sessions the facilitator needs to conduct
D. The tasks of the Task Groups
E. Appendices

APPENDIX A	Registration form
APPENDIX B	Suggested timetable for the five-day programme
APPENDIX C	HIV and AIDS Self-report form (1st copy to be used at the start and 2nd copy at the end of the programme)
APPENDIX D	Mind-setting (Learning Activity 1 & 2)
APPENDIX E	Participatory methods of teaching/learning
APPENDIX F	Module critique form
APPENDIX G	Programme evaluation questionnaire
APPENDIX H	Certificate of Satisfactory Participation

A. The roles and responsibilities of the facilitator

The facilitator carries the overall responsibility for the success of the implementation of the programme. This includes the planning, organisation, implementation, monitoring and evaluation of the programme, and ensuring that a co-operative climate is maintained throughout. Specifically the facilitator needs to do the following:

Before the programme begins:

- Study the modules in Part II and all of the Resource Material in Part III, and consider whether there are any confusions or other difficulties which can be cleared up in advance.
- Read the paper by Michael Kelly and the UNAIDS pamphlet with care and be very familiar with their contents and arguments.
- Study the timetable (see Appendix B) carefully, and modify it in the light of local conditions (times of starting, ending, length of sessions, etc.) and the expected participants.
- Design a sequence of four one-hour workshops relevant to the pandemic, HIV and AIDS Preventive Education, and Teacher Education.
- Ensure that the venue is available for the duration of the programme.
- Find out what facilities and equipment are available at the venue, and ensure that there is enough stationery and other material.
- Make whatever arrangements are needed for meals, other refreshments and, perhaps, accommodation.
- Prepare a daily attendance register – and a Certificate of Satisfactory Participation (refer to Appendix H) for participants who attend **all** the sessions in good time.

- Make two copies of the HIV and AIDS Self-report (see Appendix C) for each participant – one will be used at the start of the programme (pre-test), and one at the end (post-test).
- Ensure you have copies of all the material you need for the programme – including multiple copies of those materials needed by the participants.
- Acquire information about the local impacts of the pandemic, and the names of three or four local people who might be available to contribute in Module 5 – or in some other ways.

B. The Skills and capacities of facilitators

As a facilitator you should demonstrate the following:

Developing and supporting a sense of group spirit

- It is important that, as the facilitator, you build and maintain the group's identity by establishing an atmosphere of mutual trust and respect. This means that the training environment will be warm and allow participants to express their views, opinions and concerns. Let the participants experience your enthusiasm, friendliness, interest, sincerity, acceptance and support.
- In order to support the group spirit throughout the training programme you will be required to do the following:
  - Encourage participants to share some information about themselves with the group.
  - Let participants establish a set of rules of conduct that can be used throughout the training.
  - Support and provide positive, constructive feedback to the participants.
  - Build and maintain a sense of belonging among participants.
  - Express the need for confidentiality within the group. It is important for participants to feel that what they say will not be used against them outside the training session.
  - Let each person participate at his/her own pace. Encourage participants to express themselves but do not push those who need time to be comfortable with the group or environment.
  - Respond to criticism openly and make every attempt to obtain an agreement of all parties involved. Explaining why something has been done in a certain way often settles concerns.
  - Notice participants' suggestions, responses, feelings and questions. Previous knowledge or curiosity can be used as a starting point for subsequent learning.
  - Be sensitive to the group's needs. Every group will have a unique collective personality with different assets and needs.

Ensuring that the intended content is covered

It is important that the material in all the training modules is covered effectively for participants to subsequently, be good facilitators themselves. This will require that you help the group stay focused on the task. For this, you will need to do the following:

- Link each new topic with previous topics and with real-life examples. Not only will this make sessions more interesting, but new knowledge will also help develop a better overall understanding of the topic rather than accumulation of isolated facts.
- Ask questions that encourage thought of the task at hand. Avoid questions requiring "yes/no" answers.
- Give clear, specific instructions for all activities. Confusion about expectations will distract the participants from the issues of importance.
- Keep the focus on the content of the session. Politely attempt to keep off-topic conversations confined to tea and lunch breaks.
- Synthesise knowledge at the end of each session. Conclude sessions by restating the themes covered and by integrating the suggestions and ideas that arose, into the overall programme.

Modelling effective facilitation skills

The participants will need to use the facilitation and communication skills you exhibit during the training programme in future training sessions that they will conduct. It is therefore important to demonstrate effective facilitation skills throughout the training programme. Your behaviour as a facilitator will present the participants with a model to observe and evaluate. Be consistent in what you say and do.

SOME IMPORTANT FACILITATION SKILLS

The ability to encourage discussion:

This can be achieved by:

- Asking open-ended questions that require a thoughtful response and/or guide the discussion in a particular direction.
- Ensuring that all participants feel their participation is welcome and desired.

The ability to listen carefully:

Several tools can assist you in this:

- Restating a participant's contribution will clarify your understanding of his/her statement.
- Listening for the content and attitude of a message.
- Supporting a participant's contribution. This does not mean that you must agree with the participant, only that you respect his/her position.

The ability to deal with silence:

Sometimes silence can be a helpful stimulus. Don't rush to cover it up.

The willingness to allow the group to make their own decisions:

Facilitation is not dictation. The participants must be allowed to take responsibility for their own learning if it is to be meaningful to them.

Handling Training Problems

Successful group facilitation requires practice. Many situations will arise during a training programme that an experienced facilitator will be able to handle tactfully and effectively. Nobody can expect to be a successful facilitator overnight, but dealing with the following situations effectively will help your training session run as smoothly as possible.

1. A participant wants to agree with you.

This can be a positive sign as it shows that participants feel comfortable expressing their own points of view. By allowing discussion of opposing opinions you are allowing people to think critically about what they are expected to learn. This is a very profitable teaching/learning tool as long as each side respects the other's opinion, even if their beliefs remain unchanged. However, some participants will argue merely for the sake of arguing. Although this trait can be useful to a group discussion, it can become tiresome and time-consuming and you should tactfully try to control this behaviour to maintain focus and proper decorum.

2. The group looks bored.

You may need a change of pace, a change of venue, a change of topic, or simply a break. Some questions you can ask yourself include:

- Have I been using the same teaching techniques for too long i.e. too many lectures or too many large group activities?
- Have I made some connection between my topic and the participants' lives?

- Have I been repeating material?
- Have I been enthusiastic enough, or too enthusiastic? Is the venue suitable, e.g. too big or small, too hot or cold?
- Are there circumstances outside the session that are influencing the behaviour of the group, e.g. jetlag, peer relations, workplace stress?

3. Nobody is answering your questions.

Here are some questions to ask yourself to solve this problem:

- Am I speaking loudly or clearly enough for the group to understand me?
- Do my questions require thought to answer i.e. "How" or "Why" questions requiring "thought", "opinion" or "beliefs"?
- Am I waiting long enough for a response? Many participants will take time to think about the questions and carefully formulate an answer before volunteering their answer.
- Is the group focused on the discussion at hand?

4. Some participants do not seem to be involved in the discussion.

Some people are naturally quiet. They may be embarrassed to speak in front of a group or they may simply be learning from what others are saying. Do not confront them with specific questions if they do not appear ready to respond. However, offer them the opportunity to add their opinions or feelings when the chance arises.

5. Some participants are monopolising the discussion.

Some participants will naturally answer questions more quickly and more often than others. While their responses can be valuable for their content and for sparking responses by the rest of the group, their frequent outputs can also cause others to feel left out or unable to contribute. It is your responsibility to ensure that less assertive participants have the opportunity to make contributions by expressing their views. You may have to discreetly ask overzealous participants to delay their responses until others have had a chance to make their contributions.

6. The group takes over the discussions.

This is not a problem if the discussion is proceeding productively. Instead it shows you have stimulated interest in the topic and participants feel comfortable expressing themselves. Take a seat, listen carefully, and enjoy your time out of the spotlight. Knowledge and ideas developed by the group are more valuable than those given in a lecture.

7. Private conversations erupt.

Try to develop eye contact with, and move closer to, the participants who are having private conversations. These simple cues should be enough to eliminate off-topic conversations. However, RESPECT PRIVACY and do not attempt to overhear private conversations. Encourage these participants to share their views with the rest of the group.

8. Two or more participants are arguing.

Do not choose sides! Attempt to paraphrase the position of each side to ensure that they understand what the other is saying. Sometimes two people with the same position will argue simply because they are not making the effort to hear the other. Ask the group for their input but ensure that arguments are based on reason rather than opinion.

9. You encounter resistance.

You need to find the reason behind the resistance. Understanding the reason will help you to make adjustments to solve the problem.

C. Some advice about the session the facilitator needs to conduct

DAY 1

Opening session

In this session you need to:

- Welcome all participants.
- Clarify all arrangements for the programme – especially the timetable (see Appendix B), meal arrangements, etc.

Setting up and briefing the Task Groups

- Divide participants into eight Task Groups of roughly equal size.
- Each Task group will have two main tasks in the programme and the success with which they carry out these tasks will be a key to the success of the programme.
- The roles and responsibilities of the Task Groups must not be confused with the other groupings set up during the activities of the Modules.
- Task Groups must make their preparations during the programme but in good time before the scheduled time of the Module (evenings are good times for these preparations).
- The facilitator's job will be to enable the Task Groups to do their work well – without trying to control what they do. (Remember they are all teacher educators.)

Orientation and Mind-Setting

- This activity is crucial in the programme because you need to rapidly overcome many deeply embedded inhibitions about talking in a group about intimate matters of sexuality. Sometimes this kind of session is described as an "ice breaker"; in this case it must operate as a major thaw. You need to create a climate in which participants feel free enough to talk about things usually hidden under the blanket, using words they normally use only amongst their most intimate friends.
- There are two activities (see Appendix D) which you can use in this session, but you might be able to think of more effective activities.
- The main purpose of this session must be to create a climate of inclusiveness and active participation for the whole programme to follow.
- Your manner in this session will make an important difference to whether the programme achieves what it sets out to.
- Remember that the participants are all teacher educators – respect them as such, and encourage them to bring their knowledge and experience into play during the programme.

DAYS 2 - 4 WORKSHOPS

There are four one-hour sessions available for these workshops and the facilitator should have available a sequence of possible activities and material relevant to the pandemic, HIV and AIDS Preventive Education and teacher education. These workshops should be designed so that they are particularly relevant to local conditions (if available, statistics about the pandemic in the particular country region or city – especially if they show the figures over several years – might prove useful). Perhaps there could be a discussion with people living with AIDS (PLWAs), children from the local school, or the superintendent of the local health clinic. The facilitator should try to design activities that provide variety in the programme and are flexible enough to be changed at short notice – if, for example, the discussion in one of the Module presentations really "takes off" and deserves more time to take it in the direction in which it is moving.

DAY 3

Plenary discussion on the Paper by Michael Kelly "Defeating HIV and AIDS through education"

- Clearly you need to have read this paper extremely closely so that you are very familiar with its arguments.
- In this session you need to set up a structure for an illuminating discussion about this paper – this is not a lecture.
- Use a light hand. Set up the structure by posing two or three questions that take participants into a closer engagement with the paper, but be willing to abandon the structure if they themselves take the discussion in a fruitful direction.

DAY 4

Plenary discussion on HIV and AIDS & Education – a strategic approach

- The same kinds of considerations as above apply here.
- In this case the text is longer and it will take longer for you to study it productively.
- Participants will have read this text on the previous evening but you need to prepare a few thoughts about how to set up a structure for the discussion.
- If participants raise issues which capture attention, let the discussion flow.
- Remember to continually emphasise that this is a plenary discussion and needs to involve the whole group – part of your responsibility is to prevent side conversations from emerging.

DAY 5

Plenary discussion about the programme

- The purposes of this discussion are to provide participants with the opportunity to reflect critically on the eight Modules, and to think about how they are going to carry into their professional activities what they have learnt here.
- In reflecting about the Modules, ask participants to think of them in terms of their content and procedures as recommended in this manual, rather than about the particular ways they were presented on this occasion. The point of this reflection is for participants to imagine whether they could use these Modules in teacher education programmes for which they themselves are responsible.
- In regard to the second purpose, you could ask participants each to jot down what they think they can do in the next few weeks in their own professional (teacher education) activities. The point is to try to prompt them to think in a practical way about what they have learnt from this programme.

Closing Session

- Begin by asking participants to complete the HIV and AIDS Self-report form (Appendix C) and then collect them.
- Ask participants to think about the overall design of the programme, especially the sequencing and relationships between the Modules.
- Give them about five minutes to complete the Programme Evaluation Questionnaire (Appendix G) and to do so as honestly as possible, then collect them.
- Finally, thank all for their contributions to the programme, and wish them well as they go out into the world to help fight the pandemic.

D. The tasks of the Task Groups

- Divide the participants into eight Task Groups (called A-H below). Each Task Group should have between two and four members (depending on the overall number of participants). Each Task Group will be assigned two major tasks for the programme. The first task will be to study one of the Modules in advance, and plan how to present it in a particular session. They will be responsible for the organisation and arrangements for that session. The second task will be to critique a (different) module.
- In briefing the Task Groups the facilitator should emphasise that the Modules as currently designed are not a rigid prescription, and are not the only way they could be designed. Provided they can maintain the central focus of each Module, the Task Groups should be encouraged to use their own initiative and professional judgement. A Task Group might, for example, decide to have two rather than four learning activities in a particular case – because the time for the activities is, in their judgement, too limited. A Task Group might also have other resource material available, more suitable to the given context, etc.
- For each Module, there are suggested small group activities of various kinds. Task Groups should think about ways to set up groups so that they do not have constant membership.
- The second task of each Task Group (Critiquing a Module) should be both a critique of the particular way the Task Group conducted the Module (their manner, the extent to which they depart from the suggested Module, etc.) and of the outline, learning activities and resource material found in the manual. (See Appendix F – which should be treated as a guide rather than a recipe).
- The "critique" needs to be in the form of a short report that is to be given to the facilitator who needs to retain it, and who might refer to it in workshops, in the concluding session, or at other times.

First task – Study and present the following modules

GROUP	MODULE	TOPIC
A	1	The global, regional and local impact of HIV and AIDS
B	2	Halting the rampant advance of the pandemic
C	3	Protecting oneself from HIV infection
D	4	The impact of HIV and AIDS and living positively
E	5	Working together with the community
F	6	Care and safety in institutions such as schools and colleges
G	7	HIV and AIDS Preventive Education as part of the curriculum for teacher education
H	8	The use of participatory teaching strategies and assessment in HIV and AIDS Preventive Education

Second task – Critique the following modules

GROUP	MODULE	TOPIC
A	4	The impact of HIV and AIDS and living positively
B	5	Working together with the community
C	6	Care and safety in institutions such as schools and colleges
D	7	HIV and AIDS Preventive Education as part of the curriculum for teacher education
E	8	The use of participatory teaching strategies and assessment in HIV and AIDS Preventive Education
F	1	The global, regional and local impact of HIV and AIDS
G	2	Halting the rampant advance of the pandemic
H	3	Protecting oneself from HIV infection

E. Appendices

Each participant in the programme needs to have a copy of each of the folllowing Appendices:

Title	Revised numbering	Notes	pp	Check
A Registration form				
B Suggested timetable for the five-day programme				
C HIV and AIDS Self-report				
D Mind-setting				
E Participatory methods of teaching/learning				
F Module critique				
G Programme evaluation questionnaire		Pages to copy		

Note: Appendix H Certificate of Satisfactory Participation is handed to participants after full attendance of **all** sessions.

APPENDIX A

REGISTRATION FORM

Name (print):	Sex:
Designation:	
Complete Office Address:	
Telephone:	Fax:
E-mail:	
Complete Home Address:	

_____

Signature

_____

Date

SUGGESTED TIMETABLE FOR THE FIVE-DAY PROGRAMME

Time	Day 1	Day 2	Day 3	Day 4	Day 5
09:00 - 11:00	Registration and Self-report (Pre-test) Opening Session	MODULE 2 Group B to present Group G to critique	MODULE 4 Group D to present Group A to critique	MODULE 6 Group F to present Group C to critique	MODULE 8 Group H to present Group E to critique
11:00 - 11:15	Break	Break	Break	Break	Break
11:15 - 12:15	Setting up and briefing Task Groups Orientation and Mind-Setting	WORKSHOP 1	Plenary discussion: Kelly "Defeating HIV and AIDS through education"	Plenary discussion: HIV and Aids education – a strategic approach	Plenary discussion: Critical review of the eight Modules. What can we carry away from this programme?
12:15 - 13:30	Lunch	Lunch	Lunch	Lunch	Lunch
13:30 - 14:30	Task Groups begin to prepare presentations and critiques	WORKSHOP 2	WORKSHOP 3	WORKSHOP 4 (designed by facilitaror)	Self-report (Post-test) Programme Evaluation Closing Session
14:30 - 14:45	Break	Break	Break	Break	
14:45 - 16:45	MODULE 1 Group A to present Group F to critique	MODULE 3 Group C to present Group H to critique	MODULE 5 Group E to present Group B to critique	MODULE 7 Group G to present Group D to critique	
Evening	Task Groups prepare presentations and critiques	Read before Day 3: MJ Kelly "Defeating HIV and AIDS through education"	Read before Day 4: HIV and AIDS & education – a strategic approach		

Note: The time allocated to each module can be made flexible to meet the needs of differing situations.

APPENDIX C

HIV AND AIDS SELF-REPORT

Please complete both Part I Knowledge and Part II Attitudes and hand to the facilitator.

Name: _____

Address: _____

Name of Institution: _____

Date: _____

Part I – Knowledge

Directions: Put an X on the letter of your answer after each number.

A = Agree D = Disagree N = Not sure

Example: AIDS means Acquired Immune Deficiency Syndrome X D N

	A	D	N
1. HIV means Human Immunodeficiency Virus			
2. There is a high HIV/AIDS risk for intravenous drug users who share needles/syringes			
3. A person can be infected with HIV by donating blood			
4. A person with AIDS should be avoided			
5. Sex with multiple partners is a risk factor in HIV and AIDS			
6. HIV weakens the body's natural defence against infections			
7. Persons with HIV and AIDS should remain anonymous			
8. AIDS is a "gay disease" because it occurs ONLY amoung MSM			
9. The law should protect HIV-positive people against discrimination in the workplace			
10. HIV can spread if an HIV-positive person shares cups, plates or personal things			
11. HIV and AIDS is not a problem among out-of-college youth			
12. Preventive education in HIV and AIDS should be undertaken only at college level			
13. False information about HIV and AIDS can cause unnecessary fears			
14. There is a self-instruction kit that can determine if a person is infected with HIV			
15. HIV is spread by mosquito bites and other insect bites			
16. A person with full-blown AIDS always looks sick and weak			
17. At present there is no cure for AIDS			
18. AIDS is a fatal disease associated with a specific virus type			

	A	D	N
19. AIDS is a preventable disease			
20. People in the rural areas should NOT be concerned about HIV and AIDS			
21. Persons with HIV should not be recruited in the military			
22. HIV is passed from mother to foetus via the placenta			
23. Drug abuse contributes to vulnerability to HIV and AIDS			
24. Poverty and ignorance make people more vulnerable to HIV			
25. Persons with HIV should not be allowed to serve as peer educators			
26. AIDS patients should be isolated as a preventive measure			
27. Responsible sexual behaviour is a way to stop the spread of AIDS			
28. With AIDS, HIV has invaded the immune system,making it unable to function normally			
29. The “window period” is when the body shows no signs of the disease			
30. Media and policy-makers should support the campaign against HIV and AIDS			
31. Persons who have multiple sexual partners are at greater risk of getting HIV			
32. Many doctors and nurses caring for AIDS patients eventually contract HIV			
33. One can get AIDS by hugging or shaking hands with an infected person			
34. Retired people do not get HIV and AIDS			
35. Treatment of HIV and AIDS is definitely expensive			

Part II – Attitudes

Directions: Put a circle on the number of your correct answer using the following continuum:

1 - Strongly disagree
2 - Disagree
3 - Undecided
4 - Agree
5 - Strongly agree

Example: We should discuss HIV and AIDS in teacher education 1 2 3 4 (5)

Item					
1. We are all vulnerable to getting HIV and AIDS	1	2	3	4	5
2. People have changed their feelings about HIV and AIDS in the past years	1	2	3	4	5
3. We should be afraid to meet PLWAs	1	2	3	4	5
4. We should NOT allow students with HIV and AIDS to go to our colleges	1	2	3	4	5
5. Media have created an unnecessary fear of AIDS	1	2	3	4	5
6. Familes of AIDS patients should leave their care to the government	1	2	3	4	5
7. We should support activities for the benefit of AIDS patients	1	2	3	4	5
8. We should discuss HIV and AIDS with our families	1	2	3	4	5
9. PLWAs should be allowed to attend public gatherings	1	2	3	4	5
10. Public money should be used for treatment and care of PLWAs	1	2	3	4	5
11. Our society is affected by problems related to HIV and AIDS	1	2	3	4	5
12. We should be willing to care for family members infected with HIV	1	2	3	4	5
13. We can predict that HIV and AIDS trends will go up in the coming years	1	2	3	4	5
14. We should be angry with people who look down on persons with AIDS	1	2	3	4	5
15. Abuse of alcohol and drugs can contribute to the spread of HIV and AIDS	1	2	3	4	5

*** Thank you for your contribution to the programme! ***

APPENDIX D

MIND-SETTING
LEARNING ACTIVITY 1 – GETTING TO KNOW YOU

Approximate time:	20 minutes
Materials:	1. Nametags and felt pen
	2. Cards for "Information about Me"
	3. List of descriptive adjectives (see below)
Preparations:	1. Cut cards for nametags
	2. Cut cards for "Information about Me"
	3. Prepare a list of descriptive adjectives

Introduction

It is said that the name of a person is the sweetest music to his/her ears. At the very start of the training, you should know the names of the participants and use their names as often as you can. Perhaps it will help you to remember them faster if descriptive adjectives are added to their names. Getting to know each other promotes team-building and creates a spirit of cooperation.

Objectives

After participating in this activity, the facilitator and participants should be able to:

1. Identify as many trainers and participants as they can in the training.
2. Share some information about themselves with others.

Content

1. Names of facilitators and participants with descriptive adjectives.
2. Information about themselves.

Procedure

1. Provide participants with nametags and ask them to write their 1st and 2nd names in large letters. The facilitator should also wear a nametag.
2. Ask participants to complete the "Information about Me" card, filling in two adjectives to describe themselves using the first letter of their names. Example: Barasa Asekenye could be Bouncy Barasa and Alert Asekenye.
3. Participants should also add information such as what are they best at, their favourite food and how they see themselves ten years from now.
4. Ask the participants to form two lines and face each other.
5. Invite each participant to introduce him/herself to the person in front. Let them introduce themselves using their nametags and their answers to the "Information about Me".
6. Ask them to meet the next person in front and continue introducing themselves.

7. Ask them to go back to their seats and ask for volunteers to name five participants.

Learning outcomes

1. Name as many participants or all participants towards the end of the session.
2. Introduce some participants using their descriptive adjectives and information about them.

Examples of adjectives to describe YOU!

Able Abreast Accepting Accommodating Accomplished Active Adaptable Affectionate Affluent Ageless Agreeable Alert Aloof Ambitious Analytical Apolitical Artistic Aseptic Awkward

Bankable Beautiful Bejewelled Biographical Blue-blooded Blunt Boisterous Bold Bouncy Brilliant

Careful Capable Caring Celestial Charitable Chivalrous Classic Colourful Complex Complicated Conservative Courteous

Dainty Daring Deadly Defiant Dense Difficult Distinctive Diplomatic Distinguished Durable Dynamic

Earthly Easygoing Ecstatic Efficient Elaborate Enthusiastic Episodic Equivocal Evasive Excellent Extreme

Fabled Faithful Famous Fantastic Fashionable Fluent Fortunate Friendly Funny

Generous Genial Gentle Gifted Glamorous Good Graceful Gracious Grand Graphic

Happy Harmless Hasty Healthy Heavy Helpful Holy Honest Humble Hungry

Immaculate Important Impressive Indifferent Industrious Informal Innocent Intelligent International

Jealous Jolly Jubilant Judicial

Keen Kind Knowledgeable

Large Last Late Lavish Lawful Liberal Light Little Lively Lovable Lovely Lucky

Magical Martial Masterful Mature Meaningful Mighty Mild Modest Motherly Muscular Musical Mysterious

Naïve Natural Naughty Neat Neutral Nice Noble Non-partisan Nostalgic Numerical

Obedient Objective Obliging Observant Old-fashioned One-sided Open-minded Optimistic Original Overconfident

Pale Passionate Patient Peculiar Perfect Personal Physical Pious Pleasant Polite Popular Private Profound Prompt Proper Pure

Quaint (Cute) Quiet

Radiant Radical Rapid Rare Rational Ready Real Refined Regular Relevant Reliable Reluctant Remote Responsible Rich Rural

Sad Sarcastic Scientific Seasoned Secretive Selective Sensitive Sentimental Serious Sharp Shrewd Shy Silent Simple Small Smooth Sociable Special Strong Successful

Tactful Talkative Tender Terrible Thin Thoughtful Thrifty Tiny Tolerant Tough Traditional

Ultimate Unconditional Undecided Uneasy Unexpected Unfair Unforgettable Unusual Unwilling Urgent Usual

Vague Vain Versatile Vicious Victorious Violent Virtuous Vivid

Warm Wary Wealthy Weary Wholesome Wise Witty Wonderful Worthy

Young Youthful

Zealous Zigzag

MIND-SETTING
LEARNING ACTIVITY 2 – KEEP ON LEARNING (EXPECTATIONS FROM THE TRAINING)

Approximate time	:	30 minutes
Materials	:	Flip-chart sheets and pens or blackboard and chalk
Preparations	:	Write on top of 2 flip charts: 1. Expectations 2. New ideas and skills

Introduction

Life is a continuous process of learning. We already know many things but can learn new things if we keep an open mind. We continue to learn from others. In this training what do you want to learn? What are your expectations?

Objectives

After participating in this activity, teacher educators should be able to:

- List their expectations from the training.
- Identify new ideas or skills they want to learn.

Content

1. Expectations from the training
2. New ideas and skills

Procedure

1. Divide the big group into small groups of five members and let them choose a leader in each group.
2. Ask two or three small groups to brainstorm and list what new ideas and skills they want to learn.
3. After 3 - 5 minutes ask the leader of each group to move to another group and compare their lists, then to add the other expectations, ideas and skills to the list.
4. After moving to two or three groups, ask the leaders who have the "master lists" to read them.
5. Paste the "master lists"under the appropriate flip-chart papers. Keep the list pasted during the training. You may want to refer to them later on.

Learning outcomes

1. Listing of expectations from the training
2. Listing of new ideas and skills

APPENDIX E

PARTICIPATORY METHODS OF TEACHING/LEARNING

All training methods in which the participants learn by active interaction with others are called Participatory Learning Methods. In the Training Modules, you will find many different examples of Participatory Learning. The Methods can be divided into three types: small group activities; role plays; and games and simulations. Listed here are some of the advantages and disadvantages of Participatory Methods of Learning as well as some helpful hints for the facilitator in using these methods.

Advantages of Participatory Methods of Teaching/Learning include:

1. Active involvement of many group members i.e., promote critical thinking and learning through experience.
2. Meaningful participation in a low-risk, non-threatening environment.
3. Personal interaction between participants.
4. Opportunities for participants to teach, and learn from, each other.
5. Interesting and enjoyable ways to learn.
6. Understanding the views of others.

Disadvantages of Participatory Methods of Teaching/Learning include:

1. High time consumption.
2. Focus can easily be lost.
3. Frustration if instructions are not clear.
4. Unintended results not reflecting learning objectives.

Tips for successful Participatory Teaching/ Learning:

1. Don't be afraid of a little noise – it is often a sign of involvement.
2. As far as possible, avoid constraining activities to a strict time-frame.
3. Refocusing – the trainer should help participants to refocus if they deviate from the topic.
4. Encourage shy learners to participate.
5. Enjoy yourself – your enthusiasm will be contagious.

APPENDIX F

MODULE CRITIQUE

Module number : _____
Module name : _____
Critics : _____ & _____

Of Group : _____

A Critique of the Presentation

Date of Presentation : _____ Time of Presentation: From ___to ___
Module presented by Group : _____

1. Did the presenters modify the original? (If 'yes', indicate in what ways)

2. Did they sustain the interest of the participants?

3. Did the Module have a clear and definite message?

4. What were the strongest and weakest aspects of this presentation?

   Strongest

   Weakest

5. What advice would you give the presenters about how they could improve the presentation?

B Critique of the Module as such

6. Is the Module conceptually coherent (i.e. does it have a strong internal unity)?

7. Does the Module provide for effective learning?

8. Is the Resource Material adequate and relevant to the main purpose of the Module?

9. Would this Module be suitable in a teacher education programme?

10. How can the design of this Module be improved?

APPENDIX G

PROGRAMME EVALUATION QUESTIONNAIRE

Name (optional) _____ Sex _____

Training venue _____ Date _____

Dear Participant

Please respond to this programme evaluation questionnaire. Your frank and honest answers will help us make changes to improve the quality and relevance of the programme for future participants.

Part I

Please rate the following aspects of the programme by checking the appropriate column and using the five-point scale below:

1. Poor
2. Fair
3. Satisfactory
4. Very good
5. Excellent

Aspect	**Rating**				
1. Organisation of the training activities	1	2	3	4	5
2. Relevance of the objectives/materials	1	2	3	4	5
3. Appropriateness of topics	1	2	3	4	5
4. Co-operation of participants	1	2	3	4	5
5. Performance	1	2	3	4	5
6. Communication among participants, trainers and staff	1	2	3	4	5
7. Quality of training outputs	1	2	3	4	5
8. Amount of work participants put into the training	1	2	3	4	5
9. Training facilities	1	2	3	4	5
10. Food services	1	2	3	4	5

Part II

Please answer these questions frankly

1. Name five aspects of the programme you found most satisfying? Rank them.

2. What do you think was the weakest part of this programme? Please explain.

3. Which Module did you find most useful? Please explain.

4. Which Module did you think was the weakest? Explain your answer.

5. What improvement could you suggest for future training?

*** Thank you and have a safe trip back home! ***

APPENDIX H

HIV and AIDS Preventive Education

This is to certify that:

_____

Participated satisfactorily in the

HIV and AIDS Preventive Education
Training Programme
for Teacher Educators
in sub-Saharan Africa

Which took place at …….

On ……

Signed _____

Facilitator

Date _____

PART II

THE MODULES

This part of the programme contains an outline of the eight Modules, and the Learning Activities that are built into them.

Like all teaching guides or textbooks the Modules have been designed by those with particular views about teaching as the practice of organising systematic learning. Such views, as is always the case, are based on generalised understanding of the context of teaching and generalised views about the interests and current competence of learners.

Thus, these Modules are not considered prescriptive, and they should be used as guidelines rather than recipes. Task groups and facilitators should feel free to adapt them to local circumstances, and the specific characteristics of the participants on any particular occasion.

Introduction

The following is a list of the eight Modules and their titles. They form the central core of this training programme. The titles themselves are of some significance as they indicate the central thrust of each Module, the principle of relevance in terms of which the Learning Activities have been designed, and the Resource Material that has been selected.

1	The global, regional and local impact of HIV and AIDS
2	Halting the rampant advance of the pandemic
3	Protecting oneself from HIV infection
4	The impact of HIV and AIDS and living positively
5	Working together with the community
6	Care and safety in institutions such as schools and colleges
7	HIV and AIDS Preventive Education as part of the curriculum for teacher education
8	The use of participatory teaching strategies and assessment in HIV and AIDS Preventive Education

The sequence of these Modules (the order in which they are listed above) is not arbitrary. It is designed to foster a systematic growth of understanding. For this reason, it is a good idea for the Modules to be presented in the given sequence.

Each Module is designed for two hours of face-to-face work, but the relevant Resource Material should be available to participants in advance so that it is possible for them to read it before the face-to-face session begins. In the pages that follow, the Modules are outlined according to a standard template, which identifies the Module, provides a slightly fuller description of what it is about, and lists the Learning Activities and Resource Material it incorporates. The standard template for the Module outlines is contained on the next page.

MODULE —	
Number	The module number
Title	**The title of the Module**
Use of time	Time management is vital in teaching; the teacher needs to avoid spending too much time on what is, in fact, a relatively minor issue, thereby short-changing the main issues. In the outlines, recommendations are made about the most effective use of the two hours of face-to-face time available for the Module. However, as in the case of other aspects of these outlines, presenters might, in the light of their situated professional judgement, use the available time differently. In addition, critical discussion is central to good teaching – if a discussion "takes off" during the session, presenters should be prepared to be flexible in the use of time.
Main message	This is an attempt to capture in a single sentence or paragraph the main thrust of the Module.
Overview	In this section there is a further elaboration of the content of the Module, and the main learning it is trying to foster.
Objectives	Flowing from the previous two sections, this tries to specify (in semi-behaviourist terms) what participants should be able to do after this Module.
Content outline	This lists the main elements of the content of the Module outline.
Learning Activities	This is a list of the Learning Activities of the Module – with an indication of activities, group sizes (small groups, pairs, individuals, plenary) that are involved in each, and which Resource Material needs to be used in the activity. Learning Activities are indicated as follows: the first number is the Module number; the letter following it is the letter of the Learning Activity (e.g. "Learning Activity 1A" is the first Learning Activity of Module 1).
Material	This indicates the Resource Material (see Part III) to be used. The Resource Material is numbered using the following convention: the first figure is the Module number, and the figure after the point is the number of that portion of Resource Material (e.g. "Resource Material 5.3" indicates the third item or Resource Material for Module 5).
Feedback	This is not always completed. While assessment might be important in the case of some sets of learners, with the target learners of this programme (all perceived as teacher educators), "feedback" is much more relevant than "assessment", the former of which is usually a concluding, summarising discussion – which a participant is in as good a position as the facilitator or Task Group, to provide.

The descriptions of the Learning Activities are provided after each Module outline. Each Learning Activity is described in terms of a standard template, as follows:

LEARNING ACTIVITY _	
Title	**The title indicates what the activity is about**
Approximate time	This is the expected amount of time to be spent on this activity.
Material	Listed here are the materials needed for the activity – sometimes the material is simply the relevant Resource Material, but sometimes there is additional material – such as paper or pens. Presenters of the Modules need to make prior arrangements to ensure that the relevant material is available at the time it is needed.
Grouping	This indicates the recommended grouping for this activity. Sometimes it is three or four small groups, pairs or individuals, and sometimes it is plenary. The presenters of the Modules need to consider the availability of suitable physical spaces in cases where the plenary breaks up into small groups for a particular activity.
Introduction	This provides a brief indication of what could be said in introducing the activity.
Main purpose	This is an attempt to express what the main purpose of the activity is – it should align closely with the main purpose of the Module of which the activity is an element.
Procedure	This outlines a step-by-step procedure for how the activity should be conducted. Presenters of Modules need to be quite clear about the procedure – the discipline and orderliness of the whole Module session is heavily dependent on clarity at this level. The participants themselves need to know what the procedure is, and what they need to accomplish by the end of the activity.

The success of the Modules rests on three aspects:

1. The quality of the preparation made by the presenters.
2. Good management during the presentation of the Module – the proceedings must be orderly with appropriate time for the various activities, and participants must be quite clear about what they are expected to do at any particular time.
3. The style of the presenters – is it laboured and heavy (like most traditional classroom teaching) or is it light and disciplined yet flexible? The style of the presenters is directly related to the enjoyment of the participants, and therefore to the success of the learning that will be achieved.

Good luck!

MODULE 1

Number	**1**
Title	**The global, regional and local impact of HIV and AIDS**
Use of time	10 mins Facilitator's Introduction 15 mins Task Group Introduction 45 mins Activity 1A 30 mins Activity 1B 20 mins Feedback and wrap-up
Main message	The HIV and AIDS pandemic is catastrophic for SSA, and particularly SADC countries. All our development aspirations, including our hopes for education, will prove fruitless unless we actively fight the pandemic.
Overview	Understanding the global epidemic of HIV and AIDS will enable people to deal with this growing threat. Reluctance to talk about HIV and AIDS due to cultural and social barriers does not help promote understanding of the disease and of behaviours that put an individual at risk of exposure to the Human Immunodeficiency Virus. Some people avoid the subject matter for fear of the disease and because of the sensitive and controversial issues surrounding it, or because they feel it is not relevant to their personal lives. Considering the growing menace of the disease, the United Nations took an innovative approach in 1996 by drawing six organisations together in a joint and co-sponsored programme called UNAIDS (Joint United Nations Programme on HIV and AIDS). This module should help participants feel comfortable when discussing the HIV and AIDS situation and the UN response with other members of the group from a geographical, societal, and individual perspective. Participants should be encouraged to think about the consequences of the pandemic, and especially about its impact on education.
Objectives	After studying this module, participants should be able to: • Understand the extent to which HIV and AIDS threaten SSA's future. • Understand and demonstrate some of the ways the pandemic is a challenge to schooling systems. • Demonstrate an understanding of the ways in which the pandemic particularly affects children and the youth. • Express their own fears and other feelings about the pandemic.
Content outline	• Some figures about the extent of the pandemic • SSA is by far the worst affected region in the world • Some information about SADC countries
Learning activities	1A The extent of the pandemic in SSA and SADC – three small groups (all five parts of the Resource Material) 1B Making a personal connection – individual/plenary
Material	1.1 UNAIDS – Global Summary 1.2 UNAIDS – Regional Estimates 1.3 Factors influencing differences in HIV and AIDS epidemics among countries 1.4 UNAIDS SSA Report (extracts) 1.5 Basic data on SADC countries

Feedback

Complete any one of the following and explain your answer briefly:

I learned...

I feel...

I wish...

I discovered...

I hope...

I believe...

I will...

I plan...

I predict...

I foresee..

LEARNING ACTIVITY 1A

Title	**The extent of the pandemic in SSA and SADC**
Approximate time	45 mins
Material	Resource Material 1.1 – 1.5
Grouping	Three groups
Introduction	We can no longer pretend that schooling in SSA can proceed as if the context is "normal".
Main purpose	To enable participants to engage with the statistics reported in the Resource Material.

Procedure	• Divide participants into three groups.
	• Assign each group one of the following topics:
	  ° What are the five most striking facts reported in the Resource Material?
	  ° On the basis of the Resource Material, prepare a 5-minute presentation about the impact of the pandemic on children.
	  ° Using the Resource Material as a background, prepare a 5-minute presentation on what we can expect will happen in schooling in SSA over the next ten years.
	• The groups will have 30 minutes to prepare.
	• They will then each present their responses at a plenary session.

LEARNING ACTIVITY 1B

Title	**Making a personal connection**
Approximate time	30 minutes
Material	Index cards and marker pens (one for each participant)
Grouping	Individual/plenary
Main purpose	To begin to express personal feelings and anxieties about the pandemic.
Procedure	• Hand a card and a pen to each participant. • Ask participants not to write their name anywhere on the card. • Ask them to write on one side of the card one thing they would like to learn about HIV and AIDS during this programme; and on the other side their greatest fear about HIV and AIDS (give them 5 minutes to do this). • Collect the cards and read out the things the participants would like to learn. • Discuss whether the modules still to come will answer those questions (the facilitator might be able to assist here). • Allow discussion to develop. • Participants should hand the cards to the facilitator.

MODULE 2

Number	**2**
Title	**Halting the rampant advance of the pandemic**
Use of time	10 mins Task Group Introduction 45 mins Activity 2A 25 mins Activity 2B 15 mins Activity 2C 15 mins Activity 2D 10 mins Feedback and wrap-up
Main message	Why education is important, and how HIV is spread.
Overview	This module sets out to enable participants to understand that the role of education in respect to the pandemic is two-fold; first as a "social vaccine" (preventive education) and second, as a force for development in communities. Participants are invited to relook at the six EFA goals. This module also covers basic myths about HIV, how it is spread and key terminology.
Objectives	After studying this module the participants should be able to: • Explain basic facts about HIV and AIDS and how it is transmitted. • Understand why education matters. • Be more familiar with the use of some key terminology. • Differentiate between facts and myths about HIV and AIDS.
Content outline	• What education can do in this situation • Education for All goals • Basic information about how HIV is spread
Learning activities	2A Does education matter? – three groups (2.1, 2.2 & 2.3) 2B HIV and AIDS "myth or fact" game – two groups (2.4) 2C How HIV is and is not transmitted – plenary (2.5 & 2.6) 2D Finding the answers – plenary (2.7)
Material	2.1 HIV and AIDS education in SSA 2.2 Why education matters 2.3 Education For All (EFA) Goals 2.4 HIV and AIDS "Myth or Fact" Game 2.5 How HIV is spread 2.6 How HIV is NOT spread 2.7 Finding the answers
Feedback	1. True or False Questions a. Persons with HIV always test positive. b. HIV attacks all the organs of the body directly. c. Needle- and syringe-sharing among injecting drug users is a risk behaviour. d. HIV can thrive on toilet seats and in toothbrushes. e. All HIV-infected people have AIDS. 2. Identify one person who is vulnerable to HIV and AIDS and state why.

Answer Key:

a False
b False
c True
d False
e False

LEARNING ACTIVITY 2A

Title	**Does education matter?**
Approximate time	45 minutes
Material	Resource Materials 2.1, 2.2 and 2.3
Grouping	Three groups
Introduction	There is no cure for AIDS, there is no biological vaccine to protect us from HIV infection, the rates of infection and the subsequent slow deaths continue to remain unstabilised in SSA. The **only** resort we have is the "social vaccine" of education.
Main purpose	To emphasise the importance of education in the war against the pandemic.
Procedure	• Divide participants into three groups. • Ask them to read Resource Material 2.1, 2.2 and 2.3 and then to prepare a 5-minute response to the question: *Why does education matter in the war against the pandemic?* (30 minutes). • Back in the plenary, ask each group to make their presentation, and invite discussion (15 minutes).

LEARNING ACTIVITY 2B

Title	**HIV and AIDS "Myth" or Fact" Game**
Approximate time	25 minutes
Material	Resource Material 2.4
Grouping	Two groups
Introduction	There are many myths about HIV and AIDS, how it is transmitted, how it can be cured, and which groups of people are particularly vulnerable to infection. Many of these myths prevent us from responding adequately to the disease.
Main purpose	To distinguish between myths and facts in relation to the pandemic.
Procedure	• Copy each of the statements in Resource Material 2.4 onto a separate card (or slip of paper) and place them all in a box. • Divide the participants into two teams. • One member of team 1 draws a card from the box and, after reading the statement to themselves, calls out "myth" or "fact", and then reads the statement aloud to the whole group. • Team 2 agrees or disagrees. • One member of the Task Group acts as referee and keeps score. If the original member of Team 1 is right, his/her team earns a point; if he/she he is wrong, the team gets zero. If team 2 is right they earn a point, if they are wrong they lose a point. • Teams take turns to draw cards from the box, and once all the cards have been used up, the scores are tallied and the game is over. • It is important that this game be played briskly.

LEARNING ACTIVITY 2C

Title	**How HIV is transmitted**
Approximate time	15 minutes (another brisk activity)
Material	Resource Material 2.5 and 2.6
Grouping	Plenary
Introduction	Vulnerability to HIV infection is universal – and it is particularly so in communities with high levels of HIV infection. However, the ways in which HIV can be transmitted are limited. We need to distinguish between those and the many ways it is sometimes thought (incorrectly) that it can be transmitted.
Main purpose	To reinforce knowledge of how HIV is and is not transmitted.
Procedure	• Prepare, in advance, a visual of each item in Resource Material 2.5 and 2.6. • Show each visual in turn – but in random order – to the participants (with a short description of what they represent). • Ask them to choose an action for "yes" and another for "no" – for instance standing up for "yes" and sitting for "no". • Participants then need to indicate whether or not the visual shows a way in which HIV can be transmitted. • Discuss disagreements. • The activity can be rounded off by summarising the ways in which HIV is and is not transmitted.

LEARNING ACTIVITY 2D

Title	**Finding the Answers**
Approximate time	15 minutes (another brisk activity)
Material	Two sets of cards in contrasting colours. Copy each of the words listed under Group A in Resource Material 2.7 on cards of one colour, and copy the phrases listed under Group B on cards of the other colour.
Grouping	Pairs/Plenary
Introduction	There is some standard terminology used in the context of the pandemic, and it is important that participants become familiar with that terminology.
Main purpose	To familiarise participants with some of the standard terminology in the discourse of HIV and AIDS.
Procedure	• Distribute the cards to the participants. Some will get cards of one colour, and some of the other colour. • Participants are then instructed to find the person holding the matching card of the other colour. • Once they find the right combination they stand together until all the pairs have been formed. • Then each pair reads out their two cards to the whole group.

MODULE 3

Number	**3**
Title	**Protecting oneself from HIV infection**
Use of time	30 mins Task Group introduces the medical facts (3.1,3.2 and 3.3) 20 mins Activity 3A 25 mins Activity 3B 30 mins Activity 3C 15 mins Feedback and wrap up.
Main message	A person can protect him/herself from becoming infected with HIV with relevant knowledge, positive attitudes, rational decisions and responsible actions.
Overview	Exposure to infection with HIV can be avoided in many ways. Personal protection even for those who are at risk depends to a great extent on the determination of the individual to act responsibly. The concepts discussed in this module will help participants understand that HIV and AIDS is preventable. Knowledge needed for choosing a lifestyle that is compatible with HIV prevention will be discussed. Participants should consider the importance of following up these decisions with consistent and appropriate behaviour.
Objectives	After studying this module the participants should be able to: • Identify the elements in the chain of infection of HIV and AIDS. • List ways in which the biological cycle of HIV can be broken. • Analyse the problems and obstacles related to HIV and AIDS. • Formulate responsible actions in response to these problems.
Content outline	• Elements in the chain of infection of HIV and AIDS • Problems and obstacles in preventing HIV and AIDS • Decision-making regarding HIV and AIDS prevention
Learning activities	3A Levels of Risk – individuals (3.4) 3B Breaking the biological chain – pairs (3.5 and 3.7) 3C Obstacles to responsible decisions and actions – four groups (3.4)
Material	3.1 Facts about HIV and AIDS 3.2 Further facts about HIV and AIDS 3.3 Elements in the Chain of Infection 3.4 Levels of Risk 3.5 Elements in the Chain of Infection (diagram) 3.6 Modes of Transmission (diagram) 3.7 HIV and AIDS Transmission and Prevention 3.8 Obstacles to Responsible Decisions and Actions to Protect oneself against HIV infection.
Feedback	1. Identify the elements in the chain of infection of HIV and AIDS. 2. List ways in which the chain can be broken. 3. Explain the problems and relevant actions in the prevention of HIV and AIDS.

LEARNING ACTIVITY 3A

Title	**Levels of Risk**
Approximate time	15 minutes
Material	A copy of the 14 statements on Resource Material 3.4 for each participant
Grouping	Individual
Introduction	This is a reinforcement of the "Myth or Fact" Game (Resource Material 2.4).
Main purpose	To consolidate knowledge about how HIV is transmitted.
Procedure	• Distribute a copy of the 14 statements to participants, and ask them to fill in the boxes appropriately. • Collect the completed forms and, using the Facilitator's Key on page 154, say how many participants got each response correct. • As you go through, discuss those cases in which several participants gave incorrect responses. • Collect the completed forms.

LEARNING ACTIVITY 3B

Title	**Breaking the biological chain**
Approximate time	25 minutes
Material	Large copies of Resource Material 3.5, 3.6 and 3.7 – which can be displayed in the plenary
Grouping	Pairs
Introduction	The chain of HIV infection can be broken – and whenever this is done, the spread of the disease is halted.
Main purpose	To enable participants to understand how to break the chain of infection.
Procedure	• Display the two diagrams (3.5 and 3.6) and run through them briefly in plenary. • Divide participants into pairs and ask them to choose one circle from each diagram (try to ensure that all the circles are chosen). • Translate the contents of the chosen circle into language that will be easily understood by local children of about 13 years old. • The translations are read out in plenary, and collective decisions are taken about which is best if there are differences. • Ask for two volunteers to make a locally translated version of each diagram. • Ask participants to list ways of breaking the transmission cycle.

LEARNING ACTIVITY 3C

Title	**Obstacles to responsible decisions and actions to protect oneself against HIV infection**
Approximate time	30 minutes
Material	Resource Material 3.8 on poster-sized paper (newsprint) and four marker pens
Grouping	Four groups
Introduction	Although we know that thinking about things in an abstract (away from the actual situation risk) is not sufficient to lead to responsible decisions, this activity articulates the key issues.
Main purpose	To provide an incentive for participants to think about how they can avoid HIV infection.
Procedure	• Ask the groups to study Resource Material 3.7, and note particularly the "3 As" and the "H.U.M.A.N. method" of avoiding HIV infection. • Ask each group to complete the column called "how to overcome these risks" (Resource Material 3.8) with no more than three points in each cell. • The groups now return to a plenary to "present" what they have done. • A discussion can follow about the priorities – this will be especially fruitful if there are differences between the points mentioned by the four groups.

MODULE 4

Number	**4**
Title	**The impact of HIV and AIDS and living positively**
Use of time	15 mins Task Group Introduction (Refer to Resource Material 1.1 and 1.5 for information about children) 25 mins Activity 4A 20 mins Activity 4B 30 mins Activity 4C 20 mins Activity 4D 10 mins Feedback and wrap up
Main message	HIV and AIDS affect the physical, emotional, moral, social and economic well-being of individuals, families, communities, institutions, nations and the world. PLWAs and their families should not be stigmatised or discriminated against.
Overview	HIV and AIDS is a serious threat to the health of all, regardless of age, sex, social status or race. The loss of human life and productivity due to this disease is a deterrent to socioeconomic development. This module will enable participants to understand the impact of HIV and AIDS on individuals, families and society as a whole. It describes how AIDS impact on the physical, emotional, moral, social and economic aspects of people's lives. This module also touches on the care and support of PLWAs.
Objectives	After studying this module the participants should be able to: • List the impact of HIV and AIDS. • Classify the physical and emotional impact of HIV and AIDS. • Describe the need for living positively with HIV and AIDS. • Discuss the significance of care and support. • Suggest measures to minimise the stigma and discrimination against PLWAs and their families.
Content outline	• Impact of HIV and AIDS • Classification of the impact of HIV and AIDS • Living positively with HIV and AIDS • Human Rights in the context of HIV and AIDS
Learning activities	4A Impacts of the pandemic on various sectors – five groups (4.1) 4B Minimising stigma and unjustified discrimination – individuals 4C Care and support for PLWAs, especially children – three groups (4.2) 4D Living positively when you are HIV positive – three groups (4.31)
Material	4.1 Impacts of HIV and AIDS 4.2 Counselling 4.3 Living positively when you are HIV-positive
Feedback	Briefly describe the physical, emotional, developmental, social, moral and economic effects of HIV and AIDS on: • Children • Adults • Families • Communities • Nations

LEARNING ACTIVITY 4A

Title	**Kinds of impacts of the pandemic on various sectors**
Approximate time	25 minutes
Material	Resource Material 4.1
Grouping	Five groups
Introduction	To avoid taking too limited a view, it is useful to think of the impacts of the pandemic in terms of categories. Educational institutions, and those who work in them, need to become aware of the wide scope of the impacts of the pandemic, so that they can think about their formal curriculum, and institutional culture, in a broader context.
Main purpose	To enable participants to consolidate a more holistic understanding of the impacts of the pandemic, and to reflect on the comprehensiveness of the set of categories provided in Resource Material 4.1.
Procedure	• Divide the participants into five groups. • Ask each group to carefully work through Resource Material 4.1, then • Make a list (on a flip chart if it is available) of other impacts not mentioned in 4.1. • In plenary ask each group to report on their discussion, and • Report on the additional items they think should be added to the list of impacts. • Raise questions about the usefulness and comprehensiveness of the classification scheme used in 4.1.

LEARNING ACTIVITY 4B

Title	**Minimising stigma and unjustified discrimination**
Approximate time	20 minutes
Material	None
Grouping	Individuals/plenary
Introduction	This topic is especially important in the context of educational institutions where particular learners can suffer utter misery because either their teachers or their fellow learners discriminate against them. Teachers and teacher-educators who work in such institutions need to be alert to cases of unjustified discrimination, both in their own practices as teachers and between the learners themselves. A stigma is a mark of discredit or disgrace. Sometimes people are "stigmatised" because they have some particular characteristic or illness. To stigmatise someone is to treat them as discreditable or disgraceful. In the case of HIV and AIDS stigmatising those infected or affected has especially harmful consequences for their welfare. Those infected with, or affected by, HIV and AIDS, and especially children, need all the help they can get to enable them to cope with their situation.
Main purpose	To alert participants to the strong possibilities that people infected with, or affected by, HIV and AIDS will be unfairly discriminated against, and even stigmatised.
Procedure	• Ask each participant to think of a case of unfair discrimination against someone infected with, or affected by, HIV and AIDS (the examples can be remembered or invented). • In plenary ask each person to briefly outline their example. • If time permits, there could follow a discussion about what the solution to such a case might be.

LEARNING ACTIVITY 4C

Title	**(Note: this links to Module 6)** **Care and support for PLWAs, especially children**
Approximate time	30 minutes
Materials	Resource Material 4.2
Grouping	Three groups
Introduction	People living with AIDS need help to enable them to cope with their situation, and, in the case of children and youth, the quality of the help they get might make all the difference to their quality of life.
Main purpose	To encourage participants to think about how, in their professional lives as teacher educators, they can provide care and support for those around them.
Procedure	• Divide participants into three groups, and assign one of the following topics to each: (a) a student teacher in your college has unexpectedly been diagnosed as HIV-positive; (b) After a long, drawn-out series of illnesses, a colleague's husband has recently died of AIDS; and (c) A young student in your class lost her mother to AIDS a few years ago, and she has been taking care of her four younger siblings, all of whom seem to have constant illnesses. Now one of her siblings, a boy of 14, has died. • Ask them to think about what they, as teachers, should say to the student or colleague involved in each case (5 minutes). • Ask participants to report back to the plenary about what they have decided (5 minutes for each group).

LEARNING ACTIVITY 4D

Title	**Living positively when you are HIV-positive**
Approximate time	20 minutes
Material	Resource Material 4.3
Grouping	Three groups
Introduction	Once someone is infected with HIV they can prolong their life, and its quality, by adopting healthy lifestyles.
Main purpose	To remind participants that HIV is a disease of the immune system, and that there are ways in which a person can help their immune system to cope with (although not cure) the infection.
Procedure	• Divide participants into three groups. • Ask each group to study Resource Material 4.3, and • Then to think of a set of six (but only six) key questions to ask a person who is HIV-positive, to find out whether they are living positively. • In plenary each group will then say what their six questions are.

MODULE 5

Number	**5**
Title	**Working together with the community**
Use of time	5 mins Task Group Introduction 35 mins Activity 5A 20 mins Activity 5B 25 mins Activity 5C 25 mins Activity 5D 10 mins Feedback and wrap-up
Main message	Schools, although they reach further into communities than most other institutions, cannot, on their own, mitigate the pandemic – they need to actively form partnerships with other agencies.
Overview	Addressing the impacts of the HIV and AIDS epidemic requires concerted action. People need to understand their individual and collective roles and responsibilities in the effort against HIV and AIDS, including PLWAs and their families.
Objectives	In this module, the participants should be able to: • Identify the roles of various groups in the community in the prevention of HIV and AIDS. • Choose appropriate action in coping with problems of HIV and AIDS. • Establish linkages with various agencies concerned with HIV and AIDS prevention and control.
Content outline	• Roles of various groups in the community • Case studies • Identification of agencies concerned with HIV and AIDS prevention and control
Learning activities	5A Agencies providing services – plenary activities 5B The human side of HIV – three groups (5.1) 5C Actions appropriate for Colleges of Education – five groups (5.2) 5D What should be done in this case? – Six or seven groups (5.3)
Material	5.1 ACTIONAID: Key Recommendations 5.2 Risk Reduction 5.3 Case Studies
Feedback	1. List at least three major roles of the groups in the community who are concerned with the prevention and control of HIV and AIDS. N.B. Other groups may be added to this tabulation. 2. Discuss with family members ways of helping persons dying from AIDS. 3. Identify at least three agencies providing services to PLWAs and their families.

LEARNING ACTIVITY 5A

Title	**Agencies providing services**
Approximate time	35 minutes
Material	This activity is possible only if there are relevant panellists willing to take part.
Grouping	Plenary
Introduction	Teacher educators (and the course teachers) need to refer those they support for further, more specialised help when they need it. This activity provides exposure to the participants to some of these other services they need to know about.
Main purpose	To emphasise that teachers/teacher educators, although they often have to fulfil the role of being first-line counsellors (see Resource Material 4.2), should not arrogantly assume that they can provide all the services needed by those infected with, and affected by, the pandemic.
Procedure	• Invite two or three people from agencies that provide services for those infected with, and affected by, the pandemic (NGOs, Local VCT clinic, Health Services, Social Services, Religious organisations, etc.). • Ask each of them to attend this session to make a brief input (5 minutes), describing the services their organisation provides. • They should allow for sufficient time to answer questions from the participants.

LEARNING ACTIVITY 5B

Title	**The human side of HIV**
Approximate time	20 minutes
Material	Resource Material 5.1
Grouping	Three groups
Introduction	The Actionaid recommendations address several important issues, which will reinforce what has been discussed in other modules.
Main purpose	The main purpose of this activity is to encourage participants to focus on the idea of "the human side of HIV".
Procedure	• Divide participants into three groups. • Ask them to read Resource Material 5.1 • Then have participants look closely at the second recommendation and think about what their interpretation is of the phrase "the human side of HIV" (10 minutes). • Back in plenary invite one group to say what they thought and encourage a discussion to take root.

LEARNING ACTIVITY 5C

Title	**Actions appropriate for Colleges of Education**
Approximate time	25 minutes
Material	Resource Material 5.2
Grouping	Five groups
Introduction	Educational institutions (schools and colleges) cannot replace health and social service agencies, but there are particular actions to reduce risk that need to be seen as part of their responsibility.
Main purpose	The purpose in this activity is to enable participants to think about what particular kinds of "actions to reduce risk" are possible and appropriate for educational institutions such as schools and colleges of education.
Procedure	• Divide the participants into five groups. • Ask them to read Resource Material 5.2. • Ask participants to consider the seven actions suggested. • As a group, participants should now put the actions in priority order according to which are most important for educational institutions. • In plenary, for the last ten minutes, ask each group (2 minutes each) to report on how they prioritised the seven actions.

LEARNING ACTIVITY 5D

Title	**What should be done in this case?**
Approximate time	25 minutes
Material	Resource Material 5.3
Grouping	Six or seven groups
Introduction	The cases that teachers and teacher educators confront do not come wrapped in neat packages – and sometimes it is difficult to decide what the appropriate advice or responsible reaction should be. This activity asks participants to consider a range of cases, and to think about what should be done, and by whom.
Main purpose	To enable participants to think in a practical way about the kinds of situations they are likely to meet in their professional activities.
Procedure	• Choose an appropriate number of the case studies provided in Resource Material 5.3, and divide the participants into that number of groups. • Assign one of the case studies to each group. • Ask participants to discuss the assigned case and think about what should be done, and by whom. • In plenary, each group is provided an opportunity to report on what they have decided.

MODULE 6

Number	**6**
Title	**Care and safety in institutions such as schools and colleges**
Use of time	10 mins Task Group Introduction 30 mins Activity 6A 40 mins Activity 6B 20 mins Activity 6C 10 mins Activity 6D 10 mins Feedback and wrap up
Main message	Schools and colleges must become caring and safe places for those infected with, and affected, by the pandemic. The ILO Code of Practice on HIV and AIDS and the World of Work should be put into place.
Overview	This module provides participants with an overview of some of the obstacles to educational institutions carrying out their important role as sites of HIV and AIDS Preventive Education. In addition, it emphasises the ways in which such institutions themselves need to become havens of safety in the context of HIV and AIDS.
Objectives	After this module participants should demonstrate an understanding of: • The measures which can be taken to make educational institutions safe and healthy places to be. • The ILO Code of Practice on HIV and AIDS and the World of Work. • The way in which the power relations which are prevalent in educational institutions can themselves lead to risks. • The ways in which stigma and discrimination can operate to make the lives of people living with HIV even more unbearable.
Content outline	• The conditions in institutions which make them a possible source of risk of infection • Power relationships built into the structure of educational institutions • Gender issues in educational institutions • Compassionate institutions
Learning Activities	6A Power-relations and the pandemic – three groups (6.4) 6B Rules for educational institutions – Six groups (6.2, 6.3, 6.5 & 6.6) 6C Examples of sexual abuse in educational institutions - pairs / plenary 6D The ACTIONAID paradox – plenary (6.4)
Material	6.1 College-based Interventions. 6.2 ILO Code of Practice on HIV and AIDS and the World of Work. 6.3 Silences and Obstacles (Actionaid p 7) 6.4 Stigma and Discrimination 6.5 Power Relations (Actionaid pp 47/8) 6.6 Universal Precautions in Educational Settings
Feedback	

LEARNING ACTIVITY 6A

Title	**Power relations and the pandemic**
Approximate time	30 minutes
Material	Resource Material 6.5
Grouping	Three groups
Introduction	People infected with HIV and AIDS are often stigmatised and discriminated against by society. This leads to loss of self esteem and undermines their capacity to cope with the personal tragedy of their disease. Only with compassion and nonjudgemental support can this situation be improved. We, as educators, therefore have a vital role to play in undermining this discrimination.
Main purpose	To encourage participants to reflect on issues of subordination and powerlessness in sexual relationships, and the ways in which this increases vulnerability to HIV infection.
Procedure	• Ask participants to read Resource Material 6.5 in their group. • Ask participants to say whether or not they agree with the five key recommendations made. • Back in plenary each of the groups will report on their decision.

LEARNING ACTIVITY 6B

Title	**Rules for educational institutions**
Approximate time	40 minutes
Material	Resource Material 6.2, 6.3, 6.5 and 6.6. Flip chart paper and marker pen for each group
Grouping	Six groups
Introduction	Educational institutions are potentially dangerous places to be in a context in which HIV and AIDS is prevalent. There can be various reasons for this – some have to do with issues about the physical hygiene of the institution itself (cleanliness of toilet and washing facilities, etc.), others have to do simply with the fact that such institutions bring together in a common physical space a large number of children and adults from a range of households, and yet others have to do with the kinds of unequal relationships between the various people involved.
Main purpose	To enable participants to think about what needs to be prioritised if educational institutions are to become more caring and safer places to be.
Procedure	• Divide participants into six roughly equal groups. • Ask participants to read Resource Material 6.2, 6.3, 6.5 and 6.6. • Participants can now think about their knowledge of how HIV is transmitted, and their own experience of educational institutions. • On that basis, ask each group to formulate six of the most important rules for institutions, (keeping the ILO Code of Practice in mind) which would make them safer and more caring institutions in light of the pandemic. • Back in plenary, ask each group to present its six rules (either read them out or display them on a flip chart). • There might be an opportunity for a brief discussion about the differences in the priorities reflected in the sets of rules. • Collect the completed sheets.

LEARNING ACTIVITY 6C

Title	**Examples of sexual abuse in educational institutions**
Approximate time	20 minutes
Material	None needed
Grouping	Pairs
Introduction	Various forms of sexual abuse – including sexual violence, such as the rape of women and children – are a source of the transmission of HIV. In some schools and colleges there are distressingly high rates of sexual abuse – between students themselves, but also between teachers and pupils. If educational institu-tions are going to become safer places to be, we need to stop such practices. Sometimes people use the phrase "zero tolerance".
Main purpose	To gather some vivid examples of the kinds of abuse we find in educational institutions.
Procedure	• Divide participants into six roughly equal groups. • Ask participants to form pairs. • Instruct each pair to think of one clear example of sexual abuse in the context of an educational institution (these examples can be real or imagined, but actual names of those involved should not be used). • In plenary ask each pair to outline their example. • If the time/facilities are available, ask the pairs to describe their example in a few written sentences, then collect them.

LEARNING ACTIVITY 6D

Title	**The Actionaid paradox**
Approximate time	10 minutes
Materials	Resource Material 6.3
Grouping	Plenary
Introduction	There are several reasons for the fact that HIV and AIDS Preventive Education has not been more successful at stemming the tide of the pandemic. One common reason is teachers; shyness about discussing sexual matters with young people (see Resource Material 6.3). Another reason is the underlying assumption that young people (including children as young as 13) do not actually have sex. As a result, many people are actively opposed to the direct sexual dimensions of HIV and AIDS Preventive Education.
Main purpose	To enable participants to think about why HIV and AIDS Preventive Education may fail to have an impact on the rise in the number of HIV infections.
Procedure	• Resource Material 6.3 covers the "paradox of safer sex", which arises from two rival assumptions: (a) young people do not engage in pre-marital sex, and (b) young people do have premarital sex. • The former assumption leads to the idea that if teachers talk about sex in their classrooms, it is more likely to lead to increased sexual activity amongst the young – so they should avoid this. • The latter assumption leads to the view that issues of safer sex – especially in relation to the use of condoms – should be discussed in learning contexts. • In a plenary session state the "paradox of safer sex" and get a discussion going about the issues it raises about the very heart of HIV and AIDS Preventive Education.
Content outline	• The formal and the informal curriculum • What educational institutions can and can't do • How to mainstream HIV and AIDS Preventive Education in teacher education • "Integration" and "stand alone" approaches to mainstreaming HIV and AIDS in the teacher education curriculum

MODULE 7

Number	**7**
Title	**HIV and AIDS Preventive Education as part of the curriculum for teacher education**
Use of time	10 mins Task group Introduction 25 mins Activity 7A 40 mins Activity 7B 30 mins Activity 7C 10 mins Activity 7D 5 mins Feedback and wrap up
Main message	Both pre- and in-service education of school teachers should include strong elements of HIV and AIDS Preventive Education – as stand-alone sections and/or integrated into other parts of the curriculum.
Overview	The AIDS pandemic negatively affects all aspects of human life. Despite the ongoing search for appropriate drugs and vaccines, preventive education programmes are being developed to promote awareness that this disease is indeed preventable. College programmes should focus on the capability of the youth to make rational decisions for their well-being/safety. Since there is no cure, education plays a vital role in combating this disease.
Objectives	After studying the module participants should be able to: • Know why it is important for HIV and AIDS Preventive Education to be mainstreamed in formal curriculum for teacher education. • Understand the differences between integrating HIV and AIDS into other subjects and handling it as a stand-alone part of the curriculum. • Discuss the benefits and drawbacks of the two approaches. • Think about what topics could be included.
Content outline	• The formal and informal curriculum • What educational institutions can and cannot do • How to mainstream HIV and AIDS Preventive Education in teacher education • "Integration" and "stand-alone" approaches
Learning activities	7A The integration matrix – 3 small groups (7.2 and 7.3) 7B Critical comments on compulsory core module – pairs (7.4) 7C Limits to what educational institutions can do – 3 small groups (7.1) 7D "Integration" *vs* a "stand-alone subject" – plenary discussion.
Material	7.1 Integrating HIV and AIDS into the Formal Curriculum for Teacher Education (Kelly extract) 7.2 Integrating HIV and AIDS Preventive Education into the Teacher Education Curriculum 7.3 An Integration Matrix for the Teacher Education Curriculum 7.4 Proposed Compulsory Core Module for Professional Teacher Education Programmes (South Africa)

LEARNING ACTIVITY 7A

Title	**The integration matrix**
Approximate time	5 minutes
Material	Resource Material 7.2 and 7.3 (make three large copies of the matrix in 7.3 on flip chart paper)
Grouping	Three groups
Introduction	The teacher education curriculum (note: both pre- and in-service) should include effective HIV and AIDS Preventive Education. In Module 6 we discussed the "informal curriculum"; in this module we will discuss the formal curriculum. There are two ways in which HIV and AIDS Preventive Education can be included in the formal curriculum – one is by integrating it into other subjects; the other is by treating it as a separate subject.
Main purpose	This activity invites participants to think about ways in which HIV and AIDS education can be integrated into other subjects in the curriculum.
Procedure	• Divide participants into three roughly equal groups. • Outline the instructions at the top of 7.3. • Ask the groups to adjust the top row of the matrix to reflect the subjects in the teacher education curriculum with which they are familiar, and to think carefully about what to add to the list of possible aspects of HIV and AIDS education (column 1). • Then ask them to fill in Xs in the relevant cells of the matrix. • In a plenary session ask each group to present their results – and be prepared to defend what they have done.

LEARNING ACTIVITY 7B

Title	**Critical comments on compulsory core module**
Approximate time	30 minutes
Material	Resource Material 7.4 (each pair needs a copy)
Grouping	Pairs
Introduction	One of the objections to integrating HIV and AIDS Preventive Education into other subjects is that the message tends to get watered down, and fail to have the kind of impact it should. In this activity an example of a syllabus for a "stand alone" subject is given. It provides comprehensive coverage of the kinds of topics that are important in the teacher education curriculum, and sets out to foster a systematic development of understanding.
Main purpose	To critically analyse HIV and AIDS as a "stand-alone" subject proposed as compulsory in all teacher education programmes in your country
Procedure	• Divide participants into pairs. • Ask them to study Resource Material 7.4 and to consider: (a) whether any dimension of HIV and AIDS relevant to teacher education has been left out, and (b) whether or not they agree with the organisation, and sequencing of the main topics. • Back in plenary provide an opportunity for each pair to state their findings.

LEARNING ACTIVITY 7C

Title	**Limits to what educational institutions can do**
Approximate time	30 minutes
Material	Resource Material 7.1
Grouping	Three groups
Introduction	Kelly (see 7.1) argues that "HIV and AIDS, sexual and reproductive health, and life skills education" must be properly professionalised – in the same way in which other subject areas have been. In addition, he argues that this kind of education goes beyond what educators can be expected to provide, and must include partnerships with various other constituencies. He also argues that it is a crucial **stand-alone** area "that necessitates separate timetabling". Thus, when he uses the word "integration" he is not referring to "integrating" this kind of education into other subjects on the curriculum. This is an issue of some importance for teacher educators considering how to design a teacher education curriculum in a world with AIDS.
Main purpose	To prompt participants to think more carefully about how HIV and AIDS Preventive Education can be mainstreamed in the teacher education curriculum.

Procedure	• Divide participants into three groups.
	• Ask them to read Resource Material 7.1 with close attention, and
	• Answer the following four questions:
	  ◦ Does the author of 7.1 mean the same by "integration" as does the author of 7.2?
	  ◦ Which meaning of "integration" was involved in Learning Activity 7A?
	  ◦ Why does the author of 7.1 talk of a "radical curriculum overhaul"?
	  ◦ What does the author of 7.1 say about "the boundary between what goes on inside and outside an educational institution"?
	• Back in plenary, give each group the opportunity to share their answers to the four questions.
	• Allow discussion to develop, if time permits.

LEARNING ACTIVITY 7D

Title	**"Integration" vs a "Stand-alone" subject**
Approximate time	10 minutes
Material	None
Grouping	Plenary discussion
Introduction	This activity is about the differences between integrating HIV and AIDS Preventive Education into other subjects in the curriculum, and treating it as an independent subject area. These two strategies are, of course, compatible with each other, and, given the nature and extent of the pandemic, there is reason to use both strategies simultaneously.
Main purpose	To prompt participants to think about the concept of curriculum integration, and the two strategies for integrating HIV and AIDS Preventive Education into the curriculum for teacher education.
Procedure	• Briefly refer to the idea of "integration" used in Activity 7A, and the different way Kelly uses this word. • Introduce a discussion about HIV and AIDS Preventive Education in the teacher education curriculum. Distinguish between the two strategies, and invite comment. • One point worth mentioning is that the strategy of integrating this kind of education in other subjects will not involve the radical curriculum overhaul mentioned by Kelly – and this means it is more likely to be implementable in the short term. • This discussion should conclude with the comment that these two strategies can both be used in the same teacher education curriculum.

MODULE 8

Number	**8**
Title	**The use of participatory teaching strategies and assessment in HIV and AIDS Preventive Education**
Use of time	10 mins Task Group Introduction 45 mins Activity 8A 45 mins Activity 8B 20 mins Activity 8C 10 mins Feedback and wrap up
Main message	Participatory teaching strategies must be used if HIV and AIDS Preventive Education is to be effective. If student teachers are to take this part of their curriculum seriously, formal assessment procedures need to be used.
Overview	If a teacher is well-organised, imaginative and resourceful, participatory teaching strategies are possible, especially where class sizes are large. Teachers need a different mind-set to teach in a participatory way. However, any other style of teaching is unlikely to be effective in the case of HIV and AIDS Preventive Education and assessment is very important in relation thereto.
Objectives	After studying the module participants should be able to: • Describe the ways in which participatory teaching differs from the conventional, traditional teaching, and also from "child-centred education". • Demonstrate why participatory teaching strategies are recommended in the case of HIV and AIDS Preventive Education. • Understand what peer education is and be able to assess whether it might be appropriate in their context. • Give a justifiable view about assessment in the context of HIV and AIDS Preventive Education.
Content outline	• Participatory teaching strategies and changing teachers' mind-sets • Teaching as the practice of organising systematic learning • Peer education • Assessment of learner achievement
Learning activities	8A Participatory teaching strategies – five groups (8.1 – 8.5 and 8.8) 8B Peer education – groups of five or six (8.6 and 8.7) 8C Assessment in HIV and AIDS Preventive Education – plenary (8.8)
Material	8.1 Participatory Teaching Strategies 8.2 Learning Activities 8.3 Instructional Media 8.4 Techniques that Promote Life Skills 8.5 Assessing Youth Needs (Rutanang) 8.6 Peer Education (Rutanang) 8.7 Exploring Goals and Principles (Rutanang) 8.8 Assessment: reasons and techniques
Feedback	

LEARNING ACTIVITY 8A

Title	**Participatory teaching strategies**
Approximate time	45 minutes
Materials	Resource Material 8.1 – 8.5 and 8.8
Grouping	Five groups
Introduction	It is often claimed that HIV and AIDS Preventive Education is ineffectual if conventional teaching methods are used. Here, participants have the opportunity to understand more about participatory teaching strategies.
Main purpose	To explore some of the dimensions of participatory teaching strategies.
Procedure	Divide participants into five groups, then assign each group a task: • **Participatory teaching strategies, child-centred education and traditional teaching methods:** ° Read 8.1 ° On a flip chart draw 3 columns headed: · Participatory teaching strategies · Child-centred education · Traditional teaching methods ° In each column note the distinctive features of the three approaches to teaching (try to identify features that distinguish between the three approaches). • **Participatory teaching strategies and the use of learning activities and instructional media:** ° Read 8.1, 8.2 and 8.3 ° Do 8.2 and 8.3 enable us to understand more clearly what is distinctive of participatory teaching strategies? ° Prepare to make an input at a plenary session. • **Life skills techniques:** ° Read 8.4 ° For the plenary session, prepare a short presentation critically analysing the main points made in 8.4 • **Assessing youth needs:** ° Study 8.5 ° Do you consider this useful for needs assessment in schools? ° Make a specific comment about whether it might be suitable for learners of any age. • **Participatory teaching strategies and assessment:** ° Study 8.1 and 8.8 ° Do you think assessment will be appropriate at all if one adopts Participatory teaching strategies? ° Prepare a short presentation for the plenary. ° In this activity, the Task Group will need to manage time well. ° Allow about 25 minutes for group work. ° Use the remainder of the time for presentations in plenary. ° Keep emphasising the phrase "participatory teaching strategies", and encourage critical discussion to develop.

LEARNING ACTIVITY 8B

Title	**Peer education**
Approximate time	45 minutes
Material	Resource Material 8.6 and 8.7 – the Task Group will need to prepare cards in advance (see 8.7), and also three labels for each group (*All agree; All disagree; No consensus*)
Grouping	Groups of six
Introduction	Apart from being related to the idea of "peer education", this activity formulates a range of important issues in the field of HIV and AIDS Preventive Education and the curricula and approaches that might be suitable. This activity also serves to remind participants of some of the issues discussed in other modules.
Main purpose	To provide an introduction to thinking about peer education.
Procedure	• The Task Group should provide a very brief introduction to peer education (8.6). • Divide the participants into groups of six. • Follow the instructions found in Resource Material 8.7.

LEARNING ACTIVITY 8C

Title	**Assessment in HIV and AIDS Preventive Education**
Approximate time	20 minutes
Material	Resource Material 8.8
Grouping	Plenary
Introduction	Given the kind of education HIV and AIDS Preventive Education is, it is often thought that formal assessment is inappropriate. One problem is that many of the things this kind of education sets out to teach are simply not assessable by any conventional methods; another is that the defining purpose of HIV and AIDS Preventive Education has nothing to do with passing an examination – it has to do with how and whether the learners live. However, the problem is that if any part of a curriculum is not formally assessed, then students have a strong inclination not to take it seriously. The issue for discussion in this activity is whether or not this is so.
Main purpose	To enable participants to consider the benefits and drawbacks of the use of formal assessment in HIV and AIDS Preventive Education.
Procedure	• The Task Group should provide a short introduction to the problem – they can refer to Resource Material 8.8. • The discussion is then launched around the claim: "Formal assessment is necessary in HIV and AIDS Preventive Education". • The Task Group records the points made for and against this statement on a flip chart.

PART III

RESOURCE MATERIAL

The Resource Material in Section A is for use with the Modules and the Learning Activities built into them. The first number of each item indicates with which Module it is associated. Much of this material is quite difficult to assimilate apart from the context of those Modules and activities.

The Item in Section B is a paper by Michael Kelly "Defeating HIV and AIDS through education" which was presented at the *Conference on HIV and AIDS and the Education Sector* hosted by the South African Department of Education from 30 May to 1 June 2002.

Where material has been drawn from elsewhere, formal permission has been sought and duly acknowledged.

Section A - Resource Material for the Modules

1.1 UNAIDS – Global Summary
1.2 UNAIDS – Regional Estimates
1.3 Factors influencing differences in HIV and AIDS epidemics among countries
1.4 UNAIDS SSA Report (extracts)
1.5 Basic data on SADC countries
2.1 HIV and AIDS and education in SSA
2.2 Why education matters
2.3 Education For All (EFA) Goals
2.4 HIV and AIDS "Myth or Fact" Game
2.5 How HIV is spread
2.6 How HIV is NOT spread
2.7 Finding the answers
3.1 Facts about HIV and AIDS
3.2 Further facts about HIV and AIDS
3.3 Elements in the Chain of Infection
3.4 Levels of Risk
3.5 Elements in the Chain of Infection
3.6 Modes of Transmission
3.7 HIV and AIDS Transmission and Prevention
3.8 Obstacles to Responsible Decisions and Actions to Protect oneself against HIV infection
4.1 Impacts of HIV and AIDS
4.2 Counselling
4.3 Living positively when you are HIV-positive
5.1 ACTIONAID: Key recommendations
5.2 Risk Reduction
5.3 Case Studies
6.1 College-based Interventions
6.2 ILO Code of Practice on HIV and AIDS and the World of Work
6.3 Silences and Obstacles
6.4 Stigma and Discrimination
6.5 Power Relations
6.6 Universal Precautions in Educational Settings
7.1 Integrating HIV and AIDS into the Formal Curriculum for Teacher Education
7.2 Integrating HIV and AIDS Preventive Education into the Teacher Education Curriculum

7.3 An Integration Matrix for the Teacher Education Curriculum
7.4 Proposed Compulsory Core Module for Professional Teacher Education Programme (South Africa)
8.1 Participatory Teaching Strategies
8.2 Learning Activities
8.3 Instructional Media
8.4 Techniques that Promote Life Skills
8.5 Assessing Youth Needs
8.6 Peer Education
8.7 Exploring Goals and Principles
8.8 Assessment: reasons and techniques

Section B – a Paper by Michael Kelly

MJ Kelly "Defeating HIV and AIDS through education" paper presented at the *Conference on HIV and AIDS and the Education Sector* hosted by the Department of Education, South Africa, from 30 May to 1 June 2002.

Resource Material 1.1

UNAIDS – Global summary of the HIV and AIDS epidemic December 2003

Notes:

- Estimates based on the best available information. Work is underway to increase the precision of the estimates that will be published at a later stage.
- PLWAs are People Living With AIDS.
- 14% of the total new HIV infections in 2003 were children under the age of 15 years.
- 16% of the total AIDS deaths in 2003 were of children under the age of 15 years.

	Adults	**Children under 15 years**	**Total**
PLWAs in 2003	37 000 000	2 500 000	40 000 000
Newly infected with HIV during 2003	4 200 000	700 000	5 000 000
AIDS deaths during 2003	2 500 000	500 000	3 000 000

Resource Material 1.2

UNAIDS – Regional Estimates (as at December 2003) of HIV and AIDS prevalence for the year 2003

Notes:

- In the table below the midpoints of the estimates are used. For example, the estimated number of new infections with HIV during 2003 in sub-Saharan Africa was between 3 and 3.4 million – in the table below this is given as 3.2 million.
- 66% of PLWAs and 66% of all new HIV infections in 2003 were in sub-Saharan Africa
- 77% of all deaths due to HIV and AIDS in 2003 were in sub-Saharan Africa.

Region	PLWAs in 2003	Newly infected with HIV during 2003	Deaths due to HIV/AIDS 2003
North America	995 000	45 000	15 000
Caribbean	470 000	62 500	40 000
Latin America	1 600 000	1 150 000	59 500
Western Europe	600 000	35 000	3 000
North Africa & Middle East	600 000	55 000	42 500
Sub-Saharan Africa	26 600 000	3 200 000	2 300 000
Eastern Europe & Central Asia	1 500 000	230 000	30 000
East Asia and Pacific	1 000 000	210 000	45 000
South and South-East Asia	6 400 000	855 000	460 000
Australia & New Zealand	15 000	850	<100
TOTAL	**39 780 000**	**4 843 350**	**2 995 100**

Resource Material 1.3

Factors influencing differences in HIV and AIDS epidemics among countries

Behavioural factors

High-risk behaviours vary. Studies indicate that the type of sexual partners and patterns of sexual mixing in a community provide part of the explanation. HIV appears to spread faster where commercial sex is rampant than in communities where casual sex takes place through a diffuse network of non-commercial partners. Two variables with a positive correlation with higher HIV transmission rates are:

- The level of sex-partner turnover among female sex workers, i.e. is the average number of paying customers a sex worker has in a typical work week; and
- The percentage of the male population that resorts to the services of female sex workers in a year.

These variables are strongly relevant when considered with non-use of condoms and the practice of penetrative (vaginal or anal) sex.

Other contributing factors include:

- Mode of transmission, such as through Injecting Drug Users (IDU) and Men having Sex with Men (MSM). High HIV rates are seen in places where these are common practices. However, IDUs may also transmit HIV to their sexual partners.
- Increased incidence of maternal and paediatric AIDS from husbands having multiple sex partners.
- High incidence in sub-populations, such as police/military personnel, truck drivers, seafarers.
- Prevalence of different subtypes of HIV.

What to expect:

- A variety of situations will prevail – from stable to potentially explosive outbreaks – in the general population and/or sub-populations – depending on the intensity, speed and sustainability of control efforts of all concerned.
- Deaths among those previously infected will continue despite antiretroviral therapy and preventive measures.
- The age factor makes AIDS uniquely threatening to children, with a cumulative total of 11.2 million orphans left by either or both AIDS parents before reaching the age of 15.
- HIV and AIDS is already a public health problem of both affluent and impoverished societies, but especially in the latter case, where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.
- Substance abuse and Sexually Transmitted Infections (STIs) will accompany and reflect vulnerability to HIV and AIDS.
- Quality of life is diminished by the overall impact of HIV and AIDS.
- Life expectancy is shortened prematurely by AIDS deaths.
- The burden of disease will deter socioeconomic development.
- HIV transmission rates will continue to stabilise or be reduced in countries where preventive programmes are already operational and sustained.
- Relevant research to fill gaps in knowledge on all aspects of HIV and AIDS epidemiology and control are needed for more effective programme planning and implementation.
- Increased awareness and involvement of all sectors of society are fulfilled.

Resource Material 1.4

Sub-Saharan Africa

High levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality.

[Extracts from UNAIDS report – December 2003 <www.unaids.org>]

Sub-Saharan Africa remains by far the region worst-affected by the HIV and AIDS epidemic. In 2003, an estimated 26.6 million people in this region were living with HIV, including the 3.2 million who became infected during the past year. AIDS killed approximately 2.3 million people in 2003.

Unlike women in other regions in the world, African women are considerably more likely – at least 1.2 times – to be infected with HIV than men. Among young people aged 15-24, this ratio is highest: women were found to be two-and-a-half times as likely to be HIV-infected as their male counterparts, according to six recent national surveys. These discrepancies have been attributed to several factors. They include the biological fact that HIV generally is more easily transmitted from men to women (than vice versa). As well, sexual activity tends to start earlier for women, and young women tend to have sex with much older partners.

HIV prevalence varies considerably across the continent – ranging from less than 1% in Mauritania to almost 40% in Botswana and Swaziland. More than one in five pregnant women are HIV-infected in most countries in Southern Africa, while elsewhere in sub-Saharan Africa median HIV prevalence in antenatal clinics exceeded 10% in a few countries. While sustained prevention efforts in a few countries in West and East Africa (principally Senegal and Uganda) continue to demonstrate that HIV and AIDS can be checked with human intervention, signs that similar inroads might be building in Southern Africa remain tenuous, at best.

Based on the country's latest national round of antenatal clinic-based surveillance, it is estimated that 5.3 million South Africans were living with HIV at the end of 2002. Because of South Africa's relatively recent epidemic, and given current trends, AIDS deaths will continue to increase rapidly over the next five years at least; in short, the worst still lies ahead. A speedily-realised national antiretroviral programme could significantly cushion the country against the impact.

In four neighbouring countries – Botswana, Lesotho, Namibia and Swaziland – the epidemic has assumed devastating proportions. There, HIV prevalence has reached extremely high levels without signs of levelling off. In 2002, national HIV prevalence in Swaziland matched that found in Botswana: almost 39%. Just a decade earlier, it had stood at 4%. Neither Botswana nor Swaziland presents signs of incipient decline in HIV prevalence among young pregnant women aged 15-24. HIV prevalence in antenatal sites in Namibia rose to over 23% in 2002, while Lesotho's data collected in 2003 show median HIV prevalence among antenatal clinic attendees climbing to 30%.

Angola gives cause for concern despite the comparatively low HIV levels detected to date. After almost four decades of war, huge population movements are underway. Millions of people have been able to leave the cities and towns they had been trapped in, internal and cross-border trading movements are resuming, and an estimated 450,000 refugees are returning (many from neighbouring countries with high HIV prevalence rates). Such conditions could prime a sudden eruption of the epidemic. In Luanda, preliminary results of HIV prevalence testing in five antenatal clinics suggest a median HIV prevalence of around 3%, although a 2001 survey of sex workers in Luanda indicated that 33% of them were HIV-positive. While too little accurate information is available on the epidemic's advance elsewhere in Angola, there is no doubt that the country's HIV and AIDS response leaves much room for improvement. Prevention activities are few and far between, very few voluntary testing centres have been established, and levels of HIV and AIDS knowledge are very low.

A distinct picture emerges in East Africa and parts of Central Africa. HIV prevalence continues to recede in Uganda, where it fell to 8% in Kampala in 2002 – a remarkable feat, considering that HIV prevalence among pregnant women in two urban antenatal clinics in the city stood at 30% a decade ago.

Similar declines echo this accomplishment across Uganda, where double-digit prevalence rates have now become rare.

We are not, therefore, witnessing a decline in this region's epidemic. There is no cause for complacency. In the absence of effective interventions, the epidemic will continue to wreak havoc in these countries.

The region's epidemics are varied and diverse, which means that the driving factors (along with the circumstances and interventions that might inhibit the HIV spread) must be better understood. This seems particularly true for Southern Africa, where structural factors (including socioeconomic and sociocultural inequalities) appear to be bedevilling effective responses.

National reports tracking progress towards implementation of targets established in the Declaration of Commitment on HIV and AIDS (agreed to at the United Nations General Assembly Special Session in June 2001) show that a large number of countries have no national orphan policies in place, voluntary counselling and testing coverage is threadbare, and prevention of mother-to-child transmission is virtually non-existent in many of the hardest-hit countries. Over 70% of countries reporting from Africa on efforts to reduce HIV transmission to infants and young children have virtually no programmes to administer prophylactic antiretroviral therapy to women during childbirth and to newborns.

Almost half the African countries reporting have not adopted legislation to prevent discrimination against people living with HIV and AIDS, and only one in four countries report that at least 50% of patients with other sexually transmitted infections (co-factors for HIV infection) are being diagnosed, counselled and treated. Although treatment coverage remains low (with only an estimated 50,000 people having access to antiretroviral drugs in 2002), some countries, such as Botswana, Cameroon, Eritrea, Nigeria and Uganda have made serious efforts to increase access to antiretroviral drugs through both the public and private sectors.

Some basic data (2001)
44 countries make up the Sub-Saharan region, and 14 of them belong to SADC

Country	#GDP (Billion US$)	Per capita GDP in US$	Population	Total PLWAs in 2001	Adults (15-49) HIV-positive %	AIDS Deaths in 2001	AIDS Orphans	Childen (0-14) LWAs	Females (15-24) know that a healthy looking person can be infected with HIV %	Reported condom use for adults (15-45) with last high risk sex %	
										Male	Female
Angola	8.3	610	10 400 000	35 000	5.5	24 000	100 000	37 000	57.2	-	-
Botswana	5.1	3 057	1 600 000	300 000	38.8	26 000	69 000	28 000	21.6	85.0	-
* DRC	7.0	134	53 600 000	1 300 000	4.9	120 000	930 000	170 000	-	-	-
Lesotho	0.8	386	2 200 000	360 000	31.0	25 000	73 000	27 000	53.9	-	-
Malawi	1.5	133	10 500 000	850 000	15.0	80 000	470 000	65 000	16.7	38.9	8.7
Mauritius	4.5	3 792	1 200 000	-	0.1	<100	-	<100	-	26.3	-
Mozambique	2.4	132	19 400 000	1 100 000	13.0	60 000	420 000	80 000	62.1	-	-
Namibia	2.9	1 538	1 800 000	230 000	22.5	13 000	47 000	30 000	-	-	-
Seychelles	0.6	8 050	100 000	-	-	-	-		-	-	-
South Africa	133.3	2 492	43 600 000	5 000 000	20.1	360 000	660 000	250 000	50.0	-	-
Swaziland	1.2	1 117	1 100 000	170 000	33.4	12 000	35 000	14 000	81.5	-	-
Tanzania	8.9	247	36 200 000	1 500 000	7.8	140 000	810 000	170 000	33.0	34.0	22.8
Zambia	3.1	301	9,800 000	1 200 000	21.5	120 000	570 000	150 000	25.3	30.1	17.6
Zimbabwe	9.4	761	11 400 000	2 300 000	33.7	200 000	780 000	240 000	26.0	70.2	42.0
Total	**173.8**		**219 500 000**	**14 090 000**		**845 000**	**2 902 000**	**854 000**			
Average	792										

Gross Domestic Product (the total value of goods produced and services provided in a country in one year) * Democratic Republic of Congo

Resource Material 2.1

HIV and AIDS and education in Sub-Saharan Africa

Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach. (Peter Piot UNAIDS)

- The HIV and AIDS pandemic in SSA is going to be more terrible to live through than any of us can imagine today.
- Even if we manage to stem the tide of new infections, miraculously find a cure, or slow down the effects of HIV infection by using ARVs, we are going to have to cope with the effects of the pandemic for more than a decade into the future.
- Sub-Saharan Africa is by far the worst affected region in the world and HIV and AIDS have become the leading causes of death in sub-Saharan Africa. By the end of 2001, 8.4% of the adult population of this region were infected, i.e. they were HIV-positive. In the worst affected countries the prevalence rate is as high as 35%, i.e. more than **1 in every 3 adults**. In some urban centres, by the end of 2003, it was as high as 40%, i.e. **4 out of every 10 adults**.
- Levels of infection peak in the 15-29 age group, and the impact on families, households and communities causes untold suffering to the young people within them.
- Children and young people have been disproportionately affected by the pandemic. There are an increasing number of orphans and child-headed households in Sub-Saharan Africa. The total number of maternal and two-parent orphans for SSA as a whole is expected to increase from 9.85 million in 2001 to 18.67 million in 2010. In the worst affected countries 30-40% of all children are expected to be orphans by 2010.
- HIV and AIDS seriously threaten the attainment of Education for All (EFA) goals set during the year 2000 World Education Forum in Dakar.
- The **main** solution available to us is preventive education – that is education which teaches people how to prevent the transmission of the disease.

Resource Material 2.2

Why education matters

*(The following is an extract from **M J Kelly "Defeating HIV and AIDS through education"** which was presented at the Conference on HIV and AIDS and the Education Sector – Department of Education in South Africa from 30 May to 1 June 2002)*

Against this background, let us recall some of the features of HIV and AIDS so that we can better appreciate why, as the World Bank says in a recent report, "education matters" (World Bank, 2002).

First, there is no cure for HIV and AIDS, and many scientists believe that, because of the nature of the virus, there never will be a cure. The antiretroviral drugs suppress HIV activity and influence in the body for as long as they are being taken, but these drugs raise a host of problems relating to their cost, their continued effectiveness, the demands of administration and patient monitoring, dangers of resistance, and the creation of a false sense of optimism. This is not to decry their use, but to flag that they are not a universal panacea for HIV and AIDS.

Second, there is no vaccine. Work on vaccine development is proceeding in several locations, all of them with relatively small research facilities and funds and with none of the major pharmaceutical companies being involved. The latest word from the International AIDS Vaccine Initiative (IAVI) is that we should no longer think of an AIDS vaccine just as possible but confidently say that it is probable (Berkley, 2002). However, it will still be several years before that probability becomes a reality. Moreover, unless action is taken in the very near future to provide the human and physical infrastructure that will be needed for the production and administration of a vaccine to hundreds of millions of individuals, it will be several years after that again before an affordable vaccine becomes universally available.

With no cure available, no vaccine in immediate sight, and no consensus on how to answer the many questions surrounding drug therapy, we must, in the words of the United Nations, make prevention the mainstay of our response (UNGASS, 2001). However, there can be no prevention of HIV transmission without either the maintenance of behaviour that will protect oneself and others, or the change of existing behaviour so that it becomes protective of self and others. The only way of ensuring this is through education, regardless of the circumstances, age of the individual, or nature of the intervention. To maintain existing 'safe' behaviour or to adopt safe behavioural practices, some form of education is necessary. Given this education, the other supports provided by society can be brought into play. In its absence, they remain useless. For instance:

- At the level of practice, messages about the risks of unprotected sex are essentially educational, as are messages about abstinence or condom use.
- The same is true for messages about fidelity in marriage or about reducing the number of sexual partners.
- This also holds for the ensemble of information, appropriate practice and drug treatment for the prevention of parent-to-child transmission, all of which imply considerable behavioural changes in the context of some minimal education package.

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

Education, HIV and AIDS and the Young

A second major reason why education must play a crucial role in preventing HIV transmission is because its principal beneficiaries are young people, ranging in age from infancy to young adulthood. It is mostly the young who are in schools, colleges and universities, developing the values, attitudes, knowledge and skills that will serve them subsequently in adult life.

But if education is largely the sphere of the young, so also is HIV and AIDS. About one-third of those currently living with HIV and AIDS are aged 15-24, while more than half of all new infections – about 7 000 each day, or five each minute – are occurring among young people (UNAIDS, 2001).

Recognising that the young are especially vulnerable to HIV infection, the United Nations has established definite time-bound targets for the reduction of HIV transmission among young people. These targets set clear objectives that should direct our plans and activities in the education sector:

1. By 2005, reduce HIV prevalence among those aged 15-24 by 25 per cent in the most affected countries.
2. By 2005, ensure that at least 90 percent of young men and women aged 15 to 24 have access to information, education – including peer education and youth-specific HIV education – and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers (UNGASS, 2001, §§ 47, 53).

In these terms, the challenge before us at this Conference is to galvanise our education sector to play its part in bringing about a very substantial reduction in prevalence rates among school, college and university students from their current very high levels In 1998, about 21 per cent of women under 20 attending antenatal clinics in South Africa and 26 per centof those aged 20-24 were HIV-infected; the corresponding figures for 1999 were 16.5 per cent and 25 per cent (Whiteside & Sunter, 2000, Chart 4.4).

Will the sector be able to achieve this? Evidence from elsewhere suggests that it will. In Zambia, HIV prevalence among 15 to 19-year-olds in Lusaka dropped from 23 per cent in 1994 to 15 per cent in 1998 and in Ndola from 21 to 16 per cent in the same period. A significant feature of this decline, which was observed both among those attending antenatal clinics and those in population-based surveys, was that it was most marked in those with higher levels of education, whereas there were signs of continued increase in prevalence among the least educated – a girl attending school was three times less likely to be HIV-infected than an age-mate who had dropped out of school (Fylkesnes *et al.*, 2001).

Something similar was found in Zimbabwe where a large population survey showed that those attending school had much lower prevalence rates than those who were not in school (Gregson, Waddell & Chandiwana, 2001 Referred to in Bennell, Hyde & Swainson, 2002, p. 21.). Uganda has also registered significant success in reducing HIV prevalence among young people, with at least some of the credit for this going to the education sector (Kaleeba *et al.*, 2000).

These achievements show that, at the minimum, formal education plays a key role in protecting young people against HIV infection (Bennell et al., 2002, p.21). Even further, they also suggest that, in ways which are not yet clearly understood, a general basic education is making its own specific, intrinsic contribution to the reduction of HIV prevalence rates among young people (cf. Coombe & Kelly, 2001; World Bank, 2002). Education does work against HIV transmission. It is an effective "social vaccine".

This has major implications for the sector.

First, there is the need to ensure that every child and youth has access to education for a certain minimum number of years. The attainment of the international millennium development goals that refer to education-for-all (EFA) are crucial to overcoming HIV through education. Every young person must be enabled to attend an educational institution for as many years as possible, and within this framework, special attention must be given to ensuring the participation of girls over an extended period of years. The achievement of the millennium EFA goals will, itself, go a long way in responding to the AIDS challenge.

Second, we must ensure that within all educational institutions real and meaningful learning takes place. Basically, this is what we are about as educators, regardless of the level at which we operate. No matter how well-attended schools and colleges may be, in the absence of worthwhile learning, they will not contribute as they should to economic independence, poverty reduction, personal empowerment and gender equity. Neither will they promote the knowledge and understanding that are fundamental to the reduction of HIV transmission. Those leaving school will remain prey to the poverty trap which will see many of them being sucked into prostitution, becoming street children, living in circumstances of female subordination, and experiencing other ways of life that will increase their risk of HIV infection. They will also remain much weaker than they should be in the face of HIV risks. The same remains true of programmes for those who do not participate in the formal education system. These will accomplish their goals only if they enable learners to incorporate the

"useful knowledge, reasoning ability, skills, and values" that will stand by them in life, while enlarging their capacity to protect themselves against HIV infection.

From Prevention to Support and Care

Prevention alone is not a complete response to HIV and AIDS. Prevention may be the mainstay of our response since successful prevention education will reduce the numbers who become HIV-infected and eventually cause them to taper off. But we still have to face the legacy of the past two decades of confused and inadequate response. Our heritage today is one of broken lives, distressed people, and orphaned children. The grief and the anguish of the men, women and children of our time surround us on every side. Our milieu is one of physical and psychological pain and suffering, multiple bereavements, mourning and heartbreak, dehumanising poverty, lost opportunities, unfulfilled hopes, shattered dreams.

Resource Material 2.3

Education For All (EFA)

World Education Forum – Dakar, Senegal, 2000

EFA Goals

1. Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children;
2. Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality;
3. Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes;
4. Achieving a 50% improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults;
5. Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access and achievement in basic education of good quality; and
6. Improving all aspects of the quality of education and ensuring excellence of all so that recognised and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

Resource Material 2.4

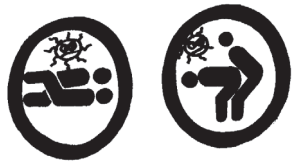
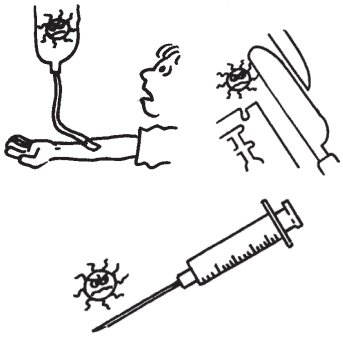
HIV and AIDS "Myth or Fact " Game

Note: You may not wish to use all the questions. Select those that seem most appropriate to the age level and maturity of the group.

1. A person can get HIV by sitting next to a person who has it.
2. A person can be infected with HIV by having sex with a sex worker.
3. An unborn child can become infected with HIV from his/her infected mother.
4. Household insects such as bedbugs and cockroaches can be HIV carriers and transmit the disease to people.
5. If a mosquito bites a person with HIV and then bites somebody else, the second person it bites may get HIV.
6. Women with AIDS may sexually transmit HIV to men.
7. You can contract HIV by using a phone that has just been used by someone with AIDS.
8. You can get HIV if a person with AIDS coughs or sneezes near you.
9. You can be infected with HIV from a toilet seat.
10 You can be infected with HIV by drinking from the same glass as a person who is HIV-positive.
11. You can get HIV by having oral sex with a man who has it.
12. You can get HIV by coming in contact with an infected person's tears.
13. Persons who have sex with many people are at greater risk of exposure to HIV infection.
14. You can get HIV by eating food cooked by someone who has AIDS.
15. You can be infected with HIV from hot tubs or swimming pools.
16. You are likely to get HIV if you sleep in the same bed as someone with AIDS.
17. You can get HIV by hugging a person who has it.
18. College students can be infected with HIV by sitting next to or playing ball with another student who is HIV-positive.
19. A person can become HIV-infected by having sexual intercourse with an infected person.
20. Brothers and sisters of people with AIDS usually also get HIV.
21. Doctors and nurses who treat AIDS patients often get HIV as well.
22 A baby can get HIV by breastfeeding from an HIV-positive mother.
23. You can get HIV by shaking hands with an infected person.
24. You can be infected with HIV from needles used in intravenous injections or blood transfusions.
25. A healthy looking person who is HIV-positive is not likely to transmit the virus to others through sexual contact.
26. A person with a negative blood test during the "window period" is not likely to transmit HIV through blood transfusion.
27. An unborn child can develop AIDS if either parent is HIV-positive.
28. AIDS affects only the poor and uneducated.
29. Needle-sharing among IDUs contributes to the spread of HIV infection.

Resource Material 2.5

How HIV is spread

	**Sexual intercourse** • Most people get HIV by having unprotected sexual intercourse with an infected person. • Unprotected sexual intercourse means having vaginal or anal sex without a condom. • HIV may also be transmitted through oral sex.
	**Infected blood** • One can get HIV through a transfusion with infected blood. • One can get HIV by using instruments used on someone with HIV for earpiercing, tattoos or circumcision, which have not been properly sterilised. • One can get HIV by using needles or syringes used by someone with HIV for injections that have not been properly sterilised.
	**Infected mother to her unborn child** • Babies born to mothers with HIV may become infected in the womb before birth, during birth, and sometimes through breast milk.

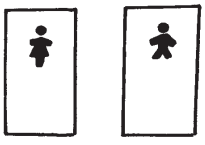
Resource Material 2.6

How HIV is NOT spread

- Attending school or college

- Coughing, sneezing, sweat or tears

- Hugging/Kissing each other



- Using toilet or shower facilities

- Shaking hands

- Mosquitoes or other insects

- Sharing clothes, phones, computers, chairs, desks

- Eating foods prepared or served by an infected person or sharing plates, spoons, cups, etc.

- Swimming, using sports and gym equipment

Resource Material 2.7

Finding the answers

Group A	Group B
"Window Period"	Time taken by the body to produce antibodies after infection
Abstinence	Choosing not to have sexual intercourse
Affected people	People who are affected by the pandemic – whether they are infected or not
AIDS stands for	Acquired Immune Deficiency Syndrome
Antibody	A substance in the blood that counteracts harmful infections
Antiretrovirals	A class of drugs which slows down the increase of a virus in a person's body
CD4 cell count	A measure of the number of white blood cells in the blood
Communicable	A disease that is passed from one person to another
Epidemic	A disease prevalent in a community
HIV stands for	Human Immunodeficiency Virus
HIV-positive	A person who is infected with the Human Immunodeficiency Virus
Immune deficiency	Lack of response by the immune system to disease-causing organisms
Immunity	The body's capacity to resist disease
Infected people	People who have been infected with HIV (they are HIV-positive)
Oral sex	Using the mouth for stimulation of genital organs
Pandemic	A disease prevalent over a whole country or continent
Rape	Forcing someone to have sexual intercourse against their will
Sexual intercourse	Vaginal or anal penetration with the penis
Sexually transmitted disease	A disease transmitted through sexual activities
Syndrome	A set of symptoms which arises from a single cause
VCT stands for	Voluntary Counselling and Testing
White blood cells	Part of the blood responsible for destroying infections that enter the body

Resource Material 3.1

Facts about HIV and AIDS

- Every normally healthy human body has a natural defence system which provides protection from disease-causing organisms. This is called the **immune system**.
- The Human Immunodeficiency Virus (**HIV**) is a virus that weakens the immune system of a human body; it makes the immune system deficient and less able to protect the body from other infections such as tuberculosis, pneumonia, malaria, etc. Such infections are called **"opportunistic infections"** because they take the opportunity to attack a person whose immune system has been weakened.
- HIV lives in human immune cells and can be transmitted from one human being to another only in the following body fluids: semen, vaginal fluid, blood or breast milk. Urine, faeces and saliva are not significant vehicles of HIV transmission.
- When HIV is detected in the blood of a person, they are described as "HIV-positive". A person without the virus in their blood is "HIV-negative". A person who is HIV-positive can transmit the virus to another person.
- Once infected with HIV, a person has a life expectancy of about 10 years.
- An HIV-positive person can live for some years without showing any noticeable effects, but gradually, as their immune system deteriorates, they develop Acquired Immune Deficiency Syndrome (**AIDS**).
- A syndrome is a set of symptoms that appear in combination and result from a common underlying cause.
- Once a person has AIDS his/her capacity to live a normal human life deteriorates rapidly, and he/she will die within a few years. HIV and AIDS diminishes or destroys quality of life before it takes away life itself.
- There is no cure for HIV and AIDS.
- Although the research community has been trying to discover a vaccine to protect people from HIV and AIDS, there has been no success as yet.
- A healthy lifestyle, and especially good nutrition, enables the body to cope more satisfactorily with HIV infection.
- There is a class of drugs called Antiretrovirals (**ARVs**) which slow down the effects of HIV, and enable a person to live a normal life for longer. However, once a person starts taking ARVs, they need to do so every day for the rest of their lives.
- We know how the disease is transmitted, but despite this knowledge it continues its rampant spread. The main solution available to us is **preventive education** i.e. that is education that teaches people how to prevent the transmission of the disease.

Resource Material 3.2

Further facts about HIV and AIDS

HIV is the virus that causes AIDS. It weakens the immune system, the body's natural defences against disease-causing organisms. A person with HIV can still feel and look healthy. He or she can continue to carry on with life's daily activities.

Did you know that:

- HIV, like other viruses, is very small – too small to be seen with an ordinary microscope. It may live in the human body for years and can be transmitted to others before any symptoms appear. As it affects the body's defence mechanism, the body becomes unable to fight disease and infections.
- To reproduce, HIV must enter a body cell, which, in this case, is an immune cell. By interfering with the cells that protect us against infection, HIV leaves the body poorly protected against the particular types of diseases that these cells usually deal with.
- Infections that develop due to HIV's weakening of the immune system are called "opportunistic infections". Examples are respiratory, gastro-intestinal and skin infections.
- Persons infected with HIV may not exhibit symptoms of the disease and can, therefore, infect others without knowing it.

Someone is diagnosed as having AIDS when HIV has done such severe damage to their immune system that death will follow within a period of not more than about two years.

The four words of the acronym AIDS stand for:

Aquired	A result of contact with the source external to the body – particularly sexual partners
Immune	The body's natural protection against being infected by disease-causing organisms
Deficiency	A lack of adequate response by the body's immune system to protect against infection
Syndrome	A group of signs or symptoms resulting from a common cause, and appearing in combination and presenting as a clinical manifestation of a disease

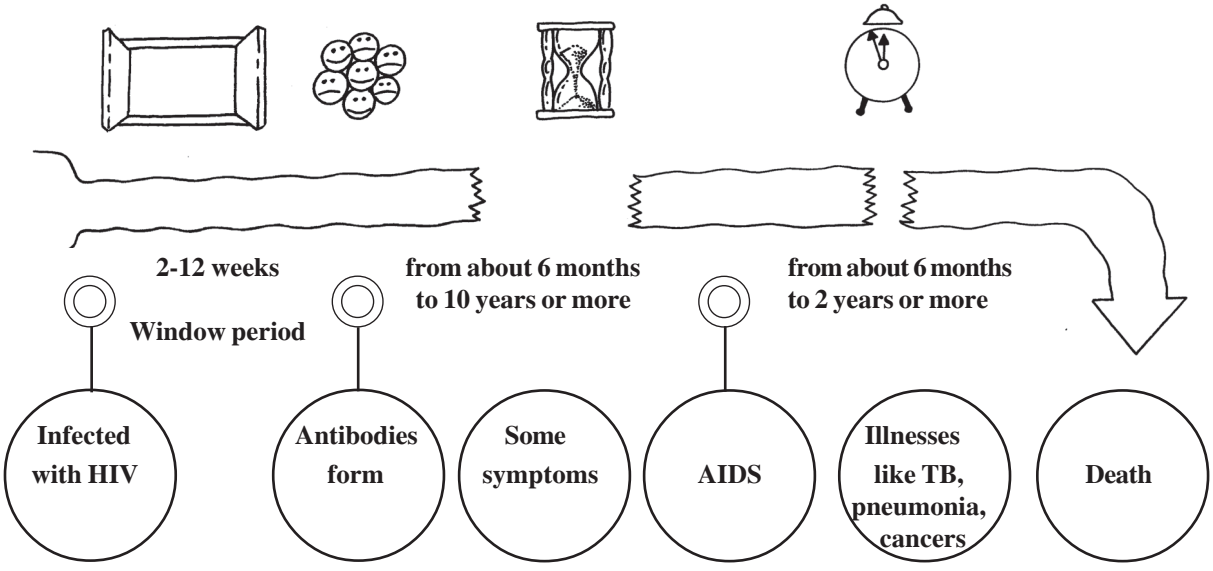
Did you know that:

- AIDS is caused by a virus called HIV, which attacks and, over time, destroys the body's immune system.
- A person has AIDS when the virus has done enough damage to the immune system to allow infections and other diseases to develop.
- Such infections make the person ill and lead to his/her death.
- For every person diagnosed with AIDS, there are many others who are HIV-positive without knowing it.
- It is not known how long it will take those who are infected with the virus to develop AIDS, but it is estimated that 25-50% will develop AIDS within five to ten years following infection with HIV.
- The mortality rate is very high (50% of adults diagnosed with AIDS die within 18 months of being diagnosed).
- Children progress from HIV infection to AIDS more quickly than adults. The survival period for children is much shorter than it is for adults.
- At present **there is no vaccine or cure for AIDS** although vaccine materials and several drugs are being tested.

What is the "Window" Period?

This is the time the body takes to produce measurable amounts of antibodies after infection. For HIV, this period is usually 2-12 weeks; in rare instances it may be longer.

This means that if an HIV antibody test is taken during the "window" period, it will be negative, since antibodies are not yet present at a detectable level. However, the infected person may transmit HIV to others during that period. People taking the test are advised, if the result is negative, to return for follow-up in three months, by which time antibodies may be detected to confirm infection. They are also encouraged to avoid risk behaviours during the three months.



Spread of HIV

HIV is not spread through everyday college and social activities. It is not spread through casual contact with persons, such as hugs, dry kisses, and hand shaking; neither through air nor water. Neither is HIV spread by just being around an infected person. The skin protects us from infectious agents, including HIV. Simple first-aid and routine cleaning suffice. Use a barrier such as a clean cloth, gauze, plastic wrap or latex gloves between you and someone else's blood. Always wash your hands with soap and water after giving first aid, whether you wore gloves or not.

Why mosquitoes do not spread AIDS

Probably the most common question about AIDS is whether the virus spreads through mosquitoes or other blood-sucking insects. Fortunately, the answer is NO. Here is why.

Malarial parasites require certain species of mosquitoes to complete their life cycle. The parasites are sucked into a mosquito's body through the blood meal, develop and multiply in gut cells, and migrate to the salivary glands to be injected into the next person's blood stream. HIV multiplies only in human immune cells and infec-tion is acquired through contact with body fluids (semen, blood, vaginal fluids).

Studies show that even with the presence of an AIDS patient in a household where insects/mosquitoes abound, no infection occurs except when there are sexual partners or there is transmission between mother and child.

Resource Material 3.3

Elements in the Chain of Infection

CAUSATIVE AGENT

RESERVOIR/SOURCE OF INFECTION

MODE OF EXIT

MODE OF TRANSMISSION

PORTAL OF ENTRY

SUSCEPTIBLE HOST

Resource Material 3.4

Levels of Risk

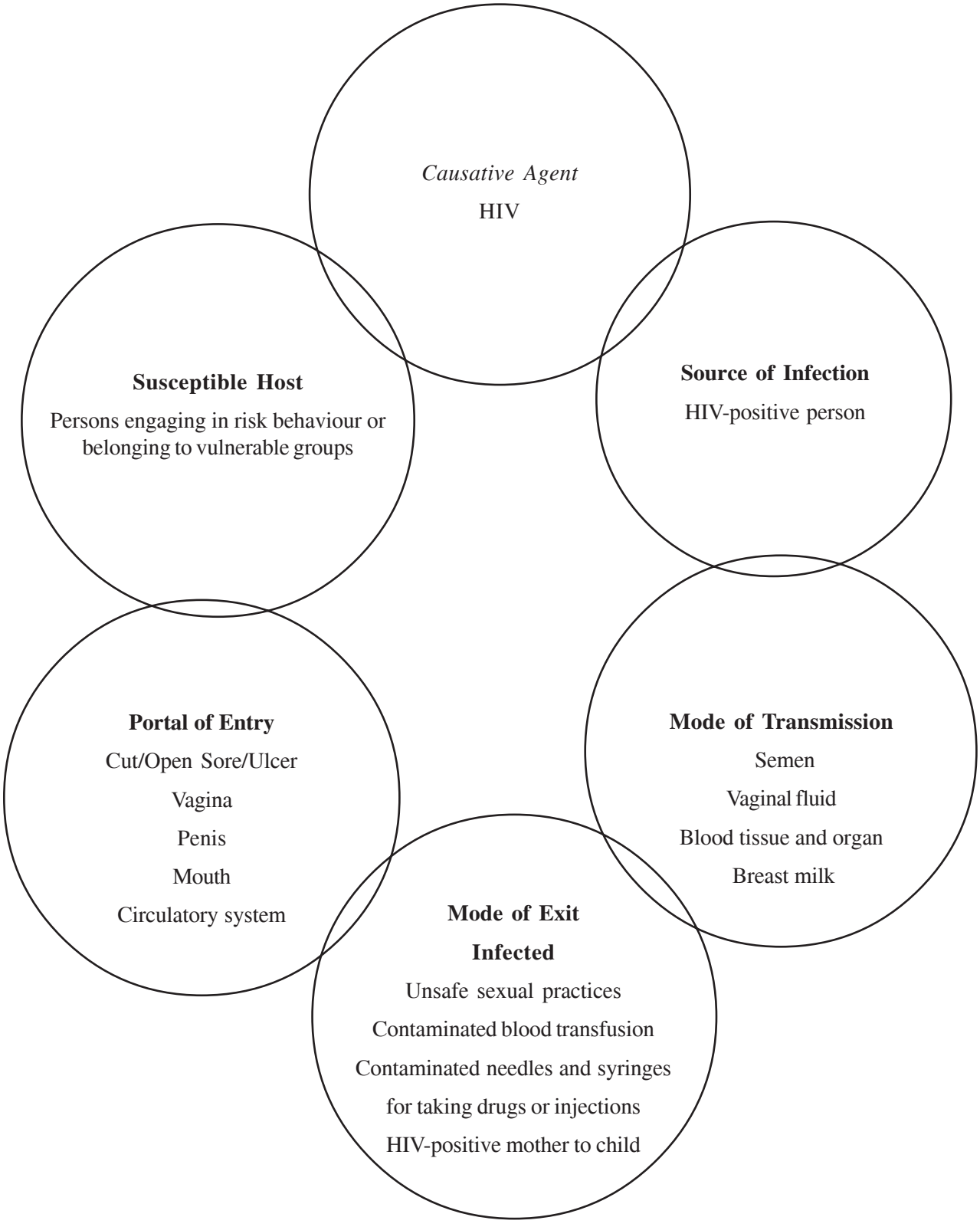
For each of the behaviour/practices listed below, indicate in the accompanying box the level of risks associated with it. The three risk levels are:

NR (No Risk)
LR (Low Risk)
HR (High Risk)

1. [ ] Using toilets in a public washroom
2. [ ] Touching or comforting someone with HIV and AIDS
3. [ ] Having sex with a person without a condom
4. [ ] Having sex with more than one partner
5. [ ] Dry kissing
6. [ ] Sharing needles for intravenous drug use
7. [ ] Swimming with an HIV-positive person
8. [ ] Sharing needles for ear-piercing and tattooing
9. [ ] Abstaining from sexual intercourse
10. [ ] Going to college with an HIV-positive person
11. [ ] Being bitten by a mosquito
12. [ ] Donating blood
13. [ ] Having sex using a condom properly
14. [ ] Eating food prepared by an HIV-infected person

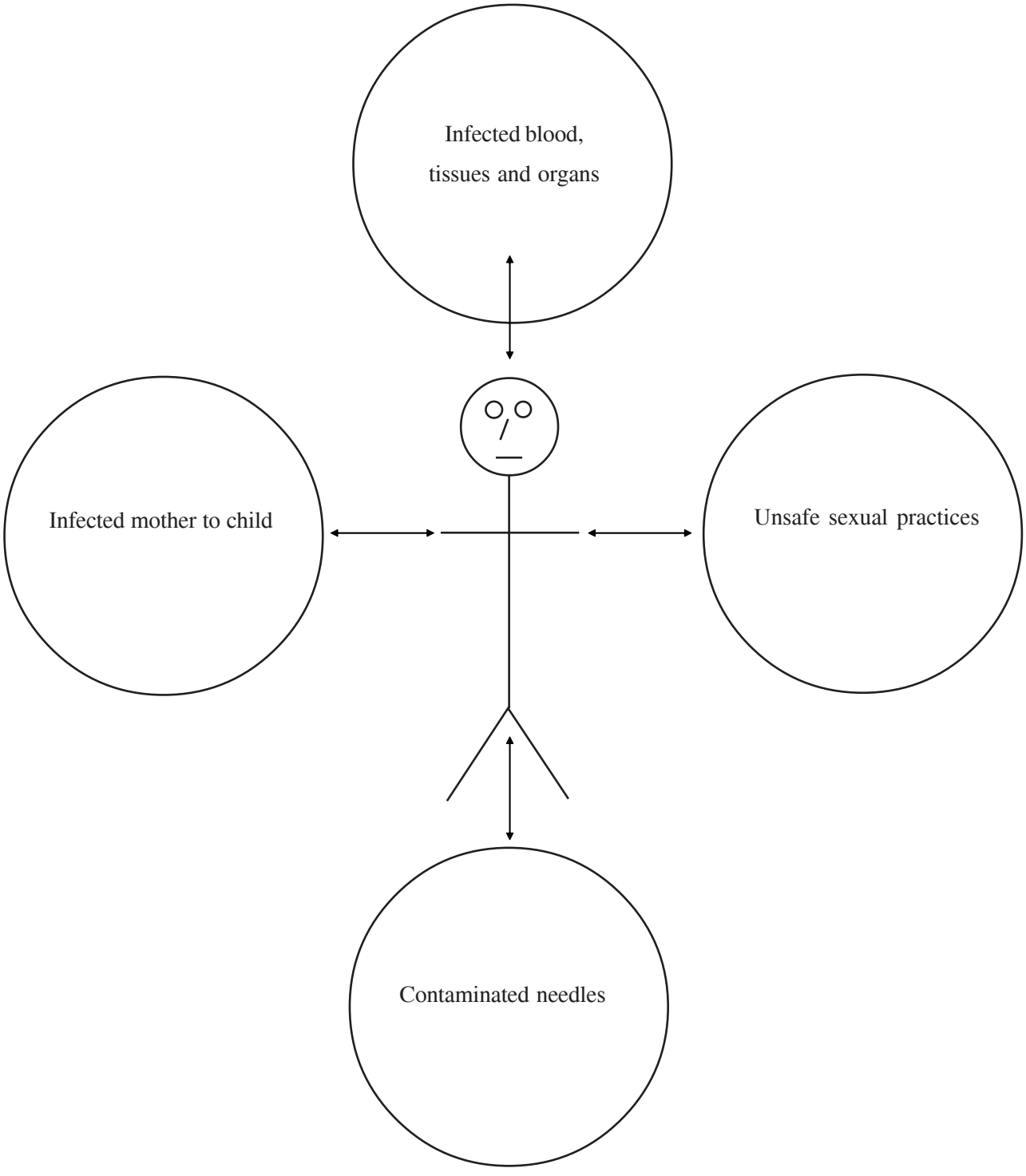
Resource Material 3.5

Elements in the Chain of Infection



Resource Material 3.6

Modes of Transmission



Resource Material 3.7

HIV and AIDS Transmission and Prevention

Is AIDS preventable and/or curable?

At present, vaccines for the prevention of HIV infection and drugs for the treatment of AIDS are being tested for their safety and efficacy. Even while some of the opportunistic infections that accompany AIDS can be treated with appropriate drugs, the individual usually succumbs to multiple infections and general debility within 5 to 15 years. **Therefore, the only way to protect yourself from AIDS is to prevent yourself from being infected with the virus.**

What is prevention?

Prevention refers to any measures undertaken to protect individuals or groups from being exposed to HIV infection.

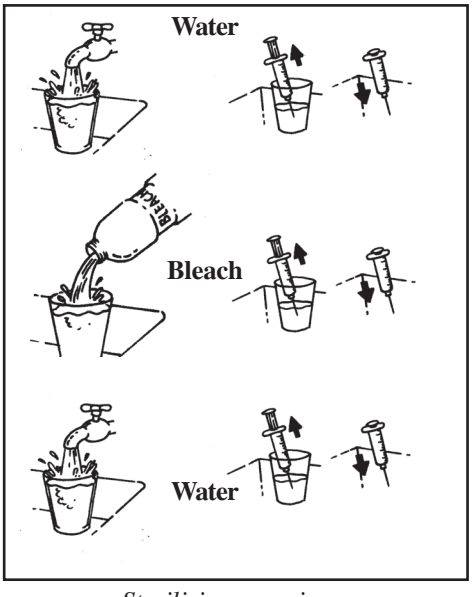
How do I protect myself and my family from HIV and AIDS?

The **safest** way to protect oneself from HIV infection is by **CONSISTENTLY** practising the **three As** of **HIV prevention**:

- **A**voiding unsafe sexual practices: vaginal, oral, anal, oral-anal;
- **A**bstaining from sex and sharing injections for intravenous drug use or use of other skin-piercing instruments unless absolutely necessary (i.e. medical emergency); and
- **A**voiding direct contact with contaminated body fluids.

Alternative, but **less effective**, ways to protect oneself from HIV infection include **CONSISTENTLY** practising the **H.U.M.A.N.** method of HIV prevention:

- **H**andling a condom properly by:
  - Using only a new condom in good condition
  - Placing the condom on the penis before ANY sexual contact (not just before penetration or before orgasm);
  - Ensuring the condom fits properly;
  - Using an effective water-based lubricant on the outside of the condom;
  - Wearing the condom for the duration of sex (do not remove it during sex);
  - Removing the condom promptly after male orgasm to avoid leaking; and
  - Thoroughly cleaning the genitals and disposing of the condom.
- **U**sing latex gloves when handling body fluid.
- **M**onogamy: a sexual relationship with one partner who has no other sexual partners and has recently tested negative for HIV. (If there is any doubt at all as to the sexual activity of your partner, a condom should be used EVERY TIME you have sex.)
- **A**ccepting blood transfusion from a trusted source and only if the blood has been screened and tested negative for HIV.
- **N**ew unused syringes, in their original packing, should be used for injecting drugs, and a NEW sterilised device for piercing and circumcisions, etc.



Sterilising a syringe

Resource Material 3.8

Obstacles to Responsible Decisions and Actions to Protect oneself against HIV Infection

OBSTACLES	HOW TO OVERCOME THESE OBSTACLES
Lack of knowledge and understanding	
Poor attitudes and values	
Risky practices and behaviour	
Lack of willpower	
Being forced to do something you know is risky	

Resource Material 4.1

Impacts of HIV and AIDS

A) On the Individual:

Immunodeficiency (a weakening of the immune system, the body's natural defences against infections) leading to secondary infections (such as diarrhoea, skin cancer, pneumonia).

1. 50% of adults diagnosed with AIDS die within 18 months of diagnosis.
2. Rejection by friends and loved ones and isolation from social and community activities.
3. About 30% of children born to HIV-positive mothers will be HIV-positive themselves.
4. Psychological issues include:
   - Fear of pain and dying (especially of dying alone).
   - Feelings of loss related to their ambitions, confidence, physical attractiveness, potency, sexual relationship, status in the community, financial stability, future plans and independence.
   - Anger towards themselves in the form of self-blame for acquiring HIV and towards others for perceived abuse of their bodies or privacy.
   - Suicidal tendency – may be seen as a way of avoiding pain and discomfort or to lessen the shame and grief of loved ones.
   - Loss of self-esteem and feelings of self-worth caused by rejection by colleagues or loved ones combined with the physical impact of HIV-related diseases such as disfigurement, physical wasting and loss of strength.
   - Hypochondria – an obsessive state due to a preoccupation with health and of avoiding infections.
   - Grief about the losses they are experiencing or are anticipating.
   - Guilt over the possibility of having infected others, over behaviour that may have resulted in infection, and over the hardship their illness will cause loved ones, especially children.
   - Depression due to the absence of a cure, and the resulting feelings of helplessness and loss of personal control.
   - Denial as a means of handling the shock of diagnosis.
5. Anxiety over:
   - Short-term or long-term prognosis.
   - Risk of infection with other diseases.
   - Risk of infecting others with HIV.
   - Loss of physical and financial independence.
   - Declining ability to function efficiently.
   - Future social and sexual unacceptability.
   - Loss of privacy.
   - Availability of appropriate medical/dental treatment.
   - Ability of loved ones to cope.
   - Fear of dying in pain or without dignity.
   - Possibility of abandonment and isolation.
   - Dismissal from employment or denial of employment for no other apparent reason.
   - Fear, anxiety, paranoia and loss of self-esteem on the part of uninfected people close to HIV-positive individuals.
   - Further acts of discrimination against members of certain groups such as gay men, intravenous drug users and sex workers.
   - Denial of entry into certain countries.

B) On the Family:

Psychological stress of all family members caused by anger, sorrow, frustration and the inability to cope with the needs of the infected individual.

Discrimination and rejection faced by all family members involved with the care of the infected individual.

Economic problems due to high cost of drugs and hospitalisation frequently combined with the inability to go on working.

C) On the Community:

Funds from other areas of public need are drained by costs associated with AIDS prevention diagnosis, treatment and care. Strain on the health-care system and insurance companies.

Loss of economic output and productivity due to illness in prime working years.

D) On the Economy:

Sector	Individual	Community	National
Health	Increased expenditure	Increased expenditure	Need to expand health infrastructure
Education	Absenteeism	Decreased value of future human resources	Loss of trained people
Trade & Industry	Loss of productivity	Increased emigration	Effects on tourism
Agriculture	Loss of productivity	Reduction in cultivated land	Threat to food security

Cost	Before infection	Infection	Illness	Direct
Direct	Control & preventive measures	Testing & oupatient care	In-patient care	Funeral & associated expenses
Indirect	Precautionary saving	Lower productivity of ill members	Lower productivity and loss of income	Income foregone
	Insurance	Reduction in consumption and investment	Reduction in consumption and investment	Drop in family income
	Acceptance of less risky, but less well-paid jobs	Opportunity cost of looking after ill member Psychological cost to ill and other family members Costs to others unwittingly affected by ill member	Opportunity cost of looking after ill member Psychological cost	Poor health of surviving members

Source: UNAIDS

Economically:

- Women have limited access to wage employment, and the responsibility for child and family upkeep force dependence on male partners for economic stability. Such circumtances obstruct any effective HIV preventive campaigns.
- Some women are compelled to turn to commercial sex work as an economic strategy, exposing themselves to high risk of HIV infection.

The common perception of AIDS in the 1980s was that it was a disease of promiscuity and drugs in the industrial countries. There is no doubt now that AIDS is closely linked to poverty (particularly of women). Poverty offers a fertile breeding ground for the epidemic's spread, and infection sets off a cascade of economic and social disintegration and impoverishment.

"The problem I had initially was as a nurturer. Taking care of my husband (who had an HIV-related illness), the household and raising a child. Doing all the ordinary tasks every day – and having someone sick. Trying to meet my husband's needs and look after my child and myself – but feeling overwhelmed by AIDS has made me sick. But if I don't work, my family will not eat."

– HIV-positive housewife and mother

Impact alleviation:

According to the 1996/7 UNAIDS Progress Report, "Research in Africa and Asia" has provided information on the impact of HIV and AIDS, both at the societal level and at the level of specific regions, countries and districts in an attempt to alleviate the impact of AIDS.

Resource Material 4.2

Counselling

Counselling is extremely important in the context of HIV and AIDS because HIV and AIDS are life-long infections and because there is stigma and discrimination against people living with HIV and AIDS.

Definition of HIV and AIDS counselling

Confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS. The counselling process includes evaluation of personal risk of HIV transmission and facilitation of prevention. This includes information, education and psychological support and allows individuals to make decisions that facilitate coping and preventive behaviours. (WHO)

The main objectives of HIV and AIDS counselling are to:

- Enable a person to cope with stress related to HIV and AIDS;
- Provide psychological/emotional support to HIV infected and affected people;
- Reduce the impact of HIV and AIDS on individuals and family; and
- Facilitate behaviour and life-style change.

Counselling involves:

- Establishing trustworthy relationships with people with HIV;
- Maintaining confidentiality;
- Empathising and showing caring attitude;
- Respecting the person; and
- Networking for care and support.

Pre- and post-test counselling

- People wanting to know their HIV status should always be counselled before the test (Pre-test counselling); and
- Should always be counselled after the test (Post-test Counselling).

Teacher educators should be good counsellors. They need to cultivate a non-judgmental attitude and respect confidentiality.

Resource Material 4.3

Living Positively when you are HIV-positive

An HIV-positive person should try to keep the body strong. This means they should:

- Maintain a good diet, whenever possible including food rich in proteins, vitamins and carbohydrates. Nutritional deficiencies may adversely influence immune function. Good nutrition strengthens the body to fight infection. Fresh food is preferable to canned and processed food. Fresh vegetables and fruits contain many vital vitamins and minerals. Food should be washed and properly cooked before consumption to avoid food-related infections. Self-help groups can support members by providing healthy recipes.
- Stay as active as possible, keep fit and sleep regularly. Exercise helps prevent depression and anxiety and can add to a general feeling of well-being and contribute to general health and stamina.
- Continue to work, if possible.
- Occupy themselves with meaningful, or at least distracting, activities.
- Socialise with friends and family.
- Talk to someone about the diagnosis and illness.
- Use a condom during sexual intercourse.
- Seek medical attention for health problems and follow the advice for care including counselling and social services. This includes preventive services by identifying potential and actual stress factors.

They should avoid:

- Alcohol and cigarettes;
- Other infections, including further doses of HIV;
- Pregnancy, because it lowers the body's immunity and, according to some reports, could hasten the onset of AIDS to an HIV-positive woman;
- Using non-prescribed drugs; and
- Isolating themselves.

The best place for proper care of people living with HIV and AIDS is home, because it is the place where the person gets love and emotional support. People living with HIV and AIDS can lead a healthy life and delay the progression of disease. This is known as living positively. People living with HIV and AIDS need support to change their lifestyle and behaviour. This can also protect other people. PLWAs can also lead a normal life.

Some important points about how to live healthily and positively when HIV-positive:

- Take care of yourself
- Maintain self-esteem
- Keep yourself healthy
- Eat nutritious food
- Take adequate rest and sleep
- Do regular exercise
- Avoid alcohol, tobacco and other addictive substances
- Be in touch with a counsellor
- Seek medical care when ill
- Get more information about HIV and its modes of transmission
- Protect others from being infected by you
- Spend time with family and friends
- Be positive and keep yourself busy
- Plan for the future

Resource Material 5.1

ACTIONAID: Key Recommendations

Boer T, Adoss R, lbrahim A, and Shaw M (2003)
The Sound of Silence: Difficulties in Communicating on HIV and AIDS in Schools
London: Actionaid
Page 8

Extending beyond the classroom

If HIV and 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 and AIDS.

Locally relevant HIV and AIDS education

There needs to be a move away from an overly scientific approach to HIV and 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 and 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 and AIDS education should focus on power and communication issues in wider human relationships. 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 and 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 and AIDS be adequately addressed in schools.

Resource Material 5.2

Risk Reduction

UNAIDS (May 2003)
HIV and AIDS & Education: A Strategic Approach
Paris: IIEP Publications
Pages 41 - 47

Good quality programmes of prevention education have beneficial effects. They result in the adoption of positive behaviours, including a delay of the age of first sex; an increase in the use of condoms among young people who are sexually active; a reduction in the number of sexual partners; a reduction in alcohol and drug use, and the risks associated with injecting drug use in particular. They have an effect on the environment, in particular, by improving health, safety and security in educational settings and elsewhere within communities.

Information is necessary but knowledge alone is not sufficient to protect young people against HIV and AIDS. What is needed is an interactive process of teaching and learning that helps young people acquire the knowledge, attitudes and skills to enable them to take greater responsibility for their own lives, resist negative pressures, minimise harmful behaviours and make healthy life choices.

A range of 'entry points' can be used for risk reduction work in and out of schools. These include work on gender, sexuality, pregnancy, violence, drug use, employment and broader social issues. However, the key elements of knowledge, attitudes and skills should be taught sequentially in ways that build upon one another. Education to prevent HIV and AIDS should always be coherent and gender sensitive and should not be spread thinly over a range of topics or subject areas.

Health risk behaviours frequently have the same root causes. Based on research, the most successful programmes are those in which policy development, health promoting environments, skills-based health education and school health services are strategically combined. One widespread programming model is the Focussing Resources of Effective School Health (FRESH) programme jointly supported by UNESCO, UNICEF, WHO, the World Bank, and Education International.

Good quality risk reduction education relies on trained and skilled human capacity. Teachers and others need to be properly trained, supervised and monitored in their work. They need to know that their interventions will be significant, and that they will be supported in their efforts. This is especially true for HIV and AIDS where, despite clear scientific evidence to the contrary, the erroneous view continues to be expressed that HIV and AIDS education does not work, or that education about sexuality leads to increased sexual activity.

School-based efforts to prevent HIV infection can be controversial, for educators as well as for the community. Political commitment at the highest level, and most certainly from within ministries of health and education, is vital for success. Despite common misconceptions about HIV and AIDS education, community resistance should not be assumed. Community members, including parents and religious leaders, are often keen to be better informed and more involved.

Table Education to reduce risk is

- **A learning/teaching issue.** Teachers, educators, youth workers, health care workers and others require training and support, good quality curricula and materials, and the knowledge, attitudes and skills to protect themselves and others from HIV infection.
- **A human rights issue.** Children and young people have the right to the information, resources and skills that will enable them to protect themselves and others against infection.
- **A cultural issue.** Schools and education systems socialise new generations into the norms that influence and regulate citizenship, economic activity, and personal relationships. To do so successfully, the messages being sent have to be sufficiently appropriate to the cultural context to be assimilated by the learners.

- **A community issue.** Schools and education systems are part of the local community, and should seek to engage with its concerns and needs, including threats to individual and social well-being such as HIV and AIDS.
- **An inter-sectoral issue.** Schools are not the only place in which children and young people learn. Education about HIV and AIDS can and does, take place in a variety of settings. Working together across settings, lends coherence to prevention messages and approaches.

Schools can reach further into the community than many other institutions. Attitudes and behaviours taught and learned in schools serve as examples far beyond the classrooms. HIV and AIDS Preventive Education in schools is, therefore, an important vehicle for reaching and enabling children and young people to protect themselves. Such efforts are likely to work best where schools are safe places for learning and playing, and where school based efforts are reinforced by community-based support.

In order to reach young people before they become sexually active, or are sexually targeted, HIV and AIDS education must begin early and extend throughout the school years. Unfortunately, many of the young people who are at most risk today are not at school, either because they have dropped out or because they never enrolled. Therefore, schools should be used as much as possible as places for outreach to a broader population. Non-formal programmes need to be linked to school-based work to ensure that young people are reached both in and out of school. Integral to such efforts is the need for multi-sectoral coordination to enhance education for the long term.

Teachers, and other educators and facilitators, are important role models. All should receive training and support to meet demands within and outside the classroom. This needs to go beyond basic awareness training to include establishing appropriate codes of practice, reviewing personal attitudes, and acquiring specific skills for teaching about HIV and AIDS.

Establishing a comprehensive, system-wide effort in countries where little or no preventive education is taking place will take effort and time. It is important to begin by building a consensus on the need for education and knowledge about the disease and ways to prevent it. It is important also to begin to construct a base on which wider efforts can rest.

Actions to reduce risk

Attention should be focused on the following key areas:

- **Policy development.** Clear national policies are needed to support education for HIV and AIDS prevention. Within schools and education authorities, clear policy frameworks need to be established and implemented to ensure that schools become HIV risk-free environments. These should specify the knowledge young people should have access to, the behaviours expected of students and staff, and the services and resources (including condoms) needed to protect against infection.
- **School-based risk reduction education specifically targeting HIV and AIDS**. Preparation and distribution of scientifically accurate, culturally appropriate, good quality teaching and learning materials on HIV and AIDS, communication and life skills. Efforts should be made to encourage learning in ways that maximise the application of relevant knowledge, promote positive attitudes, and provide opportunities for individuals to develop skills in decision-making, cooperation, coping and stress management, and creative and critical thinking. This includes support for school health programmes, such as FRESH, which include a focus on security and safety and which explicitly address HIV and AIDS.
- **Promotion of participatory and peer education** with children and young people, and among teachers themselves. Children and young people must be important participants in all aspects of HIV and AIDS prevention, and not simply the target group. Their active involvement through project work, theatre, dance and debate, as well as in other ways, is a necessary and effective way of customising the messages and ensuring programme relevance.
- **Teacher education and training.** Teachers must be well prepared and supported in their work on HIV and AIDS through pre- and in-service education and training. They are key to the delivery of risk reducing

education for HIV and AIDS prevention, but the HIV and AIDS component of pre- and in-service teacher training for teachers should be regularly reviewed. Where necessary, new resources and approaches should be developed and kept up to date. Teachers require ongoing support in introducing the enquiry-based, rights-oriented types of education about HIV and AIDS that are known to work best. Many of these approaches encourage active participation and skills development.

- **Better linkage with health services.** Wherever possible, links should be made between education for HIV and AIDS prevention undertaken in schools and youth friendly health services. Where such services do not yet exist, efforts should be made to create them in partnership with young people themselves.
- **Strengthened systems of non-formal and community education.** Non-formal and community-based education is important in reaching those not accessible through schools. School and community HIV and AIDS prevention programmes need to provide coordinated messages. The active involvement of parents and community leaders is to be welcomed, provided essential risk reduction measures are not weakened so as to deny young people the knowledge, skills and resources they need.
- **Greater involvement of people with HIV and AIDS.** People living with, or affected by, HIV and AIDS have an important role to play in education for HIV and AIDS prevention. They can assist in the design and implementation of teaching programmes and provide access to perspectives and experiences that help reduce risk (e.g. through their descriptions of key events and life experiences).

Resource Material 5.3

Case Studies

1

Susan is a sex worker. She always uses a condom except when a client refuses. She has recently tested HIV-positive and has been forced to leave the apartment she was sharing with another sex worker. She hesitates to return to her hometown, afraid of how her family and relatives will treat her...

2

Robert was badly hurt in a motor accident four years ago. He received a series of blood transfusions while in hospital. Recently he has not been feeling well and requested an HIV test from his doctor. He tested positive. Robert is now afraid he might have infected his wife and two-month-old son with HIV and is unsure of what to do...

3

Dhondu is a young man from a small village who recently lost his mother and father in a fire. Soon after he moved to Mombasa to work, he became lonely and depressed, and began using heroin. Dhondu recently learned that one of his close friends, with whom he has often shared needles, tested positive for HIV. This frightened Dhundu and prompted him to go for a similar test. The test result indicated that he was HIV-positive...

4

Alude, a teacher in a secondary school, noticed that one of the boys in her class, Vuyani, had been absent for three weeks. She decided that she had better investigate. First she asked other pupils in her class and they told her that they didn't know where he was. Then she decided to visit his home. Vuyani told her that his mother was sick with AIDS, and that he had decided that he needed to stay at home to look after her. Alude spoke to Vuyani's mother and some of the neighbours...

5

Nomandla, the principal of a primary school, was walking in the school grounds one day and at the bottom of the field, under some bushes she thought she noticed a movement. She looked into the bushes and, to her amazement, she noticed that there were some blankets and scraps of food. At first she was angry because she thought that some vagrants must have moved in. But then a gaunt-looking child came creeping out the bushes and Nomandla realised that it was one of the pupils of her school. Nomandla angrily demanded that he explain himself. Through the tears he said that he slept under the bushes because both his parents had died of AIDS and the old woman who was supposed to look after him had said she wouldn't look after him any more because he ate too much food. Then the full story started to come out. Not only this one emaciated boy but eight other pupils of her school also lived under the bushes at the end of the school grounds...

6

One day Gugu, a Standard 6 English teacher, saw Notombi – who had just turned 15 – sitting on the steps of the school crying. When Gugu asked her what the matter was, Notombi said that she has just been told by a health worker that she was pregnant. Gugu asked her who the father was and Ntombi said she couldn't be sure because she had slept with lots of men to raise money to support her mother who was dying of AIDS and could no longer work...

7

Prudence, a teacher at a secondary school thought it was strange that three of the school's pupils – all from the same family – had stopped coming to school. She went to visit them at their house, and they told her that their mother had been diagnosed as HIV-positive and that other children at the school knew this. They told Prudence that when they came to school the other children teased them, wouldn't play with them and passed horrible comments. They had become so unhappy at school that they had decided to stay away...

8

Isaac noticed that one of the pupils in his class, Thabo, had become very morose over the past month or two. Thabo had previously been a happy and cheerful boy, always ready to make a joke and laugh, and popular amongst the other pupils. Now he always seemed to be wandering around on his own and never seemed to laugh. When Isaac asked Thabo what his problem was, Thabo started to sob, and then, eventually, through his tears, managed to say that he had recently discovered that his mother was HIV-positive, and he was sure that he was going to get sick and die quite soon...

Resource Material 6.1

College-based Interventions

Communicable diseases and malnutrition will continue to be among the leading causes of illness and death in the region. Migration across borders and overseas will hasten globalisation with potential importation and spread of diseases. Meanwhile, environmental degradation, pollution, increased urbanisation, industrialisation, and changing lifestyles in metropolitan areas will serve as the breeding ground for stress factors creating health problems of both infectious and non-infectious origins.

College students are at a stage where they start to be sexually active, eager for adventure, and under peer pressure to be accepted socially. Given the proliferation of inducements catering to worldly pleasures and consumerism, young people are prone to regard these as the "in-thing" to do – sex, drugs, imitating movie idols, playing "rich and famous". All these encourage irresponsible behaviour leading to situations which render them vulnerable to HIV-infection.

In other instances, children are sold to prostitution and/or are subjected to abuse by their peers or elders. There is likewise a belief that AIDS can be cured by having sex with a younger person or virgin. Ignorance, fear and cultural taboos prevent these children from getting justice and proper care. If not AIDS victims themselves, children are orphaned early in life by AIDS parents and deprived of material and moral support when they need them most.

There are more than one billion adolescents in the world. Their number in developing countries – over 800 million – will increase by 20% in the next 15 years. Promoting effective health education programmes in colleges, alongside community efforts can protect young people from the ravages of HIV and AIDS.

Education is a national as well as a global concern, and co-operation at the highest level of government is important in making college AIDS education programmes work. Experience in various parts of the world indicates that, working in collaboration with ministries of education and with health and social services, each country's national AIDS programme should be aimed at providing 100% of school and college students with AIDS education.

Good AIDS education covers effective, preventive care and support of people with HIV and AIDS, and non-discrimination. Education of this kind has been shown to help young people to postpone sex, and when they become sexually active to avoid risk behaviour. However, AIDS education is often denied to children and young people for a variety of reasons, including the sensitive and controversial nature of the subject in some societies, and the difficulty of finding time for AIDS education in an already crowded curriculum. In some places colleges teach information on AIDS, but not the behavioural skills needed for prevention and support.

Best practices in college-based interventions include:

- Creating a partnership with policy-makers, religious and community leaders, parents, and teachers, using this partnership to set sound policies on AIDS education.
- Designing a good curriculum and/or good extracurricular programmes adapted to local culture and circumstances, and with a focus on life skills rather than biomedical information.
- Teaching students to analyse and respond to social norms, including understanding which ones are potentially harmful and which ones protect their health and wellbeing.
- Good training, for teacher educators themselves as well as peer educators (young people from the same age group) specifically selected to educate friends and acquaintances about HIV and AIDS.
- Starting HIV prevention and health promotion programmes for children at the earliest possible age, and certainly before the onset of sexual activity. Effectively, this means that age-appropriate programmes should start at primary-school level.

Resource Material 6.2

ILO Code of Practice on HIV and AIDS and the World of Work

The HIV and AIDS epidemic is now a global crisis, and constitutes one of the most formidable challenges to development and social progress. In the most affected countries, the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilising societies.

The ILO code will help to secure conditions of decent work in the face of a major humanitarian and development crisis. Already valuable lessons have been learned in attempting to deal with this crisis. These are reflected in the key principles of the code and its reliance on the mobilisation of the social partners for effective implementation.

Key principles

- **Recognition of HIV and AIDS as a workplace issue:** HIV and AIDS **is** a workplace issue, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.
- **Non-discrimination:** In the spirit of decent work and respect for the human rights and dignity of persons infected with, or affected by, HIV and AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatisation of people living with HIV and AIDS inhibits efforts aimed at promoting HIV and AIDS prevention.
- **Gender equality:** The gender dimensions of HIV and AIDS should be recognised. Women are more likely to become infected and are more often adversely affected by the HIV and AIDS epidemic than men due to biological, sociocultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV and AIDS.
- **Healthy work environment:** The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No.155). A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.
- **Social dialogue:** The successful implementation of an HIV and AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected with, and affected by, HIV and AIDS.
- **Care and support:** Solidarity, care and support should guide the response to HIV and AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to, and receipt of, benefits from statutory social security programmes and occupational schemes.
- **Screening for purposes of exclusion from employment or work processes:** HIV and AIDS screening should not be required of job applicants or persons in employment.
- **Confidentiality:** There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's Code of Practice on the protection of workers' personal data, 1997.

- **Continuation of employment relationship:** HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.
- **Prevention:** HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive.

  Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment.

  The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socioeconomic factors.

Resource Material 6.3

Silences and Obstacles

Boler T, Adoss R, Ibrahim A, and Shaw M (2003)
The Sound of Silence: Difficulties in Communicating on HIV and AIDS in Schools
London: Actionaid
Page: 7

Silences in communicating on HIV and AIDS

Given the sensitivities that surround sex and HIV, teachers reported finding it difficult to discuss HIV and 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 from 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.

Obstacles to teaching HIV and AIDS a wider crisis in education

Apart from the social and cultural constraints that exist in teaching HIV and 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 and AIDS education.

Resource Material 6.4

Stigma and Discrimination

People infected with HIV and AIDS face stigma and discrimination at various levels in families, workplaces, schools, hospitals, etc. This is not the only disease which tends to lead to stigma and discrimination – epilepsy, mental illness, TB, leprosy, skin disorders and others have also been stigmatised and in some situations still are. The main source of discrimination against those with these illnesses arises from ignorance, and myths, about how they are acquired and transmitted.

In the case of HIV and AIDS there are, in addition, strong moral undertones. This disease is linked with promiscuous sexual activities and injecting drug use and these activities are often seen as immoral. Based on prevalent ideology, people believe that HIV and AIDS is the outcome of immoral behaviour, and the infected person should therefore be punished.

But we know that many people, particularly children, who are HIV-positive have acquired this disease through no fault of their own, in ways that can in no sense be regarded as immoral. Stigmatising HIV sufferers has a profoundly negative impact on their lives. They desperately need support and help to cope with their situation. To exclude them from ordinary human life and activities undermines their capacity to cope with their unfolding personal tragedy. Given what we know about how the disease is acquired and transmitted there is no reason to exclude HIV-positive persons from entry to schools and colleges or from any of the normal services of society.

Discrimination against persons who are HIV-positive, especially if it becomes systematic, can seriously reduce their quality of life, distort their emotional lives, and deprive them of the normal human contact which is so essential to their well-being.

Legislation and mass media can play an important role in undermining discrimination against those who are infected with HIV and AIDS. They can consolidate a culture of human rights, spreading well-informed messages about the pandemic, and contribute to an inclusive concern with the pain and suffering not only of those infected but also of those countless people whose lives are affected by gradual deterioration and death of those they love.

However, educational institutions have particularly important roles in counteracting stigma and discrimination against those who are HIV-positive. They are frequently the only source, in a community, of non-mythological knowledge about the disease and how it is acquired and transmitted. Their educative role extends beyond their boundary walls. In addition, they themselves need to be models of caring and compassionate places to be; places in which reasonable precautions are taken to avoid the spread of the pandemic, while at the same time providing the atmosphere in which those infected with, and affected by, the disease can get the support and help they so urgently need to cope with their situations without being stigmatised or suffering unjustifiable discrimination.

Resource Material 6.5

Power Relations

Boler T, Adoss R, Ibrahim A, and Shaw M (2003)
The Sound of Silence: Difficulties in Communicating on HIV and AIDS in Schools
London: Actionaid
Pages 47 and 48

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 pivotal communication 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 and AIDS, a radically different type of learning experience is needed.

Key recommendations

- HIV and 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 skills they need to fulfil their sexual and reproductive rights.

Resource Material 6.6

Universal Precautions in Educational Settings

Universal precautions refers to an approach to infection control which assumes that all human blood and some other bodily fluids could be infectious for HIV and other bloodborne infections, and must be handled accordingly.

Institutions such as schools and colleges bring together, into the same physical space, a large number of people – many of them children and youth. In such settings, and particularly if there are high rates of infection in the area, there can be a risk of HIV infection. However with the correct knowledge about how the disease is transmitted, and reasonable precautions, this risk can be minimised.

The human body fluids that transmit HIV are blood, semen, vaginal fluid and breast milk – among which blood is the most likely one to be encountered by staff and students in typical educational settings. The appropriate procedures for implementing universal precautions include:

- covering any weeping skin lesions (breaks in the skin);
- using disposable latex gloves or some similar barrier for any contact with blood or body fluids containing visible blood;
- thorough washing with soap and water or a disinfectant following contact with blood or open wounds; and
- proper cleaning and disposal methods of all dressings or other materials which have been in contact with blood.

The risk of HIV exposure during ordinary activities or competitive sports is proportional to the risk of direct blood-to-blood contact. The risk of blood-to-blood contact during school-supervised activities is low since this would require that two people with uncovered bleeding or weeping skin lesions come into direct contact with each other.

Both routine infection control procedures and common sense call for requiring all weeping skin lesions to be covered with a dressing before an activity (or game) begins, and removing any player with visible blood until the bleeding is stopped and open wounds are covered.

All first aid kits should contain latex gloves and disinfectant and additional care should be taken by those administering first aid.

The risk of HIV transmission as a result of injuries which involve blood is minor compared to the definite risk of HIV transmission through unprotected sexual intercourse or the sharing of injection equipment.

Resource Material 7.1

*(The following is an extract from **M J Kelly "Defeating HIV and AIDS through education"** which was presented at the Conference on HIV and AIDS and the Education Sector – Department of Education, South Africa from 30 May to 1 June 2002)*

Integrating HIV and AIDS into the Formal Curriculum for Teacher Education

But over and above this, there must be a wholehearted effort to mainstream HIV and AIDS, sexual and reproductive health, and life skills education into the curriculum of every learning institution. The objective would be to empower participants to live sexually responsible, healthy lives. This education must start early and it must be done well. This has major implications.

First, this subject area must be properly professionalised, with the development of a corps of educators and teacher educators who are the specialised professionals in this field. We invest heavily in the multilevel preparation of teachers for mathematics, science, initial literacy, languages, the arts, and other areas – subject areas that prepare children and young people *for life*. We must also invest heavily in the multilevel preparation of educators for HIV and AIDS, sexual and reproductive health and life skills – subject areas that enhance the likelihood that children and young people *will live*. For too long we have toyed with this discipline and in doing so not only have we marginalised it but we have also failed to equip children and the young people who are at grave risk with knowledge, skills, attitudes and values that could mean the difference between life and death for large numbers of them.

Further, as a professional discipline in its own right, HIV and AIDS, sexual and reproductive health and life skills education must be fully integrated across the curriculum (Tirisano HIV and AIDS Programme, Project Two) and into the educational system. It is not an optional extra. It is not an add-on. It is not something that can be picked up in spare moments of a biology or social studies lesson. It is a crucial stand-alone area that necessitates separate timetabling, the support of appropriate materials, and the provision of all the backup guidance, training, teacher support structures, monitoring and evaluation that other subjects receive (Bennell *et al.*, 2002).

Finally, because HIV and AIDS, sexual and reproductive health, and life skills education transcend more freely than any other discipline, the boundary between what goes on inside and outside an educational institution, this subject area calls more strongly than any other for the involvement of communities and parents on the one hand, and social and health services on the other. This is where coalition, the unifying principle of this Conference, must come in. Educators cannot do everything alone. They need the support of parents and communities and the assurance that they approve of the contents and methods of what they teach. They do not want to be in uneasy conflict with them or with their cultural or religious perceptions. Educators also need to have health and social service providers working alongside them in this area, providing guidance, counselling, testing, services, supplies and referrals that go beyond what educators as such can be expected to provide.

There are two further reasons why partnerships involving these various constituencies are of such importance. They bridge the divide between school and community or home, thereby making what is incorporated through education more real and relevant to life outside of school; and, secondly, they ensure that everybody speaks with one voice – no matter what its source, the message to the young is always the same, a factor that continues to be critical to the success Senegal and Uganda have experienced in coping with HIV and AIDS.

Clearly, going down this road of wholehearted integration of HIV and AIDS and life skills education into the curriculum entails massive changes. It also entails major sacrifices, such as foregoing curriculum time for other subjects, and new ways of doing things, such as bringing the community more purposefully on board when designing the curriculum and possibly even for certain teaching activities. If this leaves some of us feeling uncomfortable, let us remember the words of the United Nations Secretary General, "this unprecedented crisis requires an unprecedented response" (United Nations, 1999).

For us in education, radical curriculum overhaul is part of that unprecedented response. The world with AIDS is not the same as the world without AIDS. Education and the curriculum, in a South Africa that is reeling under the

massive impacts of HIV and AIDS, cannot be the same as in an AIDS-free South Africa. And it may well be that we will never see an AIDS-free South Africa unless we take the bold steps needed to adjust our education and curriculum systems. Education can cure us. It is the social vaccine that can lead us progressively to a world without AIDS – but not in its present form, not unless we make the necessary changes, not unless we adjust it purposefully for use as a channel for preventing the transmission of HIV.

Resource Material 7.2

Integrating HIV and AIDS Preventive Education into the Teacher Education Curriculum

Introduction

Learning from experience promotes behavioural change and responses that will enable the individual to better face later life situations. Education includes teaching students to understand social norms and distinguish those that are potentially harmful from those that can secure their health and well-being. Here we want to teach students to make the right decisions and actions when confronted with situations that render them vulnerable to HIV infection.

Integration

Integration is one strategy for providing learning experiences on the prevention and control of HIV and AIDS in the college setting. It is the process of placing facts, concepts and messages in the context of other subjects. It focuses on stimulating the learners to participate actively in acquiring knowledge, developing attitudes and values, and sharpening their skills for purposes of health promotion and/or disease prevention.

Principles of Learning

The following principles of learning apply to preventive health education:

- Students learn by doing.
- Setting the stage of readiness for learning is important.
- Motivation is a prerequisite to learning.
- Responses must be immediately reinforced in the form of feedback.
- Learner responses vary according to how they perceive the situation.
- Learner ability to internalise the process is influenced by heredity, background and certain forces in the environment.

College subjects

Students should be exposed to various learning experiences in order to become responsible and productive members of society. Ideally, they should come from colleges with a well-integrated curriculum, which is balanced, refined and includes several instructional areas of college subjects including those that deal with relevant problems and issues confronting the community.

Examples of college subjects where HIV and AIDS facts, concepts and messages can be incorporated are:

- Science
- Health
- Languages
- Mathematics
- History
- Geography
- Arts
- Physical Education
- Others

Selection of content

Guidelines in the selection of HIV and AIDS facts, concepts and messages that may be included in the content of college subjects:

- Consider the objectives of the subjects where you want to integrate.
- The content should be suitable to the learning readiness of the students.
- The content selected should be organised according to the logical arrangement of the subject.
- Time allotment must be reasonable so as to sustain the interest of the learners.

Reasons for integration

Many colleges claim that the curriculum is already burdened with too much subject matter. Actually, integration can facilitate optimum use of time allotted for existing subjects as a holistic approach to learning.

Innovative teachers look for new ideas to motivate their students to discover ideas and concepts. They encourage creative thinking in identifying problems/issues, and in finding ways to resolve them. In this case, teachers should be able to show the non-relatedness of subject-matter areas.

In many classes today there is a natural trust, respect and acceptance in student-teacher relationships. Students have the opportunity to discuss and ask questions. Teachers welcome these attempts of students to think creatively. Thus, HIV and AIDS facts, concepts and messages can be easily integrated. Students ask personal questions about HIV and AIDS without fear of being embarrassed or ridiculed.

Towards this end, teachers of various subjects can come together and determine which HIV and AIDS facts, concepts and messages can be integrated into each college subject. In this activity, the teachers can also identify gaps in their teaching. They can eliminate unnecessary duplications and reinforce essential ones. To accelerate this process, a person or teacher should be assigned the task of integration from its initial stage of planning to its implementation, monitoring and evaluation.

As in any activity, integration has many advantages and limitations.

- **Some advantages are:**
  - HIV and AIDS Preventive Education can be included in the college curriculum by adding appropriate facts, concepts and messages to existing subjects.
  - Instructional materials can be developed and teachers can be trained to use them.
  - Short-term training programmes can be conducted to train teachers in using the instructional materials effectively.
  - Administrators and supervisors can also be oriented to the programme so that they can include HIV and AIDS Preventive Education in their responsibility for monitoring and evaluation.

Some limitations of integration are:

- Existing college subjects are already very crowded with their own content and activities, there may not be sufficient time for HIV and AIDS Preventive Education.
- Resistance from teachers and administrators themselves.
- Misinformation, lack of appropriate teaching materials.
- Cultural and religious sensitivities.
- Resistance from parents and the community.
- Lack of proper expertise.

Proposed goals of HIV and AIDS Preventive Education

These goals can be used as a guide in determining what contents to integrate into the various college subjects:

- Develop life skills that are necessary for dealing adequately with the daily problems of living.
- Encourage independence but recognise that limitations are inevitable.
- Consider the complex environmental forces that can affect normal growth and development of learners.
- Enhance skills necessary for overcoming problems of self-expression.
- Emphasise health promoting behaviour and lifestyles.

An Integration Matrix for the Teacher Education Curriculum

Instructions:

1. Work along the top row, remove any subjects which are not in your curriculum and add those which are not listed.
2. To the first column, add other aspects of HIV and AIDS which are relevant to this exercise.
3. Work through the matrix column-by-column and row-by-row and place an X in each cell where you can think of possibilities of how the relevant aspect of HIV and AIDS could be incorporated into each subject.

Teacher Education Curriculum Subjects	Civics	English	Health	Mathematics	Geography	Population Education	History	Psychology	Language	Foundations	Arts	Physical Education	Teaching methods	Other
Aspects of HIV and AIDS														
How HIV is transmitted														
Impact of HIV on health														
Economic consequences of the pandemic														
Rates of HIV-infection are higher in urban than in rural areas														
AIDS orphans														
Safe sex														

Resource Material 7.4

Proposed Compulsory Core Module for Professional Teacher Education Programmes (South Africa)

Introduction

This module is specifically constructed around, but not limited to, the **Community, Citizenship and Pastoral** role of an educator as prescribed in the *Norms and Standards for Educators* (Government Gazette #20844 – 4 February 2000 p 14 and pp 18/19).

This is a 12-credit 120 hours of Notional Learning Time module that will be required in **all** pre- and in-service professional teacher education qualifications up to NQF Level 6, but it can be offered as a stand-alone credit-bearing module, or be used as part of other education programmes.

This module specifies the **minimum** competences to be achieved by all qualifying educators across all phases of schooling and all learning areas.

It does not replace the more specialised HIV and AIDS dimensions of Life Skills/Life Orientation modules (see *Draft Revised National Curriculum Statement* for Grades R-9 (Life Orientation) 30 July 2001) which are expected to enrich and expand educators' competence in handling HIV- and AIDS-related issues in the educational context. In addition, other modules in professional teacher education programmes should incorporate appropriate HIV- and AIDS-related issues.

Primary purposes of this module

The primary purposes of this module are to:

- Provide educators with a basic knowledge of HIV and AIDS and how they impact on all aspects of our schooling and society;
- Develop competences in the teaching approaches and styles appropriate to teaching about HIV and AIDS to learners;
- Develop the personal capacities and confidence needed by educators in coping with HIV and AIDS responsibly in the daily life in schools; and
- Develop appropriate collegial attitudes and values to contribute to the maintenance of a caring and compassionate climate in the school and other settings of their professional activities.

Outline

This module must include due attention to **all** of the following matters:

1. Understanding HIV and AIDS in a broader context

Qualifiers should develop an understanding of the economic, psychosocial, political, cultural and community factors that have facilitated the spread of HIV, as well as the impact of the epidemic on society.

2. Gender equity and respect for persons

Qualifiers need to explore and understand gender inequality, gender-based discrimination, gender identities and gender stereotypes, which have contributed, and continue to contribute, to the spread of HIV. They need to be able to challenge dominant stereotypes of masculinity and femininity. In addition, they should be made aware of various forms of abuse, gender-related or not.

3. Knowing basic facts about HIV and AIDS

Qualifiers should know how HIV is transmitted, the role of risky sexual and social behaviour, how to ameliorate its spread, and the standard universal precautions which can be adopted, especially in institutional

settings such as schools. In addition qualifiers should know what the symptoms and stages of the disease are, its impacts on the body, and about Voluntary Counselling and Testing and treatment options. Opportunistic infections (such as TB) should also be addressed, although not in detail.

4. Knowing key relevant policies and laws

Qualifiers should have sound knowledge of the following policies and regulations: (a) National HIV and AIDS Policy (1999) - *The HIV and AIDS Emergency Guidelines for Educators* (*2002*) is a "user-friendly" version of the policy; and (b) *HIV and AIDS and STDs – Strategic Plan for South Africa 2000-2005*. This document (which is to be revised every five years) spells out the national strategy, and provides the framework for all work in respect of HIV and AIDS in South Africa and (c) the SACE South African Council for Educators *Code of Professional Ethics*, and how they are to be adhered to in their own professional prac-tice. They should also have basic knowledge of those laws that regulate professional teacher behaviour and relationships.

5. Responding to HIV and AIDS in the classroom, school and community

The primary purposes of this module are:

- ***Personal development***
  Qualifiers need to explore and understand their own inhibitions, anxieties, prejudices, vulnerability and fears related to HIV and AIDS.They should also be able to adopt non-judgmental attitudes in addressing issues related to HIV and AIDS in classrooms and other contexts.
- ***Competence in developing an appropriate response to the local HIV and AIDS epidemic***
  Qualifiers need to be able to analyse the context within which the school exists, the possible determinants of the HIV and AIDS epidemic in the community and develop an appropriate comprehensive response on the basis of this context. This is to ensure that the response is specific and relevant to the issues driving the epidemic in that particular school and community.
- ***Care and Support Competences***
  Qualifiers need to able to identify people (particularly children) who might be at risk, be aware of the problems faced by learners and colleagues infected with, and affected by, HIV and AIDS, and how these impact on learning, teaching and community life. They need to develop the competence to deal with these matters as one defining aspect of their roles as educators. For example, educators need to know (a) what resources (including referral and support structures) are available in their context, how and when to access such resources, how to develop partnerships within their schools and with the community and (b) how to deal sensitively with those infected with, and affected by, the disease. This includes dealing with bereavement, learners who no longer have parents or who are themselves heads of households or caregivers for others with HIV or AIDS.
- ***Competence in methods and approaches in teaching about HIV and AIDS***
  Qualifiers should be competent in using interactive and participatory modes of teaching in relation to teaching about HIV and AIDS, particularly in relation to those dimensions likely to be sensitive and intimate to learners.
- ***Curriculum and lesson planning***
  Qualifiers must plan a series of lessons appropriate for their specialist phase and learning areas, which integrates aspects of HIV and AIDS.

6. Addressing stigma

Qualifiers must demonstrate a capacity to foster positive attitudes and values of caring and non-discrimination towards, and between, learners and colleagues, and to contribute to the creation of the school as a compassionate and inclusive community.

7. Links to Health Promoting Schools and Inclusive Education

Qualifiers should understand current policies of "Inclusive Education" and "Health Promoting Schools" and their significant links to HIV and AIDS education.

Resource Material 8.1

Participatory Teaching Strategies

Participatory teaching strategies are those which promote the active participation of learners in the process of learning. Most "traditional" teaching consists merely of the teacher standing in front of a class of learners and talking (a monologue) while the learners are expected to "sit still" and passively absorb the words of wisdom delivered by the teacher. Sometimes learners might be asked to do some sort of exercise which, essentially, involves their recalling or reproducing what the teacher (and sometimes a textbook) has said.

Participatory teaching strategies are designed in such a way that they engage the learners in a variety of structured learning activities. This involves the teacher in thinking in a very different way about how to plan teaching – in a way which involves the imaginative use of a variety of learning activities which foster learning by setting up situations in which the learners have to use the knowledge and skills they already have to advance their own learning.

A main obstacle to the use of participatory teaching strategies is that they involve a different mind-set from teachers, one which runs counter to most of the teaching they themselves have ever experienced. This is a mind-set that is centred around the idea that the main point of teaching is not a "performance" but to promote genuine learning. Teachers need to change from seeing their main (only?) job as standing and talking to seeing their job as designing learning programmes which promote systematic and coherent learning. Participatory teaching strategies can be very effective in large classes, but the shift in mind-set mentioned above is especially crucial in such cases. However, changing a mind-set is never a straightforward matter.

There are four main steps in planning a sequence of lessons on the basis of the idea of participatory teaching:

1. **Decide what it is you are trying to enable the learners to learn in this sequence of lessons:**

   This is a very important first step because unless you are clear about this, each lesson and the whole sequence could become simply a random collection of activities without any unifying point. The conceptual coherence (in other words the ways in which the various elements hang together and reinforce each other) of a sequence of lessons is a criterion for whether or not it will successfully promote the relevant learning.

2. **What is the "content" needed in order that learners can learn what it is you are trying to enable them to learn?**

   The "content" is the knowledge and information relevant in this case. Traditionally the only way in which "content" is "delivered" is by the teacher talking or reading from a textbook. Most good teaching is NOT "delivery of content by monologue". However, we need to avoid the idea that participatory teaching **never** includes such activities (this is what goes wrong in the case of some uses of "child-centred education".) However, when participatory teaching does include this traditional activity it is the result of a definite professional decision that this is the best way in the circumstances. The next steps are to think about the two basic elements of this teaching strategy: Learning Activities and Instructional Media.

3. **Learning Activities:**

   These can be varied and usually involve dividing up the whole class into smaller groups, sometimes even pairs of learners. At the heart of all learning activities is the idea of **dialogue**, i.e. **interaction** between:

   - Learners and the teacher.
   - Learners and some other source (such as texts or other documents).
   - Amongst the learners themselves.

   Orderly discussion in which two or more persons genuinely participate stands behind all models of good teaching, and participatory teaching strategies use various techniques to promote discussion and develop the capacities needed to participate in discussion. Discussion is a form of conversation which has a definite

goal or purpose, and the social and intellectual skills of discussion need to be learnt. In the case of HIV and AIDS Preventive Education, peer education has been found to be very effective.

4. Instructional Media:

This rather technical phrase refers to any kind of medium used to foster learning. Typically, in our situations, it is printed material, which includes both written and visual material, but it can include such things as tape recordings, video recordings, radio, television and, but more remotely in our context at present, the many kinds of ways in which computers can be used to foster learning. Teachers should not forget that the social and physical environment itself has many artefacts which can be used as instructional media.

Perhaps the most important lessons, once teachers have expanded their view of what kinds of things might be used to promote learning, are that:

- Teachers need to be taught how to be imaginative and resourceful in the circumstances in which they find themselves. They should plan their teaching with what is readily at hand. The lack of media – even basic printed material, never mind lack of electricity or equipment – is never a reason not to use participatory teaching strategies.
- Participatory teaching stategies can be very effective in large classes, but the shift in mind-set mentioned above is especially crucial in such cases.
- Teachers need to learn how to choose material in light of the specific learning they are trying to promote (see Step 1 above), and then to integrate it into the learning process in such a way that it genuinely contributes to that learning.

Resource Material 8.2

Learning Activities

Points to consider in selecting Teaching/Learning Activities

- Characteristics of the students
- Skills of the teacher
- Content of the lesson
- Available time to deliver the lesson
- Available facilities
- Knowledge, attitudes and skills to develop
- Methods that are interesting to the students
- Methods relating to the objective(s) and assessment.

Tips to teachers for teaching HIV and AIDS Preventive Education

- Change attitudes and behaviour, develop communication and interpersonal skills rather than focusing on disease causation.
- Use strategies to help students cope with stress and fears about AIDS.
- Use situations to emphasise what to do, which actions to take and the benefits of doing so; and the consequences of failing to do so.
- Deliver clear and consistent health messages through a variety of communication channels.
- Keep an open mind and continue to explore issues meaningful to the students.
- Promote creative and collaborative learning by asking students to process new information.
- Ask students which part of the lesson is affected and why.
- Ask students which information they will discuss with their friends.

Resource Material 8.3

Instructional Media

Instructional media are the physical means by which instruction is given to the students. They include all the traditional means of giving instruction such as chalkboards, books, maps, charts, newspapers and other print materials. Audio-visual media are audio-cassettes, video, radio and TV broadcasts, slides and films, computers and interactive videos. Examples of visual materials are diagrams, charts, maps, graphs, photographs, cartoons and transparencies.

Effective instructional media are those that:

- Provide a concrete basis for conceptual thinking.
- Have a high degree of interest for the learners.
- Help make learning more permanent.
- Contribute to efficiency, depth and variety of learning.
- Encourage learners to respond actively.

Some basic questions in choosing instructional media:

- Are the media really available?
- Are they practical to use?
- Are they appropriate to students' characteristics?
- Are they the best means of presenting a particular instructional activity?

Criteria for choosing and using media

- Do they give a true picture of the ideas they represent?
- Do they contribute to the meaning of the topic under study?
- Are the media appropriate to the age, intelligence and experience of the learners?
- Do they make the learners become better thinkers and critically minded?
- Is the material worth the time, expense and effort involved?

Resource Material 8.4

Techniques that Promote Life Skills

Life skills enable an individual to cope with challenges and threats in the environment, thus ensuring self-preservation and well-being.

Examples of life skills are:

- Enhancing self-esteem;
- Reinforcing the resistance skill to say "No"; and
- Responsible decision-making skills.

Self-esteem: To have self-esteem is to accept oneself, to be able to admit one's shortcomings and to take responsibility for one's actions. Self-esteem can be reinforced by parents, teachers and friends. Individuals with high esteem are most likely to avoid situations that will put them at risk of HIV infection.

Some positive "image-building statements" to enhance self-esteem:

- I am OK.
- I like myself.
- I am creative.
- I can learn from others.
- I can start each day with a smile.

Reinforcing your resistance skill by saying "No":

Decisions about sex are a personal and sensitive matter. Saying "No" in an unwanted situation requires skill. Examples of what one might say:

- "I like you a lot, but I'm just not ready for sex."
- "I don't believe in having sex before marriage. I want to wait."
- "I enjoy being with you, but I'm not old enough for this."
- "I don't have to give you a reason for refusing. It's just my decision."

Sharing thoughts, beliefs, feelings, and most of all, mutual respect, is what makes a relationship wholesome and lasting.

Ways of practising resistance skills:

- Using assertive behaviour.
- Using non-verbal behaviour that matches verbal behaviour.
- Influencing others to choose responsible behaviour.
- Avoiding situations where there will be pressure to make harmful decisions.
- Resisting pressure to engage in illegal or unhealthy behaviour.

Responsible decision-making skills:

These skills can be developed by following these steps:

- Clearly describe the situation or problem.
- List actions that can be taken based on the situation/problem.
- Share the list of possible actions with responsible adults.
- Carefully evaluate each action – responsible actions are healthy, safe, legal, respectful to self and others, consistent with guidelines of parents and teachers and compatible with good character.
- Describe which action is responsible and appropriate.
- Act in a responsible way and evaluate the results.

Resource Material 8.5

Assessing Youth Needs

Book 3 Rutanang: A Peer Education Implementation Guide for Schools in South Africa
Department of Health, South Africa (August 2002) {ISBN 1 875017 78 X}
Pages 91 - 92

1. Are you male or female? ☐ Male ☐ Female
2. How old are you? _____
3. What's the best thing about your life at the moment? _____
4. What's the worst thing? _____
5. Who do you talk to about your problems or big decisions? _____
6. Who would you go to for help if you were pregnant/got someone pregnant? _____
7. If you discovered you were HIV positive, where would you go for help? _____
8. What percentage of young people under 17 do you think are sexually active? _____
9. Are you currently sexually active? ☐ Yes ☐ No
10. Have you ever been sexually active? ☐ Yes ☐ No
11. What makes it difficult to say no to sex? _____

    _____

    _____

    _____
12. What do you think your chances of being HIV-positive are?

    ☐ Very High ☐ High ☐ Medium ☐ Low ☐ Very Low
13. Do you know anyone who is HIV-positive? ☐ Yes ☐ No
14. How do you treat people who are HIV-positive in your community? _____
15. What do you think you should do to keep yourself from getting HIV and AIDS? _____

    _____
16. What unanswered questions do you have about HIV and AIDS? _____

    _____

    _____

    _____
17. Do you know where to get condoms? ☐ Yes ☐ No
18. Do you know how to use a condom? ☐ Yes ☐ No
19. If applicable: The last time you had sex, did you/your partner use a condom? ☐ Yes ☐ No
20. Where would you go to get tested for HIV? _____
21. Where would you go for help if you thought you had a sexually transmitted infection (STI)? _____

    _____

22. How do you feel about going to the local clinic for HIV testing or help with a STI? _____

_____

23. How satisfied are you with the health services available to you? _____

_____

24. How can health services for young people be improved? _____

_____

25. From where do you get the best information about HIV and AIDS? _____

_____

26. What specific topics would you like peer educators to address when it comes to sex and AIDS? _____

_____

_____

27. What can peer educators do to help you avoid HIV and AIDS? _____

_____

_____

28. How common is unwilling sex in your group of friends?

☐ Very Common ☐ Common ☐ Not So Common ☐ Non Existent

29. How common is rape in your group of friends?

☐ Very Common ☐ Common ☐ Not So Common ☐ Non Existent

30. Do any of your friends sell sex for money or favours? ☐ Yes ☐ No

31. How common is child abuse in your group of friends?

☐ Very Common ☐ Common ☐ Not So Common ☐ Non Existent

32. How common is incest (sex between family members) in your group of friends?

☐ Very Common ☐ Common ☐ Not So Common ☐ Non Existent

33. What types of drugs, if any, do your friends use? _____

_____

Resource Material 8.6

Peer Education

Book 3 *Rutanang: A Peer Education Implementation Guide for Schools in South Africa* Department of Health, South Africa (August 2002) {ISBN 1 875017 78 X} Pages V VII

Since young people do most of their talking, listening, thinking, and learning about sexuality with other young people, peer education is a crucial component of prevention programmes addressing HIV and AIDS and other threats to health. For many youth, adults are not credible messengers of sexual abstinence and other responsible behaviours; and many adults, whether professionals or parents, are not comfortable helping youth examine their attitudes, understand the risks, and develop new skills related to sexual behaviour. The necessary outcomes of HIV education, including reinforcing accurate and consistent information, helping young people examine and change how they think and behave sexually, building their decision-making skills, facilitating voluntary counselling and testing, and strengthening community sanctions against sexual violence require face to face discussion with people who are trusted, knowledgeable, accessible, and relatively comfortable talking about sexual matters. In South Africa and globally, that is the rationale behind peer education programmes in schools, NGOs, community-based organisations and in institutions of higher education.

Peer education has important practical advantages as a component in a comprehensive HIV and AIDS strategy. Properly structured, it is proactive and flexible in delivering stimulating and memorable education to youth in a wide variety of settings, while also taking advantage of the informal interpersonal influences these peers will then have in natural situations. It is often more feasible to train, motivate, prepare and supervise peer educators than adult educators, and to establish personal linkages with clinics and other services so that young people who need STI or HIV testing or help dealing with a relative who is infected can be recognised and successfully referred. Peer educator teams appeal to more diverse youth than any single adult educator. Perhaps most important, by utilising rigorous peer education a few effective adult educators can reach many more learners with meaningful, beyond awareness level HIV and AIDS education, than they could if they were working directly with learners themselves. Finally, the peer educators themselves are a sustainable human resource; with appropriate planning and incentives, many will become excellent peer educators at their next life stage (higher education, community, home or workplace) and some will go on to careers in education and health.

But in spite of peer education's sound theoretical basis, practical advantages and widespread use, there has never been agreement on what constitutes good practice. The world over, peer education means different things to everyone. Without a common language, vision and standards of practice, programmes operate independently and competitively and are difficult to evaluate and improve.

Part Two, The What and Why of Peer Education, explains what peer education is, what it is not, and why we turn to it in these circumstances. Most importantly, it describes four complementary and interrelated roles peer educators play. The pivotal role, on which all others depend, is the role of educator. Peer educators are trained to use lesson plans and simple learner centred teaching materials to achieve educational objectives in structured, scheduled sessions. This role is critical for two reasons. First, South African youth need to be exposed to more interactive HIV education. Second, proactively delivering such learning enables peer educators to play their other three roles: Recognising and referring learners in need of help; acting as role models and informal influences; and promoting activism and becoming advocates for youth health.

Working Definition of Peer Education

Peer education is the process whereby trained supervisors assist a group of suitable learners to:

1. Educate their peers in a structured manner.
2. Informally role model healthy behaviour.
3. Recognise youth in need of additional help and refer them for assistance.
4. Advocate for resources and services for themselves and their peers.

Resource Material 8.7

Exploring Goals and Principles

Book 3 Rutanang: A Peer Education Implementation Guide for Schools in South Africa
Department of Health, South Africa (August 2002) {ISBN 1 875017 78 X}
Pages 95 - 971.

Instructions

Stage 1 Just For Fun!

1. Copy the statements on the next page onto sheets of cardboard, so that you have one complete set of cards for each group of six people.
2. Divide the large group into groups of six.
3. The object of this stage of the activity is for each player to have four cards in his or her hand with which he/she completely agrees.
4. Deal all the cards out, so that each person has four cards. Players silently read the cards they were dealt.
5. Each group member picks one card, unseen, from the person on his/her left. A player may not set aside or protect the cards he/she wants to keep – he/she must make all his/her cards available for selection.
6. If anyone has four cards with which they agree, he/she reads the cards to the group. If the group agrees with all four, that person is declared the winner.
7. Allow ten minutes for this part of the game.

Stage 2 Getting Consensus

1. Distribute a set of the All Agree/All Disagree/No Consensus labels to each group.
2. Ask each group member to read one of his/her cards in turn. After a lively discussion, the group as a whole should decide in which pile to place the card.
3. Proceed with all the cards in the deck.

Stage 3 Large Group Discussion

1. Invite each group to select two cards the group would most like to hear, discussed in the large group.
2. Re-unite the large group and compare what groups found were easy to agree on, what they disagreed on and what they found difficult to agree on.
3. List the implications for peer education on a flip chart/overhead projector as you work through the statements.

1. Schools cannot do everything. They are being asked to do too much, and often fail learners academically for that reason.	2. Programmes reaching in-school learners have little in common with programmes reaching older, out of school youth.
3. Peer education is really about what happens informally between youth when adults are not present. Structured contact between peer educators and learners in the classroom is only intended to make learning possible.	4. Most parents know what they believe in, what they value, and how they should teach their children about health. But the mass media and peer pressure are so powerful that parents today have little influence.
5. If adults established firm, clear and consistent rules as they used to do, young people would be involved in less trouble.	6. For most health issues, we know what young people should and shouldn't do. It's wrong to pretend we don't. We have to tell them what's right and proper.
7. We have to be clear about the difference between health and morality. We're helping youth learn to keep healthy, not teaching them our version of how to be good.	8. By asking learners to examine their own values and beliefs about health issues, we may create the impression that all values and beliefs are equally valid.
9. The problem with activities that get learners talking is that the most vocal youth say all the wrong things, and influence the good youth.	10. We can't teach youth skills they don't want to use. Before we get to skill-building, we have to help learners examine the attitudes and experiences they already own.

11. Most peer pressure is covert; it's about what youth are afraid others (not necessarily their friends) may be thinking.	12. A common and crucial error in peer-delivered curricula is low dosage having too little educational contact between peer educators and learners.
13. Many curricula devote too much time to the transmission of knowledge that will not be used in situational decision-making.	14. The most common error in all health promotion is reaching the audiences that are most ready to participate.
15. Unless learners ask for help with personal problems, teachers and counsellors must respect their right to privacy.	16. There is a fine line between intervention and interference. What might be considered intervention in some communities and cultures would be considered interference in others.
17. Some of the best opportunities for counselling and referral arise as a result of structured educational sessions.	18. Those who would teach young people to be honest have to be honest themselves - even when it comes to questions about their own past (and present) behaviours.
19. If young people want help, they will ask for it. If they don't ask for it, they probably won't accept it.	20. It is best for the sustainability of peer education programmes if there are no incentives for peer educators. You need young people who simply want to be involved.

Resource Material 8.8

Assessment: reasons and techniques

Assessment refers to finding out whether learners have learnt what the programme set out to enable them to learn. As all teacher educators know, many different forms of assessment have been developed over the years, and sophisticated statistical techniques have been developed to try to ensure that grades are valid and reliable, etc. In addition, all teacher educators know that the forms of assessment have a profound wash-back effect on the manner of teaching and learning, and on learners' perceptions of how to learn, and what is significant and important.

Assessment is sometimes treated as a discipline in its own right, and perhaps this is important if one is thinking about national education systems, the value of various official certificates of attainment and trying to achieve fairness across large numbers of learners in mass schooling systems. In such situations "assessment" sometimes becomes such a predominant feature of the schooling system that teachers spend so much of their time and effort on assessment that they almost forget that their main job is to teach, i.e. that is to organise systematic learning, and that assessment is secondary to that.

There is reason to say that in the case of HIV and AIDS Preventive Education assessment is both inappropriate (any kind of assessment will give a misleading view of the main kinds of competences such a programme is trying to develop) and irrelevant (what matters is not whether the learners have learnt enough to pass or fail a test, but whether they have learnt what will enable them to avoid HIV infection and contribute to the mitigation of the personal and social effects of HIV and AIDS). Although this is true, our problem is that if any programme of learning is not formally assessed at some stage, there is a tendency for students to see it as "voluntary", requiring less effort than other parts of the curriculum, and as being of less significance overall. Formal assessment (with consequences) signals that it is a part of the curriculum which is important, and which will take some effort to "pass". This is a convincing reason to think that in most situations some type of formal assessment (with consequences) is important as an incentive to encourage students to approach HIV and AIDS Preventive Education with the seriousness it deserves.

In teacher education programmes

A It is important to emphasise that any assessment must be critiqued in the light of the following key questions:

- What are you trying to test?
- Why are you trying to test it?

What are you trying to test?

There are some kinds of learning (and in some ways they are the most durable and important) that are impossible to measure by any conventional means. The learning of values and attitudes – which are crucial in the case of HIV and AIDS preventive education – is a prime example.

In the case of Participatory Teaching Strategies there might be thought to be a particular problem about how to assess its outcomes when they involve much beyond "information" and "knowledge", are not specified in detail and in advance, and depend a great deal on the students' own contributions. We can accept that some of the outcomes – and they might be the most important in the long run – cannot be measured but some can be and it is important for teachers to analyse the situation in such a way that they can identify which of the outcomes of participatory teaching can be assessed.

Why are you trying to test it?

Teachers should be encouraged to think about the various purposes of assessment, such as:

- To measure the effectiveness of learning activities or programmes
- To motivate students

- To grade student performance according to some norm
- To diagnose learning problems
- To provide targeted feedback to students
- To design "remedial" interventions etc.

There is a fashionable distinction made between "formative" and "summative" assessment – and this is an answer (although limited) to the question of why you are trying to test. "Formative" assessment has the purpose of finding out what the learners already know so that they can be given feedback about what they still need to learn, or so that the learning programme can be modified to take account of current knowledge and knowledge still to be acquired. "Summative" assessment has the purpose of finding out what learners have learnt from a programme with a view to comparing the success of various learners, and to underwrite "pass" or "fail" decisions.

But this distinction is misleading if it is understood as having only to do with the different purposes of assessment in these two cases. The most significant difference lies in what the follow-up to the test is. What kind of feedback is going to be given to the student? Is it merely a percentage mark, or will there also be critical comments?

There is also a fashionable distinction often made between "Criterion-referenced" and "Norm-referenced" assessment. The former is where the student's performance is measured against standards or criteria, which have been determined in advance; the latter is where the student's performance is measured against the performance of other students.

But this distinction, again, can be misleading unless it is understood that neither form of assessment can ever be found in a "pure" form. Whatever standards we have for any performance always already include an implicit reference to the typical learners at that level in that field; and any "norm-referenced" assessment necessarily involves some criteria for judging the quality and level of the student's performance.

B Teachers need to be encouraged to think carefully about:

- Different forms of assessment
- The advantages and disadvantages of different forms of assessment
- Practical considerations.

Different forms of assessment

- There are different forms of assessment which might be appropriate in different situations and according to the purposes of the assessment. Here follow some fairly standard examples:
  - **To assess knowledge:**
    Essays, short answer tests, matching exercises, fill-in (missing words, etc), true-false, multiple-choice.
  - **To assess attitudes:**
    Inventories, anecdotes, surveys, rating scales, observations, interviews.
  - **To assess skills:**
    Questionnaires, problem-solving, checklists, rating scales, observations, discussion.
  - **To assess multiple capacities:**
    Projects, case studies, portfolios.

The advantages and disadvantages of different forms of assessment.

- In general terms, there is a conflict between the width and depth of forms of assessment. For example, conventional multiple-choice test can provide quick information about a very large number of learners – but the information tends to be shallow; essays and in-depth interviews can provide very rich information about what the learner understands and can do. However, such forms of assessment require special ex-pertise and are very labour-intensive – a major disadvantage if one has more than a small number of students.

Practical considerations

There are considerations about the availability of material and stationery, and also about venues and student time, which place general boundaries around the forms of assessment that are convenient and appropriate in different contexts and situations. Teachers should be encouraged to think about how to balance the value of the

information that will be yielded by a form of assessment against the time and effort needed to conduct that form of assessment. Overall, as indicated above, teachers have a tendency to spend a disproportionate amount of time on assessment to the detriment of their teaching, and teachers need to learn how to avoid this distortion.

Defeating HIV and AIDS through education

By Michael Kelly

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History has placed a great burden on our shoulders. As members of the human race and as educators, every one of us here today faces a task that has ramifications for the lives and well-being of countless individuals – adults, youth and children. Each of us bears the lives of others in our hands. The understandings we develop these two days, the decisions we make, the commitment we show, will not be confined to this auditorium but will have repercussions throughout the whole of South Africa and will echo from there into other parts of the continent and the world. Our task is simply described; its execution is difficult and challenging. Our job in these two days – and in the weeks that follow – is to establish a dynamic education coalition against HIV and AIDS that will accelerate the progress of South Africa and the world towards a world without AIDS.

For too long we have been standing by – timid, confused, uncertain, feeling that we were powerless, wanting to do something constructive but not quite sure what. And all the time, men, women and children continued to be infected in their millions, to fall sick in their millions, to die in their millions. We work in the middle of the AIDS killing fields (Akukwe & Foote, 2001). We have daily experience of the passive genocide of our most productive people (Coombe, 2001). We live through a silent holocaust that makes the Jewish Holocaust in Nazi Germany pale by comparison (Nyumbani, 2001). We have let two decades slip through our hands when our response to HIV and AIDS was little more than a scrappy rearguard action against what we saw as an almost insuperable enemy.

The young people today are the AIDS generation (Kiragu, 2001). They have never known a world without HIV or AIDS, no more than they have ever known a world without television or air transport. But AIDS is of much more recent origin than either television or air transport. It was on 5th June 1981, almost exactly twenty-one years ago, that the United States Centers for Disease Control published a report about a new disease that was hitting gay men. That report marked the formal beginning of the AIDS era. It ushered in what we now know as the AIDS pandemic. During the twenty-one years that have passed since then, the disease has grown to nightmarish proportions, with almost every passing year seeing a revision upwards of dire estimates and predictions. The challenge to us is to put a halt to this obscene growth of the disease, to say to it in forceful action-backed terms: "Thus far and no further".

To accomplish this, we must undertake a threefold task:

1. We must harness the huge potential of the education sector to prevent further HIV infection.
2. We must mobilise the sector to offer support and care to those within our educational constituencies who are infected with the disease or are in any way affected by it.
3. We must take steps to keep our own house in order, to protect the education sector itself from the inroads and ravages of the disease, so that it continues to make educational provision in the quantity and quality that is required, while at the same time it exercises its potency to stem HIV infection.

What Has Gone Wrong?

If we are to use the potential of the education sector to defeat HIV and AIDS, it is important that we base our initiatives on some understanding of what has gone wrong, why the AIDS pandemic has got out of hand and why, in particular, the response so far from the education sector has been so limited.

The Inadequacy of Action at International, National and Local Levels

It is unfortunately all too true that in many ways the world, countries and communities, have allowed themselves to get into the current HIV and AIDS crisis almost by default. Notwithstanding the urgency with which warning signs presented themselves, the world (and we as part of it) has stood by and watched a steady, seemingly unstoppable, drift into crisis, disaster and catastrophic human tragedy. Factors that have made a major contribution to the ease with which the disease has spread and the ineptitude of the response include:

1. Lack of leadership and vision at global, regional and national levels. In the few cases where these were available, such as in Senegal and Uganda, the disease made slower progress or receded.
2. Silence and denial at various levels – national, community, and individual. To some extent, silence and denial are a primordial and protective human response to situations that are excessively stressful. In the words of the poet, T. S. Elliott, "humankind cannot bear too much reality". But trying to cover up the existence of AIDS, as still commonly occurs in families and communities, and even in some countries, will never lead to mastery over the disease or its impacts.
3. Attitudes, behaviours, insidious associations, and adverse social reactions that discriminate against and stigmatise those with HIV and AIDS and drive acknowledgement of the disease into an underground of silence, secrecy, shame and self-recrimination. Fourteen years ago, Jonathan Mann, the Director of the agency that preceded UNAIDS, spoke of this as the "third epidemic," the other two being the silent epidemic of HIV infection and the manifest epidemic of clinical AIDS, and noted that allowing this third epidemic to go unchecked would ensure that neither of the other two could be controlled (Walrond, 2000).
4. Lack of correct information on how the disease can be contracted, how it can be prevented, and what those infected can do to ensure that they live a longer life of better quality. Even today a significant proportion of young people, in South Africa as elsewhere, do not know any way of protecting themselves against HIV infection, are not aware that oral and anal sex involve extensive HIV transmission risks, and think that you can judge by appearances whether or not a person is HIV-infected.
5. Failure by the international community and national governments to commit the human and financial resources needed for a large-scale onslaught on the disease. The Global Fund for AIDS, TB and Malaria, which the United Nations established with considerable fanfare in June 2001 has so far raised less than one-fifth of its target. Doubling the resources currently available to the Fund would represent only about one cent of each US$100 of income in the world's wealthiest countries (Harvard, 2001, p. 18), but in the absence of a sense of international responsibility and urgency this is not forthcoming.
6. Weak capacity to design and deliver response measures.
7. A strong focus on short-term measures aimed principally at behaviour change, but with minimal attention in the context of the disease to the enabling environment of poverty, malnutrition, the powerlessness in many societies of women and young girls, inadequate health support services, lack of job opportunities, and the absence of recreational outlets.
8. Inadequate attention to developing comprehensive strategies that focus on the physical, social, economic, recreational and psychological needs of youth (ECA, 2001). The war against AIDS will be won when it is won among the youth – no sooner, no later.
9. Overriding attention to dealing with the disease at the level of the individual, but with little recognition that the disease was also undermining the ability of systems, organisations and institutions to cater for the needs of individuals and society. Education, health and agricultural sectors have been particularly at risk. The results are already with us in terms of unanticipated shortages in educational provision (UNICEF, 2000), health care systems that are being brought to a standstill (UNAIDS, 2000), and food shortages coupled with the increased production of easier-to-manage but less nutritious food crops (FAO, 2001).
10. Failure in many approaches to be sensitive to cultural and religious perceptions and values, with the result that suspicions, intransigence and conflict over peripheral issues (such as condom use) have tended to overshadow what should be a shared world and community vision of how to respond to the disease.

The Hesitant, Uncertain Education Response to HIV and AIDS

The uncertainty up to fairly recently of the education sector's response to the disease is brought out by the fact that, early in 1994, the International Institute for Educational Planning in Paris produced and disseminated a very comprehensive report on how HIV and AIDS was likely to impact the education sector, but almost six years passed before education ministries began to take on board the contents of that seminal work (Schaeffer, 1994). During these lost years, the AIDS situation in general, and in the education system in particular, grew steadily worse.

The constrained response of education sectors to HIV and AIDS in the 1980s and 1990s was due, among other things, to:

1. Inability to provide for the basic learning needs of every child, youth and adult.
2. Lack of appreciation of the scale of the epidemic and its potential to undermine the education system.
3. Absence of strategic planning for HIV and AIDS in the education sector.
4. Considerable piloting of HIV and AIDS education programmes, but with little coordination between interventions and few, if any, being brought to scale.
5. Lack of teacher capacity to deliver relevant HIV and AIDS education.
6. Uncomfortable recognition by educators and system managers that addressing HIV and AIDS raises questions about their personal HIV status and social behaviour.
7. Concern lest teaching content and activities conflict with community, cultural or religious practices, norms and values.

The tragedy of the past twenty years is that education sectors worldwide, but especially in the most severely affected countries, did not get moving early enough to respond to the demands of HIV and AIDS. When they did begin to take account of the epidemic, they adjusted themselves in an almost random way to its demands, cautiously, hesitantly, timidly. Even today, many have not succeeded in taking on board either the potential of the epidemic to undermine their systems or, equally important, the potential of the system to counterattack and undermine the epidemic. They are still in a state of virtual disarray, inadequate understanding and piecemeal response. They have a multitude of projects that address facets of the disease, but few coordinated, strategic programmes that address the challenges on the scale that is required.

In this climate of hesitation and vacillation, the Call-to-Action, Tirisano HIV and AIDS Programme of 1999, marked a significant advance. However, much of that programme still awaits implementation. It is the responsibility of this Conference to move the process forward and to establish a coalition of partners who will ensure that the education sector in South Africa forges steadily ahead in the implementation of this comprehensive plan.

Education and the Prevention of HIV and AIDS

Against this background let us recall some of the features of HIV and AIDS so that we can better appreciate why, as the World Bank says in a recent report, "education matters" (World Bank, 2002) and why it matters.

Why Education Matters

First, there is no cure for HIV and AIDS, and many scientists believe that, because of the nature of the virus, there never will be a cure. The antiretroviral drugs suppress HIV activity and influence in the body for as long as they are being taken, but these drugs raise a host of problems relating to their cost, their continued effectiveness, the demands of administration and patient monitoring, dangers of resistance, and the creation of a false sense of optimism. This is not to decry their use, but to flag that they are not a universal panacea for HIV and AIDS.

Second, there is no vaccine. Work on vaccine development is proceeding in several locations, all of them with relatively small research facilities and funds and with none of the major pharmaceutical companies being involved. The latest word from the International AIDS Vaccine Initiative (IAVI) is that we should no longer think of an AIDS vaccine just as possible but confidently say that it is probable (Berkley, 2002). However, it will still be several years before that probability becomes a reality. Moreover, unless action is taken in the very near future

to provide the human and physical infrastructure that will be needed for the production and administration of a vaccine to hundreds of millions of individuals, it will be several years after that again before an affordable vaccine becomes universally available.

With no cure available, no vaccine in immediate sight, and no consensus on how to answer the many questions surrounding drug therapy, we must, in the words of the United Nations, make prevention the mainstay of our response (UNGASS, 2001). But there can be no prevention of HIV transmission without either the maintenance of behaviour that will protect oneself and others, or the change of existing behaviour so that it becomes protective of self and others. The only way of ensuring this is through education, regardless of the circumstances, age of the individual, or nature of the intervention. To maintain existing 'safe' behaviour or to adopt safe behavioural practices, some form of education is necessary. Given this education, the other supports provided by society can be brought into play. In its absence, they remain useless. For instance:

- At the level of practice, messages about the risks of unprotected sex are essentially educational, as are messages about abstinence or condom use.
- The same is true for messages about fidelity in marriage or about reducing the number of sexual partners.
- This also holds for the ensemble of information, appropriate practice and drug treatment for the prevention of parent-to-child transmission, all of which imply considerable behavioural changes in the context of some minimal education package.

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

Education, HIV and AIDS and the Young

A second major reason why education must play a crucial role in preventing HIV transmission is because its principal beneficiaries are young people, ranging in age from infancy to young adulthood. It is mostly the young who are in schools, colleges and universities, developing the values, attitudes, knowledge and skills that will serve them subsequently in adult life.

But if education is largely the sphere of the young, so also is HIV and AIDS. About one-third of those currently living with HIV and AIDS are aged 15-24, while more than half of all new infections – about 7 000 each day, or five each minute – are occurring among young people (UNAIDS, 2001).

Recognising that the young are especially vulnerable to HIV infection, the United Nations has established definite time-bound targets for the reduction of HIV transmission among young people. These targets set clear objectives that should direct our plans and activities in the education sector:

1. By 2005, reduce HIV prevalence among those aged 15-24 by 25 per cent in the most affected countries.
2. By 2005, ensure that at least 90 per cent of young men and women aged 15-24 have access to information, education – including peer education and youth-specific HIV education – and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers (UNGASS, 2001, §§ 47, 53).

In these terms, the challenge before us at this Conference is to galvanise our education sector to play its part in bringing about a very substantial reduction in prevalence rates among school, college and university students from their current very high levels In 1998, about 21 per cent of women under 20 attending antenatal clinics in South Africa and 26 per cent of those aged 20-24 were HIV-infected; the corresponding figures for 1999 were 16.5 per cent and 25 per cent (Whiteside & Sunter, 2000, Chart 4.4).

Will the sector be able to achieve this? Evidence from elsewhere suggests that it will. In Zambia, HIV prevalence among 15 to 19 year-olds in Lusaka dropped from 23 per cent in 1994 to 15 per cent in 1998 and in Ndola from 21 to 16 per cent in the same period. A significant feature of this decline, which was observed both among those attending antenatal clinics and those in population-based surveys, was that it was most marked in those with higher levels of education, whereas there were signs of continued increase in prevalence among the least educated – girl attending school was three times less likely to be HIV-infected than an age-mate who had

dropped out of school (Fylkesnes et al., 2001).

Something similar was found in Zimbabwe where a large population survey showed that those attending school had much lower prevalence rates than those who were not in school (Gregson, Waddell & Chandiwana, 2001 Referred to in Bennell, Hyde & Swainson, 2002, p. 21.). Uganda has also registered significant success in reducing HIV prevalence among young people, with at least some of the credit for this going to the education sector (Kaleeba et al., 2000).

These achievements show that, at the minimum, formal education plays a key role in protecting young people against HIV infection (Bennell et al., 2002, p.21). Even further, they also suggest that, in ways which are not yet clearly understood, a general basic education is making its own specific, intrinsic contribution to the reduction of HIV prevalence rates among young people (cf. Coombe & Kelly, 2001; World Bank, 2002). Education does work against HIV transmission. It is an effective "social vaccine".

This has major implications for the sector.

First, there is need to ensure that every child and youth has access to education for a certain minimum number of years. The attainment of the international millennium development goals that refer to education-for-all (EFA) are crucial to overcoming HIV through education. Every young person must be enabled to attend an educational institution for as many years as possible, and within this framework, special attention must be given to ensuring the participation of girls over an extended period of years. The achievement of the millennium EFA goals will, itself, go a long way in responding to the AIDS challenge.

Second, we must ensure that within all educational institutions real and meaningful learning takes place. Basically, this is what we are about as educators, regardless of the level at which we operate. No matter how well-attended schools and colleges may be, in the absence of worthwhile learning, they will not contribute as they should to economic independence, poverty reduction, personal empowerment and gender equity. Neither will they promote the knowledge and understanding that are fundamental to the reduction of HIV transmission. Those leaving school will remain prey to the poverty trap which will see many of them being sucked into prostitution, becoming street children, living in circumstances of female subordination, and experiencing other ways of life that will increase their risk of HIV infection. They will also remain much weaker than they should be in the face of HIV risks. The same remains true of programmes for those who do not participate in the formal education system. These will accomplish their goals only if they enable learners to incorporate the "useful knowledge, reasoning ability, skills, and values" that will stand by them in life, while enlarging their capacity to protect themselves against HIV infection.

Integrating HIV and AIDS into the Curriculum

But over and above this, there must be a wholehearted effort to mainstream HIV and AIDS, sexual and reproductive health, and life skills education into the curriculum of every learning institution. The objective would be to empower participants to live sexually responsible, healthy lives. This education must start early and it must be done well. This has major implications

First, this subject area must be properly professionalised, with the development of a corps of educators and teacher educators who are the specialised professionals in this field. We invest heavily in the multilevel preparation of teachers for mathematics, science, initial literacy, languages, the arts, and other areas – subject areas that prepare children and young people for life. We must also invest heavily in the multilevel preparation of educators for HIV and AIDS, sexual and reproductive health and life skills – subject areas that enhance the likelihood that children and young people will live. For too long we have toyed with this discipline and, in doing so, not only have we marginalised it but we have also failed to equip children and the young people who are at grave risk with knowledge, skills, attitudes and values that could mean the difference between life and death for large numbers of them.

Further, as a professional discipline in its own right, HIV and AIDS, sexual and reproductive health and life skills education must be fully integrated across the curriculum (Tirisano HIV and AIDS Programme, Project Two) and into the educational system. It is not an optional extra. It is not an add-on. It is not something that can be

picked up in spare moments of a biology or social studies lesson. It is a crucial stand-alone area that necessitates separate timetabling, the support of appropriate materials, and the provision of all the backup guidance, training, teacher support structures, monitoring and evaluation that other subjects receive (Bennell et al., 2002).

Finally, because HIV and AIDS, sexual and reproductive health, and life skills education transcend more freely than any other discipline, the boundary between what goes on inside and outside an educational institution, this subject area calls more strongly than any other for the involvement of communities and parents on the one hand, and social and health services on the other. This is where coalition, the unifying principle of this Conference, must come in. Educators cannot do everything alone. They need the support of parents and communities and the assurance that they approve of the contents and methods of what they teach. They do not want to be in uneasy conflict with them or with their cultural or religious perceptions. Educators also need to have health and social service providers working alongside them in this area, providing guidance, counselling, testing, services, supplies and referrals that go beyond what educators as such can be expected to provide.

There are two further reasons why partnerships involving these various constituencies are of such importance. Firstly, they bridge the divide between school and community or home, thereby making what is incorporated through education more real and relevant to life outside school; and, secondly, they ensure that everybody speaks with one voice – no matter what its source, the message to the young is always the same, a factor that continues to be critical to the success Senegal and Uganda have experienced in coping with HIV and AIDS.

Clearly, going down this road of wholehearted integration of HIV and AIDS and life skills education into the curriculum entails massive changes. It also entails major sacrifices, such as foregoing curriculum time for other subjects, and new ways of doing things, such as bringing the community more purposefully on board when designing the curriculum and possibly even for certain teaching activities. If this leaves some of us feeling uncomfortable, let us remember the words of the United Nations Secretary General, "this unprecedented crisis requires an unprecedented response" (United Nations, 1999).

For us in education, radical curriculum overhaul is part of that unprecedented response. The world with AIDS is not the same as the world without AIDS. Education and the curriculum, in a South Africa that is reeling under the massive impacts of HIV and AIDS, cannot be the same as in an AIDS-free South Africa. And it may well be that we will never see an AIDS-free South Africa unless we take the bold steps needed to adjust our education and curriculum systems. Education can cure us. It is the social vaccine that can lead us progressively to a world without AIDS – but not in its present form, not unless we make the necessary changes, not unless we adjust it purposefully for use as a channel for preventing the transmission of HIV infection.

From Prevention to Support and Care

Prevention alone is not a complete response to HIV and AIDS. Prevention may be the mainstay of our response since successful prevention education will reduce the numbers who become HIV-infected and eventually cause them to taper off. But we still have to face the legacy of the past two decades of confused and inadequate response. Our heritage today is one of broken lives, distressed people, and orphaned children. The grief and the anguish of the men, women and children of our time surround us on every side. Our milieu is one of physical and psychological pain and suffering, multiple bereavements, mourning and heartbreak, dehumanising poverty, lost opportunities, unfulfilled hopes, shattered dreams.

The education sector cannot stand aside from this. Those who are suffering are its own clients and providers, whether they are themselves infected with the disease or whether they are members of the great multitude of those who have been affected by it in one way or another. Let us remember that unlike other sectors in society, the education sector is highly person-intensive. Its fundamental technology of one teacher with a class of 15 to 50 students has remained the same for thousands of years. Educators and education support personnel constitute the largest proportion of public service employees. The vast numbers of students to whom they reach out constitute a significant proportion of the population. All told, an education sector may well involve a quarter or more of a country's population. Because it is so person-intensive an education sector is particularly vulnerable to the way HIV and AIDS can scythe its way through its personnel and operations, affecting the present adult generation in the persons of educators and support personnel and the coming generation in the persons of learners.

The outcomes are there for us to see. There may be debate about precise numbers and percentages, but none of us can deny the reality that HIV and AIDS is having a catastrophic impact on educators and learners. We see this in:

- Increased mortality of teachers and education support personnel.
- Discontinuities in classroom and learning activities because of teacher and learner sickness.
- Anxiety so many experience regarding their HIV status, yearning to know but fearing to hear it.
- Trauma and distress brought into the classroom by children who are in daily contact with the dehumanising illness of a parent or other loved adult.
- Termination of studies by older students who have progressed to clinical manifestations of AIDS.
- The sense of disorientation, catatonic detachment and second-rate status of orphaned children who have never known the "time of joy and peace, of playing, learning and growing" that the World Summit for Children saw as being their prerogative (UNICEF, 1990).

The education sector has a responsibility to take account of this multi-faceted situation of distress in which so many of its learners, educators and support personnel find themselves. It must position itself to respond to the special need for care and support that HIV and AIDS is creating in learners. Likewise it must respond to the need for care and support that the epidemic is creating in educators and education personnel. But in both cases it must do so in accordance with its own proper character as an education sector. Because it is so person-intensive, the education sector cannot separate itself from health concerns. Neither can it divorce itself from the provision of social services. But it must make its own characteristic response, as a provider of educational services and as a major employer, to the differing needs for care and support of learners and educators infected with, or affected by, HIV and AIDS.

Regarding learners, the sector must, above all else, make a coherent response to the challenges presented by orphans and those experiencing the trauma, discrimination and financial difficulties that all too frequently arise when there is AIDS in a family. It must also take account of the needs of learners who are HIV-infected.

Responding to the Orphans Challenge

HIV and AIDS is bringing a massive increase in the number of orphans. Currently there are some 12.5 million learners in all learning institutions combined. One projection is that in a few years time, there will be more than 3.5 million children under the age of 15 – more than 30 per cent of this age group –who will have lost one or both parents, mostly because of AIDS (Hunter & Williamson, 2000). It can be expected that social and financial problems will make it difficult for a significant number of these to participate in schooling in the ordinary way. As they grow into late adolescence, many will not have family structures for their support through higher education, as we are experiencing to our cost in Zambia. The learning capacity of those who participate in educational programmes may be severely impaired by their sense of personal loss, their uncertain status in the households of relatives or friends, and their experience of being set adrift in life before their due time.

Faced with so great a challenge, which is escalating by the day, the education sector must be prepared to guide a rapid extension of actions directed towards immediate and long-term solutions that respond to the educational and human rights needs of orphans and other vulnerable children. This should be done right now, when there is time, before the dimensions of the problem grow so large that they become unmanageable. We have let AIDS become virtually unmanageable. We should not let anything similar happen with orphans. This is a special challenge at the moment not only for the Department of Education but also for universities, colleges of education, and individual schools.

Collectively, they must devise an adequate educational response to ensure that, in imaginative and creative ways, children orphaned by HIV and AIDS, or vulnerable for any other reason, can be educated in a way that will help to compensate them for their human loss while preparing them for a full and satisfying human life.

For the education sector, this means paying attention to the following:

- Ensuring that children of school age in communities seriously affected by HIV and AIDS have the opportunity and financial means to receive education of good quality.
- Paying particular attention to the school and education needs of girls who are frequently required to assume a disproportionate share of the responsibilities associated with caring for siblings and parents who are ill.
- Supporting community pre-school facilities and programmes, with a view to giving older siblings the time and opportunity to attend school.
- Supporting community schools and other innovative forms of educational provision for orphaned and disadvantaged children.
- Making use of information and communication technologies, including interactive radio and other forms of distance education, with the twofold objective of bringing education out to children who are unable to come in to school and of providing some compensation for the AIDS-related loss of qualified teachers.
- Putting 'orphanhood', the strengthening of family and community caring/coping capacity, and coping with HIV and AIDS trauma at the centre of the research agenda in universities and social research units. It is estimated that at least 99 per cent of the children who have been orphaned and otherwise made vulnerable by AIDS are living within their extended families and communities, though often with great hardship (CID, 2001), but the scientific understanding of coping strategies and tolerance limits is not commensurate with the scale of the problem.
- Determining whether it would be desirable and productive to establish orphans and vulnerable children desks at central, provincial and district levels to maintain the momentum of the response to the orphans challenge.

Some further observations are in order, in relation to responding to the orphans challenge. One is that here, possibly more than in any other area, there is need for a dynamic coalition of all partners. This is not something that the education sector can address all on its own. The response must be based on the collaborative involvement of central and local government institutions, NGOs, faith-based organisations, and communities themselves. Second, there is need for a bottom-up approach to dealing with orphans and other children made vulnerable by HIV and AIDS. Very rightly, the majority of orphans live in communities and so must be supported by community-based initiatives. The various partners, including the education sector, should promote and support such initiatives. But these must remain initiatives of the community, developed at the local level and not in central or local government offices or in the offices of NGOs or faith-based agencies.

Thirdly, the education sector could contribute to forestalling growth in the magnitude of the orphans problem by spearheading a campaign to keep mothers alive. In the circumstances of HIV and AIDS, keeping mothers alive means being prepared to provide antiretroviral treatment not only to HIV-positive pregnant mothers, but also to all HIV-positive mothers with young children who still stand in need of their mothers' care. Without the mother the family falls apart. It is essential that mothers be enabled to stay alive and thereby prevent the disintegration of the family and the burgeoning in the number of orphans. The provision, through life, of antiretroviral therapy for these mothers will be at significant economic cost. But it is a cost that will pre-empt even more costly economic and social outlays if families fall apart and orphan numbers continue to swell.

Responding to Trauma

HIV and AIDS also affects learners through the trauma, silence, prejudice and discrimination frequently associated with it. Trauma and psychological distress may arise from the experience of seeing a parent or other loved adult enduring remorseless suffering and a dehumanising death, from anticipatory grief in the face of one's impending orphan status, from observing the physical deterioration of a teacher or fellow-student, from the repeated occasions for mourning and grieving in the school or community. Prejudice, frequently symptomatic of fear, and discrimination arise from the negative and judgmental attitude shown by some towards HIV and AIDS and those affected by the disease. Even in the absence of any overt discrimination, learners from affected families may experience subtle forms of prejudice manifested in their being isolated or in having to bear the taunts and derision of their colleagues.

The experience of trauma or discrimination may lead some young people to discontinue their education or be erratic in participation. Others may find that they are not able to learn as they ought. Educators and school heads may be at a loss as to how they should cope with the emotional, psychological and resulting behavioural problems that students may present.

Clearly, there is great need for an enlarged cadre of guidance and counselling personnel, qualified to provide the assistance that is needed, and with the space and time to do so in the way that is required (Bennell et al., 2002, p. 46). Appropriately qualified professional counsellors in educational settings should be enabled to extend their services both to learners in distress and to educators who need assistance in school-related matters or who are themselves enduring AIDS-related psychological turmoil.

Expanding the cadre of counselling personnel will require enlarged and possibly revamped programmes in universities and training institutions. It will also require national and provincial education departments to re-examine their staffing norms. Hard decisions may have to be made that give priority to this area, ahead of more traditional concerns. The education departments and the training institutions may also need to consider the appropriateness of including training in counselling skills (and ability to provide life skills and HIV and AIDS education) as an integral part of all pre-service teacher preparation programmes. The crisis situation in schools and institutions calls for some such crisis response.

Responding to the Needs of Infected Learners

It is necessary to face the sad fact that already many students, in institutions of learning at all levels and perhaps even more so in non-formal educational programmes, are HIV-infected. Moreover, these numbers will increase. A small percentage of those to whom their mothers transmit the virus perinatally may survive to school-going age and beyond, carrying infection with them through school days and further. The unfolding picture of extensive child abuse reveals another potential channel whereby children and minors can become infected with HIV. In addition, the Human Watch and other reports have documented the extent of coerced sex and rape to which girls are exposed, the heavy involvement of teachers and male schoolmates, and the way this can be linked to HIV infection (George, Finberg and Thonden, 2001; Coombe, 2002; Jewkes et al., 2002). There has also been some documentation of the incidence of HIV in tertiary institutions, in addition to evidence of its progression to AIDS in certain cases (Chetty, 2001; Kelly, 2001).

The picture that emerges is of a significant number of children in primary and secondary schools who are infected with HIV, a relatively small number (mostly in secondary schools) who show signs of AIDS, a comparatively high percentage in tertiary institutions who are HIV-positive, and because of the time lapse between HIV infection and clinical AIDS, a much lower percentage who have progressed to AIDS.

What response can the education sector and institutions make to the special needs of these learners? Perhaps the first need is to establish an atmosphere of acceptance and welcome where there will be no suspicion, no anxiety on anybody's part, and certainly no stigma or discrimination. It may take considerable skill to educate all members of a school community, as well as parents and other stakeholders, to this, but the human dignity of infected learners cannot be upheld with anything less. The full integration of HIV infected learners into the life and affairs of a school or college affirms in a powerful and natural fashion the principle of inclusion of people living with HIV and AIDS enunciated at the African Development Forum in 2000 (ECA, 2001).

There will also be need to make special provisions to enable those whose learning is interrupted by illness to make up for lost time and catch up on lost opportunities. Responding to this need can be a very practical expression of acceptance. Since this makes its impositions on educators and, through them, on other learners, it may also be the touchstone by which the humanity of an institution can be gauged.

Educational institutions can also use one specific curriculum area to manifest support for those who are HIV infected. This is by putting emphasis in appropriate parts of the curriculum on the importance of a healthy lifestyle.

Healthy living is one way of slowing down the progression from HIV to clinical AIDS. All other things being equal, infected persons who maintain a healthy lifestyle are likely to enjoy more years of life than infected

persons who do not take balanced nourishing meals, who smoke, take alcohol or use drugs, and who do not take adequate exercise and rest. Information about the significance of living in a healthy way is an important message that educators can always communicate, without fear of giving any offence to parents or other stakeholders. It is also a universal message, which is of value to all learners, irrespective of their HIV status. But for the infected, it could also be a life-saving message since, given the developments in vaccine technology, living in a healthy way might help keep a learner alive until such time as a vaccine applicable to infected persons becomes available.

Finally, having ascertained that this is what parents or guardians would want, the school or college should establish systems that would allow the social, welfare and medical providers play their proper role when their services are specifically needed. It would be valuable to explore the possibility of involving the wider community of parents, and of community and faith-based organisations, in aspects of these services, such as in providing transport. This would be integral to the education coalition against HIV and AIDS.

Providing Support for Educators

In addition to counselling, the education sector must consider what other forms of support it can provide to educators who are affected by AIDS. The sector is the largest employer in the country. There is no reason to think that its employees are less infected with, and affected by, HIV and AIDS than those in other areas of formal employment. In fact there are some grounds for thinking that they may be more so. What support can the sector offer in a situation of personal HIV infection, or where this is occurring in educators' families, or where they encounter it in the classroom?

Perhaps the basic thing is for the sector to demonstrate care and concern through its regulations, procedures and systems. These range from those governing absenteeism and time off, through those that relate to the workplace, to those concerned with medical schemes, disability, retirement and death benefits.

Clearly every one of these may need to be adjusted in the light of what HIV and AIDS is doing or could do to sector employees. It would not be appropriate for an outsider to go into details on any specific area, but the following broad issues deserve consideration:

- The desirability of wide consultation and the involvement of educators and support staff in AIDS-occasioned reviews of regulations, procedures and systems. Of particular value here would be inputs from educators who are themselves living with HIV or AIDS.
- Measures to protect educators against burnout due to AIDS-related work overload or stressful working conditions.
- Making provision for the speedy appointment of replacements and substitutes when staff are ill or die so that, among other things, an undue burden will not be placed on institutional managers and other surviving staff.
- Express recognition of and allowance for the way women employees remain responsible for providing much of the health- and child-care in the home and for holding a family together in time of crisis, death or financial difficulty.
- Ensuring that local administrators and institutional heads have sufficient autonomy to make humane staff-related decisions in response to potentially surprising or unexpected effects of HIV and AIDS.
- The provision of credible HIV and AIDS education-in-the-workplace programmes for staff in all institutions and education offices.
- The development of every education establishment as a health-promoting and health-affirming institution with systems in place to ensure access to treatment for opportunistic infections and tuberculosis.
- The possibility, including the cost-effectiveness, of providing educators with antiretroviral treatment, or of having this included in medical schemes, in view of the scarcity value of many of them and the crucial role that all of them play in the prevention through education of HIV transmission.
- Vigorous and sensitive public relations efforts to ensure that every educator perceives the sector as caring and concerned.

Caring for the Education Sector Itself

The Threat to the Sector

HIV and AIDS places every system and institution under profound threat. The epidemic and the variety of its impacts have the potential to overwhelm them, debilitating them in somewhat the same way as they debilitate individuals. When a person is infected with HIV, the immune system slowly but inexorably breaks down, leaving the individual vulnerable to the hazards of several opportunistic illnesses. The disease does something similar to institutions and systems.

In the absence of appropriate protective measures, these are likely to experience various problems that can develop to the stage where institutions or systems are no longer capable of functioning in the way they ought. Ironically, the very system that should be strengthening society's ability to protect itself against HIV and AIDS may itself be in danger of succumbing to the disease, as follows:

- **HIV and AIDS has negative effects on learners.** Numerically they are fewer. Financially, they are less able to support their education. Psychologically, they are less well able to learn and may not even want to be educated. Socially, many of them are orphans, some of whom may be heading households.
- **HIV and AIDS has negative effects on educators**. Deaths are very numerous. Many experience frequent and progressively more extended bouts of sickness that prevent their proper functioning. Many experience sickness in their family. In institutions where deaths are numerous and replacements inadequate, morale is low.
- **HIV and AIDS has negative effects on departments and agencies responsible for the provision of education services**. It does not spare technical, supervisory and managerial staff. Dealing with it absorbs a disproportionate share of the scarcest and most valuable resource possessed by these bodies, the expertise and time of their staff. In addition, because HIV and AIDS creates new and competing resource demands at national community and household levels, resources for education are under threat.
- **HIV and AIDS has negative impacts on the quality of education provided**. Learning achievement, the very touchstone of quality, is rapidly eroded by frequent teacher absenteeism, shortages of teachers in specialised areas such as mathematics or science, intermittent learner attendance, considerable educator and learner trauma, inability to concentrate on learning activities because of concern for those who are sick at home, repeated occasions for grief and mourning in school, in families, in the community, a widespread sense of insecurity and anxiety among both educators and learners.

Taking Action to Safeguard the Sector

Faced with the immense task of responding to these and other negative impacts, the education sector has the formidable task of ensuring adequate levels of quality education that take due account of the epidemic. Protecting HIV and AIDS-threatened education systems, so that they can continue to provide and, where necessary, expand education and training, requires efforts directed at stabilising the system, mitigating impacts on learners and educators, and responding creatively and flexibly to the varied, demanding and surprising imperatives of the disease (Coombe & Kelly, 2001).

Stabilising the system means that departments and providing agencies must ensure that even under attack by the pandemic, the system works so that teachers are teaching, children are enrolling and staying in school, older learners are learning, managers are managing, and personnel, finance and professional development systems are performing adequately.

Mitigating the pandemic's potential and actual impact on all learners and educators (and therefore on the system as a whole) implies ensuring that those affected and infected by the disease can work and learn in a caring environment which respects the safety and human rights of all. Of major concern here would be efforts to make the system fully and patently inclusive by challenging all forms of AIDS-related stigma and discrimination, providing for the most extensive possible participation by persons living with HIV and AIDS, and rooting all provision in strong human and child rights frameworks. A further concern would be to bring it about that each and every learning institution is a haven of safety for all who are associated with it, with zero tolerance for

violence, harassment or sexual abuse.

Mitigation efforts should also be addressed to providing counselling services; making provision for voluntary counselling and testing; working with social welfare and health ministries to provide learner-friendly services and adequate supplies; and ensuring responsiveness to the special needs of infected or affected learners and educators.

An education system responds creatively and flexibly to HIV and AIDS when it continues to provide meaningful, relevant educational services of acceptable quality to learners within and outside the formal system, in complex and demanding circumstances. This creative response will require a policy and management framework that can make things happen. Key components of this framework include:

- Committed and informed political and educational leadership.
- Broad-based multisectoral management partnerships with other government sectors, non-governmental organisations, faith groups, community groups, and the private sector.
- A policy and regulatory framework that includes common understanding about the nature of the pandemic and its potential impact on education, as well as guidelines, regulations and codes of conduct which clarify the responsibilities of implementers.
- Strategic and operational planning processes which lead to realistic and realisable operational plans.
- The appointment of senior full-time mandated HIV-and-education managers at all levels and within major institutions.
- Capacity building at all levels of the system, and adequate provision for personnel replacement and training.
- An HIV and AIDS-in-education research agenda that can develop an understanding of the multi-faceted impact of the disease on the system and that provides for the regular monitoring of a set of benchmarks and crisis indicators.
- Adequate budgetary provision with streamlined access to resources.

In essence, this means that at central and provincial levels the Department of Education must commit itself to a major exercise in strategic planning for its response to HIV and AIDS. The same holds for non-governmental bodies that provide educational services, whether through formal or non-formal systems, as also for universities and other major semi-autonomous educational bodies. In the absence of a strategic framework, the response to the epidemic is likely to be haphazard and ad hoc. The strategic approach ensures better coordination and more comprehensive incorporation of issues, while the process of developing a plan generates understanding, ownership and commitment to outcomes.

The Way Forward

On the basis of the considerations raised in this paper, a number of principles and activities emerge that can constitute a powerful and dynamic response from education and training sectors to HIV and AIDS. Doing something about all of these would see an education system really doing something about AIDS. Likewise, acting in the ways that are proposed would protect the education system so that it does not collapse under the onslaught of the pandemic.

The principles and actions are as follows:

1. Get every child, especially girls, into a school or appropriate educational programme, and keep them there for as long as possible.
2. Expose learners to a curriculum that takes full account of HIV and AIDS realities, be these in the sphere of life skills, sexual and reproductive health, cultural, traditional and moral imperatives, changing economies, the loss of skills by society, the need for school leavers to engage in economic activity at a very young age, or wherever.
3. Take steps to ensure that each class has a teacher, that arrangements and resources are in place to cover replacements and substitutes, and that all serving and new teachers come to be comfortable with the curriculum modifications which must be made in a total response to HIV and AIDS.

4. At the school or institutional level, work very closely with communities and parents, arranging for the school community to serve the HIV and AIDS needs of the local community and for the local community to participate with the school in the delivery of its HIV and AIDS-responsive curriculum.
5. At district, provincial and national levels, form broad-based partnerships that will bridge the gap with NGOs, the private sector, faith communities, and relevant government departments, and that will ensure the participation of every part of society in supporting the efforts of schools and communities.
6. Within education departments at central, provincial and lower levels, establish AIDS management units that will have the authority, resources and time to get things done.
7. Get good information on what is happening in the system, through impact and response assesment studies, and through the regular collection of HIV and AIDS-related data.
8. Develop planning, management and financial systems that will incorporate HIV and AIDS-related projections and data from the sector.
9. Review and update all legislation, policies, regulations and procedures to ensure that they are relevant to the HIV and AIDS situation and that they are friendly to people living with HIV and AIDS.
10. Institute AIDS-in-the-Workplace training, information and support programmes at all levels and within institutions, basing provision and activities on a continuum that runs from prevention to care.
11. Expend considerable effort in building capacity at all levels for planning, management, resource management, resource mobilisation, and speedy but transparent financial disbursement, in response to identified HIV and AIDS priorities and needs.
12. Coordinate, monitor and evaluate all that is going on, and disseminate to practitioners information about HIV and AIDS in the system and about good practices for its control.

Three further simple principles provide guiding frameworks for these activities and interventions: be open, be committed, be confident:

1. **Be open** to what is new, untried or unusual. Recognise that the disease and its impacts can be surprising. Be prepared to question and adapt all that already exists, since an education system with AIDS differs greatly from an education system without AIDS.
2. **Be committed**. Recognise that the gravity of the situation requires dedication and commitment, often beyond the call of duty, from every educator and official, but most especially from those of senior or executive rank.
3. **Be confident** that education can do it. Education can make a difference. The future need not be the same as the past (Whiteside and Sunter, 2000, p. xi). The future can be brighter and better, and education has a significant role to play in making it so. The statistics are bad, so bad that this may be our darkest hour. But remember, after winter summer comes, after the night day comes, after the storm a perfect calm ensues. Be confident that education can usher in this new bright, calm, era of an AIDS-free world and be proud that you can be part of such a movement.

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Facilitator's Key 2.4

1. Myth	11. Fact	21. Myth
2. Fact	12. Myth	22. Fact
3. Fact	13. Fact	23. Myth
4. Myth	14. Myth	24. Fact
5. Myth	15. Myth	25. Myth
6. Fact	16. Myth	26. Myth
7. Myth	17. Myth	27. Fact
8. Myth	18. Myth	28. Myth
9. Myth	19. Fact	29. Fact
10. Myth	20. Myth	

Facilitator's Key 3.4

NR (No Risk)

LR (Low Risk)

HR (High Risk)

1. NR
2. NR
3. HR
4. HR
5. NR
6. HR
7. NR
8. LR
9. NR
10. NR
11. NR
12. NR
13. LR
14. NR

Additional Reading

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Red Ribbon

Red Ribbon was conceived in 1991 by a group of artists in the U.S. who wanted to draw attention to AIDS. Since then the Red Ribbon has become an international symbol of AIDS awareness and visual expression of support for people affected by AIDS.

The Red Ribbon is increasingly being worn by people all year around to demonstrate their concern and care about HIV and AIDS, and to remind others of the need of their support and commitment.

Wear the Red Ribbon with pride!

WORLD AIDS DAY

World AIDS Day emerged from the call by the World Summit of Ministers of Health on Programmes for AIDS Prevention in 1988 to open channels of communication, strengthen the exchange of information and experience, and forge a spirit of social tolerance. Each year, it is the international day of coordinated action against AIDS.

Themes for WORLD AIDS DAY

Each year, a particular theme is chosen for World AIDS Day. Over the last eleven years, the themes have been as follows:

1988	Communication
1989	Youth
1990	Women and AIDS
1991	Sharing the challenge
1992	Community Commitment
1993	Time to Act
1994	AIDS and the family
1995	Shared rights, shared responsibilities
1996	One World, One hope
1997	Children living in the world with AIDS
1998	Force for Change: World AIDS Campaign with young people
1999	Listen, Learn, Live: World AIDS Campaign with children and the young
2000	AIDS: Men make a difference
2001	I Care, do you?
2002 -3	Stigma and Discrimination
2004	Girls, Women and HIV and AIDS