Education Division



Awareness – Safety – Competence

HIV/AIDS and teacher education

Consultation on HIV/AIDS and teacher education in East and Southern Africa

Benoni, South Africa, 28–30 October 2003

inWent
Internationale Weiterbildung und Entwicklung gGmbH
Capacity Building International, Germany

Remember the children for whom we are accountable

The Sinosizo home-based care programme in Kwa-Zulu Natal helps children aged nine to 14 who are the primary caregivers for parents dying of AIDS and for smaller brothers and sisters. The majority live in households with no incomes, many with parents who have been sent home from hospital – sometimes comatose – a day or two before they are expected to die. In the many homes where there are no beds, the children, often malnourished, struggle to lift and turn their parents and to help them to the toilet. Children from some of the 900 families with whom Sinisizo is working told ... the [13th International AIDS Conference, Durban, July 2000] about their difficulties. "They say waste disposal is the most difficult thing - getting rid of soiled dressings and incontinence pads. They also have to find food for their families, cook for and feed their parents and younger siblings. They have to ask for food from the neighbours and it takes hours to get enough for one day. They have to cook on paraffin stoves and open fires while they are carrying smaller children on their backs or hips. They have to fetch water for drinking, cooking, bathing and washing clothes, and a small child can't carry enough."

If there is any medication available, the children also dispense that, "but most of the time they can't even get aspirin". So, the children help their parents die; there is no time to mourn, because they must go and seek assistance to arrange a funeral.

The Natal Witness, 11 July 2000

Remember that we are each accountable

We have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.

Nelson Mandela

Report and Working Papers

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Carol Coombe

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Capacity Building International, Germany

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Contents

Appendices

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retroviral (Drugs)
CBO	Community-Based Organisation
DFID	Department for International Development (United Kingdom)
EFA	Education for All
FBO	Faith-Based Organisation
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HIV	Human Immuno-Deficiency Virus
(I)NGO	International Nongovernment Organisation
INSET	Inservice Training (for educators)
InWEnt	Capacity Building International, Germany
NGO	Nongovernment Organisation
PEA	Primary Education Advisor (Malawi)
PLWHA	Person/People Living with HIV/AIDS
PRESET	Preservice Training (for educators)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TDC	Teacher Development Centre
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing (for HIV/AIDS)

EPIDEMIC: A disease that affects a large number of people in particular place within a relatively restricted time is known as an epidemic. A pandemic is an epidemic that has spread more than one country. Thus HIV/AIDS around the world is called the "global pandemic" while a single country it is called an epidemic.

Preface

Education has a pivotal role to play in HIV/AIDS prevention and mitigating its effects. Educational interventions for learners of various ages, as well as for educators, should provide the necessary knowledge and encourage the development of attitudes and skills that can limit the spread and impact of the pandemic. The special responsibility of schools and teachers as role models and instructors has been acknowledged for more than 20 years. But education systems are themselves struggling with the impact of the disease on learning institutions, particularly in countries where HIV prevalence rates are high. The majority of the education systems in these countries are comparatively young and still on their way to establishing universal access to good quality basic education. HIV/AIDS threatens this process although the pandemic clearly shows how important it is to bring about real learning achievement on a broad basis.

A recent survey by the International Bureau of Education (IBE) demonstrates the range of work that has been done in the past two decades to develop more than 300 curricula and teaching/learning materials for life skills and prevention education. Modules and materials are commonly introduced to teachers through different forms of in-service training. In places, NGOs are mobilising civil society against the pandemic to care for affected adults and children. Strategies to prepare HIV specialists, trainers, planners and managers within the education sector for wide-ranging new tasks have been developed and partially implemented in the countries.

Despite all these efforts the disease continues to spread. The speed with which it is devastating countries in East and Southern Africa requires even more urgent action: every day it is

> taking more and more lives,
> causing health, psychological and socials distress for individuals, their families, and their communities,
> orphaning children and
> putting a burden on the economic and social systems of societies.

The highest rate of people infected with the deadly virus occurs in the age group of the 15 to 24-year olds, young people who should have been reached by prevention efforts in schools. The fact that girls and women continue to be 2.5 times more affected by the disease casts a light on unresolved problems of gender inequality.

Why does it seem that the prevention message schools are meant to deliver has failed? Perhaps it is the difficulty of really implementing HIV/AIDS education in schools, both at an institutional and personal level. The topic of HIV/AIDS and everything that is related to it touches on the most intimate spheres of society that are shaped by social, cultural and religious attitudes. Existing social rules and patterns of behaviour have developed in each community over a very long period of time. They are, however, as with all societal, cultural and social rules, never static but dynamic and are constantly adapting to complex change.

This is where teacher education and training within HIV/AIDS work is so important. Teachers need to be provided with the necessary contents, appropriate instruction methods, didactic aids, organisational skills and techniques to provide counselling and care. Furthermore, teacher development must ensure that teachers examine their own behaviour with respect to the disease and their treatment of those affected - and learn how to change their attitudes, skills and behaviours as necessary. Not least teachers need to be enabled to talk sensitively about intimate taboo subjects with pupils, colleagues, parents and others. This is an ambitious task for teacher education and training that clearly

needs improvement in many countries with high prevalence rates.

Within the context of the efforts of InWEnt (Capacity Building International, Germany) to improve the quality of basic education and to contribute to the fight against HIV/AIDS, the Education Division convened a regional consultation on "HIV/AIDS and Teacher education in East and Southern Africa". This initiative is part of InWEnt's HIV/AIDS policy that includes specific advanced training and dialog events in the areas of education, health, public administration, the promotion of small and medium-sized enterprises and rural development.

The objective of the conference "HIV/AIDS and Teacher Education" was to analyse existing assumptions, weaknesses and achievements of pre-service and in-service teacher education within the broader context of HIV/AIDS and education, and to reflect on necessary steps in order to improve and to extend what has been done and what has not been done. Sixty senior officials and representatives of governments, universities, teacher training colleges, non-governmental organisations and teacher unions met in the Conference Centre in Benoni, South Africa, from 28 to 30 October 2003. The consultation was kindly co-hosted by the Department of Education, South Africa. Participants and resource persons came from countries in which education or health are priority areas of German development cooperation, including Kenya, Malawi, Mozambique, Rwanda and Tanzania, or from countries that were able to share best practice experience, such as South Africa and Uganda. Central questions that they discussed were: What support do teachers and teacher educators require to respond to the complex needs of learners and educators affected by HIV/AIDS? What kind of educators do we need? What are the characteristics of good in-service and pre-service upgrading training programmes? Given the numbers of orphans and children and educators at risk, do we have appropriate structures and management skills to carry HIV messages into learning situations? Who is responsible for ensuring suitable action? How can teacher/ educator pre-service and in-service programmes be improved, adjusted and enlarged to ensure most serving teachers and teacher educators are HIV-aware, HIV-safe and HIV-competent? What are management issues that challenge the capacity of governments and their partners in the education sector, to deliver quality HIV programmes on a large scale? What can be done to rectify shortcomings?

This report is the result of the three-days work. The author, Carol Coombe, has succeeded in compiling a comprehensive and lively synthesis of the intensive analyses, inputs, discussions and deliberations of the plenary sessions and workshops. It is by design not a pure documentation but rather a working paper that has been supplemented with some of the discussion papers. The form of the report is supposed to be a source for the participants and their colleagues in their efforts to improve HIV/AIDS-related teacher education and training at national or institutional level. For InWEnt the results of the consultations are the basis for further measures to improve HIV/AIDS-related teacher education and training in the region.

We would like to express our sincere thanks to all participants for their dedicated and critical participation in the consultations. I would also like to extend my special thanks to the team of resource persons and participants who helped us to put together the country delegations and enriched the conference with beneficial inputs, syntheses and by moderating our meetings: Catherine Barasa, Dhianaraj Chetty, Liesel Ebersohn, Ken Longden, Cosmas Kamugisha, Kgobati Magome, David Mbetse, Hartford Mchazime, Elaine McKay, Mokgadi Moletsane, Jane Mulemwa, Wally Morrow, Gabriel Muita, Lydia Nzomo, Margaret Ojuando, John Rutayisire. We owe the greatest debt of gratitude to Carol Coombe for her dedicated and excellent planning and organisation of the conference as well as for editing this report.

Ulrike Wiegelmann
Education Division, InWEnt

Executive Summary

- Capable Professional Educators
- Effective INSET and PRESET HIV/AIDS-Competence Programmes
- HIV/AIDS-Competent Teacher Educators
- Alternatives to Lifeskills: Complementary Interventions

In October 2003, InWEnt (Capacity Building International), Germany convened a regional meeting of 60 senior officials and representatives of governments, universities and other tertiary institutions, nongovernment organisations, and unions. Professionals from Kenya, Malawi, Mozambique, Rwanda, Tanzania, South Africa and Uganda met in South Africa to determine what support teachers and teacher educators require to respond to the complex needs of learners and educators affected by HIV/AIDS.

The consultation focused initially on teacher education (PRESET and INSET) and how best to upgrade the capacities not only of school teachers, but of teacher educators in colleges and universities, to deliver lifeskills curriculum. In general, lifeskills programmes for educator and learner populations have taken a very long time to set in place, many educators have been reluctant to teach sexuality curriculum, and there are too few teaching and learning materials in the system. INSET programmes are rarely comprehensive or systematic enough to deliver adequate skills and materials to serving teachers. Not all teacher trainees are getting HIV-awareness training in PRESET programmes. Finally, little or nothing has been done by education systems to help teachers address the condition of orphans, to provide care and counselling for affected learners and educators, or to protect children at risk especially in deep rural, impoverished urban, or war-torn areas of Africa.

There are complementary alternatives to the conventional – and thus far largely unworkable – lifeskills/sexuality curriculum that may have potential to achieve quicker success in containing the spread of HIV, providing a modicum of comfort and stability to those infected and affected by the pandemic, and sustaining the quality of the education service: provision of condoms in adequate numbers, treatment of sexually transmitted infections (STIs) among students, peer health educator teams, school feeding, providing potable water and hygienic, secure sanitary arrangements at schools, improved school management and planning, improved safety and hygiene in the learning environment and a greater focus on discipline and ethical conduct.

Ultimately two routes were identified for further strategic planning:

1. a slower, long-term *development approach* to prevention, care and counselling in which the aim is to change the behaviour of learners – as well as educators, parents, elders and others – so as to save lives and mitigate the consequences of HIV and AIDS; and
2. a quicker, short-term direct *humanitarian approach* to prevention, care and counselling in which the aim is to save lives now, keep learners safe, healthy and in school, and at the same time support the build-up of capacity to deliver on behaviour change.

Capable Professional Educators

There are three primary tasks for educators:

- **Prevention:** helping prevent the spread of AIDS among learners and educators;
- **Care and Support:** working with others to provide basic care and support for learners and educators affected by HIV/AIDS, including orphans; and
- **Sustaining Education Provision:** protecting the education sector's capacity to provide adequate levels of quality education, principally by stabilising the quantity and quality of education provision.

What kind of educators can save lives?

Multiskilled: Very generally all educators need to be HIV-aware, HIV-competent, and HIV-safe. That means being multiskilled and capable of multitasking to respond to increasingly complex needs of the school and community. Not all teachers are able to do the specialist tasks of care and counselling for learners and for colleagues: some teachers will teach and counsel; others will counsel and teach. For some teachers this will require a lower teaching load.

Realistic curriculum in schools, colleges and universities: AIDS-competent educators need to work with a curriculum that reflects the new vision of what education is in the days of AIDS, and the socio-economic context in which learners learn and teachers teach. A greater degree of realism must influence curriculum selection, curriculum delivery, and teacher education.

If teachers are unable or unwilling to take on this additional HIV-related burden given their current professional and personal circumstances:

- Informed choices must now be made about what should and should not be included in an already overloaded curriculum, aimed at community as well as learner needs.
- Arrangements must be made to appoint trained counsellors in senior learning institutions to take some load off teachers and teacher educators.
- HIV-related subjects must become stand-alone (examinable) subjects: then all learners will have a chance to get all the information they require.

This is the minimum. But is the school curriculum the best tool for responding to HIV as an emergency? Can educators do what needs to be done? If it is not possible to create the 'new teacher' with a realistically adjusted curriculum, then what are the alternatives for saving lives?

Effective INSET and PRESET HIV-Competence Programmes

Teacher education is not keeping up with teacher needs. INSET and PRESET programmes must be able to train and support educators in their broader capacities as agents of behaviour change and front-line carers. Teachers in training, and teacher educators, also need help internalising and changing their own behaviour vis a vis both AIDS and the way they teach lifeskills.

There have been no known evaluations of content, implementation and outcomes of HIV INSET programmes in any participating country. For the most part INSET provision from the centre has been superficial, ad hoc, unsystematic, and poorly funded and managed.

It would help to have a standard HIV emergency INSET curriculum capable of reaching hundreds of thousands of serving teachers. Even then, regular and systematic upgrading of teachers will require upgrading the HIV-competence of INSET tutors, principals, deputy heads, and senior teachers, and teachers who have been out of work for some years, but are coming back into the system. Appropriate sensitisation courses are also required for district education officers, district inspectors and finance administrators, with appropriate materials.

Such courses must be comprehensive and intensive, capable of reaching all educators regularly and systematically, and subject to regular evaluation. So far, the management foundation for undertaking such a huge task is not in place in education sectors in the region. The consultation did not comment on how systematic INSET could be implemented: this is a

persistent problem throughout education sectors in the region. Currently, it is not realistic to assume that HIV-competence upgrading can be piggy-backed on very fragile INSET programmes in the region.

To deliver HIV-competence effectively to teacher educators and teachers in training during PRE-SET, the whole institution must be HIV-competent, -aware, and -safe. The HIV ethos must pervade and permeate each institution. Lifeskills must be mainstreamed in teacher training institutions: preferably it should be offered as a mandatory core course, and be examinable.

HIV/AIDS-Competent Teacher Educators

Tertiary institutions must play a prominent role in maintaining education quality as it is attacked by HIV/AIDS, improving the content, implementation and evaluation of lifeskills programmes, and teaching sexuality in a sensitive and effective way. To do this, they need to broaden their responsibilities beyond simply preventing HIV infection among tertiary learners, to prevention, care and counselling for students and staff, researching and analysing HIV and education issues within the national education sector, and providing information and data to help in planning effective and realistic responses to the pandemic.

However, many tertiary institutions in the region, with their teacher inservice and preservice programmes, depend on external aid; recently the latter has focused almost exclusively on basic education. Inadequate attention has been paid to quality upgrading for senior teacher trainers, and resources have been scarce for upgrading secondary schools and teacher training institutions. Thus far it is not apparent that any higher education staff have been regularly sensitised to HIV concerns if at all, or that there are any HIV curriculum courses in faculties of education outside South Africa.

All teacher training staff in colleges and universities must be HIV/AIDS-aware, HIV-competent, and HIV-safe. It is not clear who can do this training of teacher educators, although mobile teams of specialists, and the provision of virtual or hardcopy HIV and education libraries in each teacher training institution would be a good start. Existing teacher training institute curricula require review and adjustment so that HIV can be mainstreamed there as well as in schools. So far the cart has been put before the horse: schools are required to do HIV tasks that teacher training colleges do not, and perhaps cannot, do.

Alternatives to Lifeskills: Complementary Interventions

Given the fragility of current inservice and preservice upgrading for teachers, teacher educators and other education personnel, it seems advisable to initiate complementary actions to save lives and keep learners and educators healthy and in school at least in the short-term, while longer-term behaviour change interventions take hold. Creating an HIV-aware teaching service, with appropriate INSET structures, is a very long-term development process. Further, evidence worldwide indicates that lifeskills curriculum is a necessary but not sufficient response to the pandemic.

Therefore, we might assume that we cannot rely on curriculum alone to respond to the challenge of HIV/AIDS. We can complement the lifeskills curriculum with other methods, alternative interventions including 'zero budget' or low budget options including:

Support and Development

- Make sure a policy framework is in place, and that monitored and costed plans of action derived from it are complete and ready for implementation – and implement if possible - for
  - creating partnerships for action among social sector ministries of education, among education ministries and (I)NGOs, CBOs and FBOs, and among schools, communities and district offices, with clearly identified roles for partners.
  - strengthening INSET through self-study, peer-group study in school clusters, local peer support groups, peer counselling, using the services of local NGOs, FBOs and CBOs as well as volunteers – whatever works systematically, intensively and extensively.
  - making teacher educators HIV-competent through similar methods plus provision of (virtual) libraries and resource materials which are easily produced locally.
  - mainstreaming an HIV-awareness curriculum (core, mandatory, and examinable) in college and faculty of education programmes.
- Improve the HIV-management skills of heads, deputy heads, senior teachers, and other district officials for planning, managing and implementing school and community HIV programmes.
- Ensure educators are role models for learners, and that schools are safe places, by applying and adhering to a strict code of conduct for all learning institutions.
- Create an ethical and value-laden environment in learning institutions with regard to discipline, gender safety, non-toleration of violence, abuse, stigma or discrimination.
- Flood the sector with teaching and learning materials to ensure that communities, schools and colleges have access to basic knowledge about HIV and have the chance to become HIV-safe, HIV-aware, and HIV-competent, even when there is no one to teach them.
- Be realistic about resource and capacity issues by designing interventions that take account of workloads at schools, the need to 'zero budget', the mental and social strains that HIV puts on individual educators and the school as a whole, and the value of peer education.

Health

- Establish anti-AIDS clubs or, preferably, para-professional youth peer health educator teams for awareness, prevention, care and support for pupils and students; establish similar peer counselling teams for educators.
- Reinstitute school health programmes, or start them where they have not existed before, and guarantee drugs and qualified personnel through the international community if necessary.
- Work with partners in health and social services to create a circle of care for those infected and affected by HIV/AIDS.
- Work to create safe and hygienic conditions in schools: provide potable water and latrines that are clean, gender-separate, and as safe for girls as for boys.
- Identify and guarantee treatment of sexually transmitted infections (STIs) and other HIV-related infections through health care programmes for learners: send a health worker to the school each term and guarantee drugs as required or refer to nearest clinic or hospital.

Condoms, provided in sufficient numbers, *do* make a substantial impact on levels of infection and should be distributed freely. School feeding programmes, especially in hot-spot areas, can keep disadvantaged and HIV-affected children in school.

At times, especially in a crisis, it is possible and perhaps advisable to move forward quickly without an articulated policy, and to wait for policy to evolve from experience on the ground. Policy is merely a statement of intent, not of action. Nevertheless, an organised conceptual framework that sets out what needs to be done, and how it can be done, is ultimately essential in order to use available resources effectively.

Where there is a plan – whether by government or by government and partners within the sector – funding will almost certainly be found for it, from government's budget, from the SWAp budget, from international agency programmes, or through stand-alone negotiations on the basis of costed plans of action. Without costed plans for selected policy priorities – a package that includes improving INSET, training teacher educators, and treating STIs among students, for example - it is unlikely that urgently required action will find the resources needed to save lives, and keep children and young people alive and in school.

How common is Sexual Abuse of Children?

- In South Africa, 40-47% of sexual assaults are perpetrated against girls aged 15 or younger.
- In rural Malawi, 55% of young girls reported in a survey being forced to have sex.
- In one Ugandan district, 31% of schoolgirls were sexually abused, mainly by teachers.
- In Nairobi, Kenya, one-fifth of teenage girls reported being sexually abused.
- The South African Medical Research Council reported late in 2000 that one half of all schoolgirls had been forced to have sex against their will, one third of them by teachers.

Sources Gachuhi, 1999; UNAIDS 2000;
Medical Research Council, South Africa 2000.

HIV/AIDS in Context

Kenya, a country with an external debt of US$ 8.94 billion, has recently declared HIV/AIDS a national disaster: over 2 million of 29.5 million Kenyans (2000) were HIV infected and a cumulative number of 1.5 million people had died due to AIDS. Because of HIV/AIDS, life expectancy has dropped by 13 yrs to 51 yrs (1998); while GDP reduced by -0.3 in 2000 and is expected to worsen in coming years. The average literacy rate is estimated at 78% (1995) and total fertility rate in Kenya is about 4.4 (1998). Over 50% live below the poverty line, women constituting the majority.

Burden adult prevalence: 15–49-years-old 14% (2000)

Malawi, with an estimated population of 11.2 million (2002) is one of the worst HIV/AIDS-affected countries with an HIV/AIDS prevalence of 15%, the eighth-highest globally. HIV infection concentrates in younger age groups, particularly women, and life expectancy is expected to drop from 57 to 44 by 2010, with implications for productivity. The country's population is mainly rural (86%, 1998) and only 56% of the adults are literate (1995), while the total fertility rate is 5.7 (2002).

Burden adult prevalence: 15–49-years-old 15.0% (2002)

Mozambique's population is estimated at 18 million people, of whom 52% are women. The population is predominantly rural, with only 23% of the population living in urban areas. Fertility rate is 5.9%, and life expectancy projection for 2010 was revised down from 50 to 36 years, allowing for the impact of HIV/AIDS. Illiteracy is estimated to be 50%, 71% women. HIV/AIDS is one of the greatest threats to development but response is constrained by lack of adequate human, technical and institutional capacities.

Burden adult prevalence: 15–49-years-old 13% (2001)

Rwanda emerged from a period of mass displacement, war and genocide to face a problem that further threatens survival—the HIV/AIDS epidemic. Rwanda's population is over 7.5 million, but the annual growth rate from 1990–1998 has been –0.7%. Most people live in rural areas, where the HIV/AIDS epidemic has caught up with the prevalence rates of the urban centres perhaps as a result of living in refugee camps after 1994. Prevalence rates across all prefectures are similar and suggest a well-established epidemic. 70% of the population lives on less than $1/day, in a rural subsistence economy, characterised by strong religious biases, and low literacy. Post-genocidal society is now in a new phase of development including release of large numbers of accused from long-term imprisonment back into communities.

Burden adult prevalence: 15–49-years-old 11.21% (1999)

South Africa. HIV/AIDS was thrust upon a country that was trying to redress the political, social and economic imbalances of the past. South Africa has a population of over 45 million, an adult literacy rate of 82% and an urbanization rate of 49%. HIV prevalence increased from 0.7% in 1990 to 24.8% in 2001. Teenage prevalence declined from 20.1% in 1998 to 15.4% in 2001 but is now stable at about 22%. Unprotected sex, multiple sexual partners, migration and the low status of women aids spread of the epidemic.

Burden adult prevalence: 15–49-years-old 20.1% (2001)

Tanzania ranks 151 on the Human Development Index (2002) with a population of about 35 million (2000). Adult literacy is about 75% (2000), fertility rate 5.4%; life expectancy has declined from 51 years to 47 years between 1988 and 1999 and about 25% of households are headed by females. Macroeconomic indicators have consistently improved over the last five years. The health care system is being overstretched by increasing numbers of AIDS patients, and the increasing number of orphans is overwhelming the coping capacity of communities. Among the public, there is a lack of a sense of urgency in responding to the epidemic, and denial and stigma discourage many from seeking VCT and care.

Burden adult prevalence: 15–49-years-old 7.8% (2001)

Uganda is a low-resource country that is recovering from years of dictatorship; civil war continues to rage in the north. The population of 24.6 million (2002) includes 50% who are under the age of 15. The average fertility rate is 6.9 and life expectancy has dropped to 42 years due to AIDS, the leading cause of death. Most people (87%) live in rural areas; adult literacy is 68% (2001).

Burden adult prevalence: 15–49-years-old 5.0% (2001)

Source: UNAIDS Country Fact Sheets, November 2002

Report and Working Papers

HIV/AIDS data for 12 SADC countries

Table courtesy of Rose Smart, HIV/AIDS Consultant and Member, Mobile Task Team on the Impact of HIV/AIDS on Education in Africa

COUNTRY	ADULTS AND CHILDREN LIVING WITH HIV/AIDS (END 2001)[1]		ADULTS (15-49 YEARS) HIV PREVALENCE RATE[2]	TOTAL ORPHANS AS % OF ALL CHILDREN[3]	ORPHANS DUE TO AIDS AS % OF TOTAL ORPHANS AND ABSOLUTE NUMBER[4]
	LOW ESTIMATE	HIGH ESTIMATE			
Angola	250 000	450 000	5.5%	10.7%	14.9% 104 000
Botswana	260 000	390 000	38.8%	15.1%	70.5% 69 000
DRC	960 000	1 700 000	4.9%	9.4%	41.8% 1 366 000
Lesotho	230 000	480 000	31%	17%	53.5% 73 000
Malawi	720 000	1 100 000	15%	17.5%	49.9% 468 000
Mozambique	860 000	1 500 000	13%	15.5%	32.8% 418 000
Namibia	150 000	230 000	22.5%	12.4%	48.5% 47 000
South Africa	4 000 000	6 000 000	20.1%	10.3%	43.3% 662 000
Swaziland	130 000	200 000	33.4%	15.2%	58.8% 35 000
Tanzania	1 200 000	1 700 000	7.8%	12%	42.3% 815 000
Zambia	930 000	1 400 000	21.5%	17.6%	65.4% 572 000
Zimbabwe	1 800 000	2 700 000	33.7%	17.6%	76.8% 782 000

1 UNAIDS; Report on the global HIV/AIDS epidemic (July 2002)

2 UNAIDS; Report on the global HIV/AIDS epidemic (July 2002)

3 UNAIDS, UNICEF & USAID; Children on the brink 2002: A joint report on orphan estimates and program strategies (November 2002)

4 UNAIDS, UNICEF & USAID; Children on the brink 2002: A joint report on orphan estimates and program strategies (November 2002)

No one else in the world has experienced [these levels of HIV/AIDS prevalence]. While we can learn from others, we must remember our own context, which is particular. Our job is trying to bring perhaps unrealistic dreams to reality.

Gulam Mayet, 1996

Chapter 1

Introduction

Ho! AIDS, Ho! AIDS.

You are a killer and you don't open your mouth.

You pretend not to be during darkness.

Ho! AIDS, Ho! AIDS.

When I look around, you also look around.

When I don't look around, you just remain there, the same.

Ho! AIDS, Ho! AIDS.

Student at Canon Lawrence Primary Teachers College, Uganda

Late in October 2003, the Education Division of InWEnt (Capacity Building International), Germany, convened an East and Southern Africa regional meeting of senior officials and representatives of governments, universities and other tertiary institutions, nongovernmental organisations, and educator associations. Almost 60 professionals from Kenya, Malawi, Mozambique, Rwanda, Tanzania, South Africa and Uganda met outside Johannesburg, South Africa, to determine what support teachers and teacher educators require in order to respond to the very complex needs of learners and educators affected by HIV/AIDS in primary and secondary schools in the region. (See Appendix 1, Programme.)

Methodology: A Graduate Seminar

This consultation was designed in the form of a graduate seminar that avoided description of problems and projects, and focused instead on critically analysing progress, or lack of it, in confronting HIV/AIDS in the primary and secondary school classroom, particularly in terms of the readiness of teachers. Participants were asked to critique their assumptions – about the lifeskills curriculum, about educator willingness and preparedness, about the capacity of INSET and PRESET programmes to develop educator capacity, and particularly about the skills of teacher educators including university staff members. They were asked to be aware of possible fallacies in the assumptions that have driven lifeskills planning for almost 20 years, based on the original fundamentally-uncritiqued lifeskills model of prevention.

Principal Conceptual Challenges

A number of particular challenges were put to participants at the outset of the consultation and they served as themes for subsequent debate:

- The onslaught of this pandemic might be compared to the murderous sweep of the nightmare horsemen of Genghis Khan through city after city across the known world in the 13th century. Participants were asked if we, like monkish researchers, watch as the Mongols gallop through our gates, *observing in horror*, scribbling, desperately trying to calculate the odds against Khan's men destroying our battlements, how best to train our stout citizens to ride horses – or just where to get the horses – and where, especially, to find a general to lead them? What are we actually doing other than think, and discuss, research and plan? (Professor Wally Morrow)

- What we think and what we do are two sides of the same coin. When we organise our thinking, does our thinking limit our practice? Do our ideas develop into a conceptual framework which functions as a box which constrains further creative thinking? Can we *think outside the box* even when doing so puts pressure on our 'common sense'? How can we move out of our current conceptual box, to do some *'disciplined divergent thinking'* about lifeskills, saving lives and protecting education quality? (Professor Wally Morrow)

- The English school model was imported into Africa. For at least a century attempts have been made to improve teacher training for this model: to create a multi-skilled professional. In the days of AIDS, we imagine that such schools and such teachers *can change the behaviour* of our young, but that is not proven. And we see all too well the past and continuing *failures of an expanded, complex, European schooling model*, in both rich and poor countries. (Professor Wally Morrow)

- There will *never be enough* qualified, competent teachers. If this is a terminal crisis of schooling, then this is not the school model we need under present circumstances. Perhaps it is time to *change the way we think about schools*: their primary function in Africa may be to care for and monitor the socialisation, education, health and the general well-being of our children. Their staff might consist of educators, health and social workers, among others. (Professor Wally Morrow)

- There are a number of concerns that make us want to *fast-track our response to HIV*: the fact that many teachers are unwilling to talk about sexuality and that we cannot expect them to play a leading role; that many lack

professional responsiveness to children, and some are even capable of cruelty to children; that there is a great need to cultivate a human rights ethos in our places of learning; and that we constantly encounter gender and social constructs that inhibit behaviour change. (Kgobati Magome)

- What we achieve in our HIV policy and practice should characterise good education generally where values and ethics are paramount, along with human rights, a caring environment, counselling for those in trauma and a decent chance to learn. HIV *gives us this opportunity to strengthen our educators* in coping with many kinds of problems. *It shines a torch on our weaknesses.* (Kgobati Magome)

- For almost twenty years, educators have been told that they are responsible for saving the lives of literally thousands, perhaps millions of children. Can we make this happen? *How can we make this happen?* What is stopping us? (Carol Coombe)

- The difficulty of delivering support to hundreds of thousands of serving educators (400,000+ in South Africa, 250,000 in Kenya, 122,000 in Ugandan primary schools alone) is not just a teacher education issue. It is *primarily a management issue*: what kind of management foundation within the education sector is required to deliver lifeskills and other support systems adequately, and to create a climate for behaviour change and learner wellbeing? (Carol Coombe)

Meeting Contextual Challenges

Senior educators' observations and comments about their experiences indicate that, in general,

- There has been inadequate lifeskills education for both educator and learner populations, a recalcitrant teaching force, and insufficient teaching and learning materials *in the system.*

- INSET programmes are rarely comprehensive or systematic enough to deliver sexuality skills and materials to serving teachers.

- Not all teacher trainees are getting adequate HIV-awareness training in their PRESET programmes.

- Little or no provision has been made by education systems to address the condition of orphans, care and counselling for affected learners and educators, or for the protection of children at risk especially in deep rural, impoverished urban, or war-torn areas of Africa.

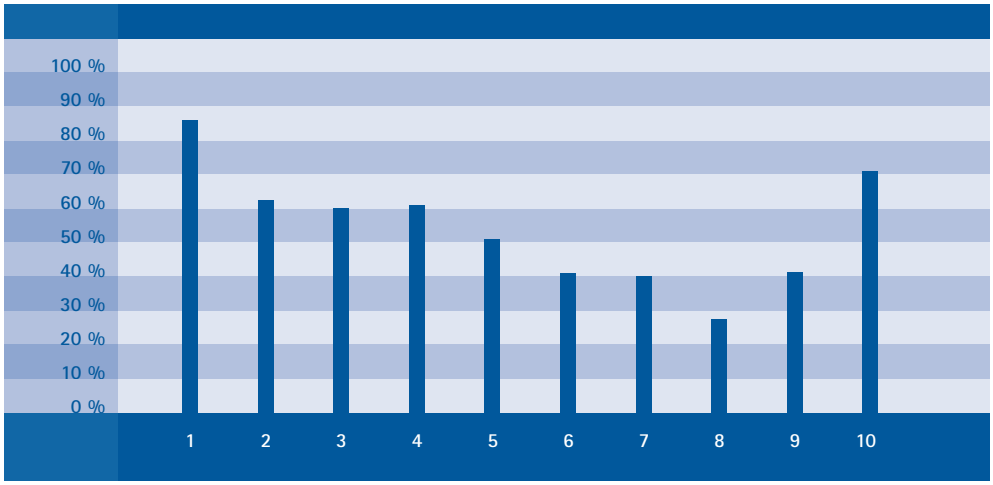
A snapshot of INSET and PRESET development and support programmes for educators in the region was achieved by asking participants to rate, before the consultation began, the quality of their country's provision. (See Rapid Appraisal Pro Forma, Appendix 2.) The outcomes support their anecdotal evidence.

The scan suggests that while all countries are making progress by addressing needs of both learners and educators (1/87.2%), confident action apparently declines with regard to appropriate curriculum (2/64%), mainstreamed curriculum (3/60%) and adequate materials distributed to schools (4/61%). Substantially fewer teachers and teacher educators have access to educator-specific materials (5/49%), concordant with the lack of preparation for teachers and for teacher educators (6 and 7/40% in each case). Evaluation of programmes in terms of either content, delivery and/or outcomes is rarely done (8/26%). Other school-based interventions (anti-AIDS clubs, or

less often peer health teams, inter alia) are sometimes attempted (9/41%). On the other hand, the education sector seems to have moved relatively far in developing partnerships for effective programmes (10/73%).[5]

In sum, countries are now concerned about learners and educators and there is a 60% confidence in lifeskills curriculum delivery in schools, usually in partnership with other providers in the sector. But there is low confidence in the capacity of teachers and teacher educators to deliver. Whether the confidence demonstrated in columns 1-4 is justified in view of concerns about development and support of serving/new teachers and of teacher educators, and about the lack of evaluation of current programmes, is questionable. Respondents are not particularly positive that care and counselling for learners in difficulty is

Providing Guidance on HIV/AIDS



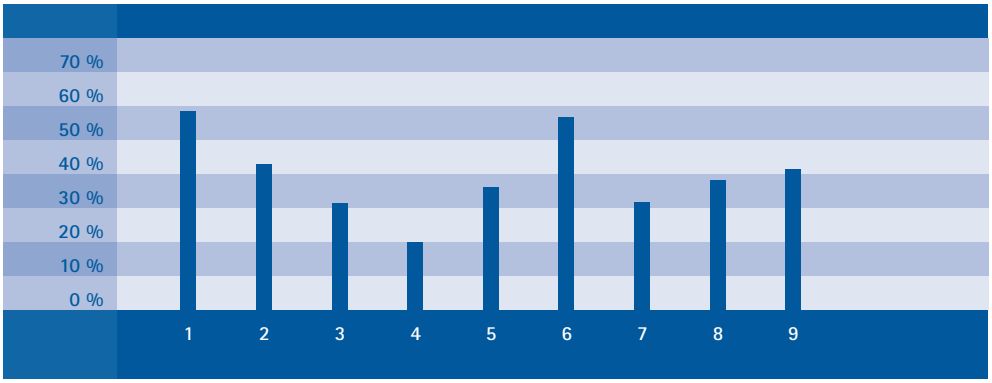
1 Teachers and learners.
2 Appropriate behaviour curriculum.
3 Curriculum mainstreamed.
4 Materials developed, distributed.
5 Materials for teachers.
6 Serving teachers prepared.
7 Teacher eduacators upgraded.
8 Evaluation of content, action, outcome.
9 Altenative techniques.
10 Partnerships in operation.

[5] The inferences that can be drawn from this scan (N=26, or just over half the official participants) are likely to be significantly flawed by misapprehension of the questions by some respondents. For example, representatives of one country that is known to be particularly uncertain in terms of its HIV/AIDS and education response structures, mechanisms, staff and planning, gave top marks for the sector's managerial performance. It is not possible to ascertain why they did so.

There is also an ambivalence between the perceptions of ministerial and other sector officials, and those of management and HIV specialists, who would certainly query a number of the self-evaluations. An overly-optimistic official/national perception of what is adequate or appropriate to drive the sector's response to the pandemic perhaps explains the continuing difficulty in managing it, and creating effective opportunities to save lives through the system. An exercise of this kind requires benchmarks, tangible indicators of success and change.

a classroom responsibility (1/59%). Whether this is because they take account of the reality of teachers' poor working conditions and questionable professionalism, or because they do not believe this is a matter for educators is not clear. Learning institutions are generally not seen as safe places for learners, especially girls (2/45%), nor are they considered places where children at risk or their teachers can feel supported and sustained by the system (3 and 4/33% and 20%). Little has been done to combat discrimination (5/36%), although some steps are being taken to develop and implement codes of conduct in schools and other educational workplaces (6/57%). Specific support for orphans is receiving some but not enough attention (7-9/35%, 39% and 41%). In general terms therefore, it is possible to suggest that care and support for learners and educators has not been a priority for action by education sectors in the region although it is commendable that stricter attention is being paid to codes of conduct, human rights, values and professional ethics, and their more rigorous application.

Care and Support for Affected Learners and Educators



1 Care is an educator responsibility.
2 Schools are safe and secure.
3 Educators can help children at risk.
4 Educators can access counselling.
5 Stigma is being reduced.
6 Codes of ethics are applied.
7 Multisectoral links exist to help OVCs.
8 Sectoral policy is defined on responsibility for OVCs.
9 Effective partnerships are in place.

Is it possible to make progress without a management base? Respondents were suitably modest in their appreciation of the capacity of their ministries and institutions – the education sector as a whole – to manage the response to the crisis presented by this pandemic. However, their relatively strong confidence in leadership (3/64%), partners (4/68%), and the idea that there is a strategic plan of some kind (8/60%) is outweighed by recognition of continuing weakness in information (5/51%), policy formation (7/39%), and mobilisation of resources (9/42%).

The relatively high confidence in management (6/60%) – full-time, senior management, with standing structures for the sector, and multisectoral partnerships – is puzzling in view of the reality on the ground in most ministries of

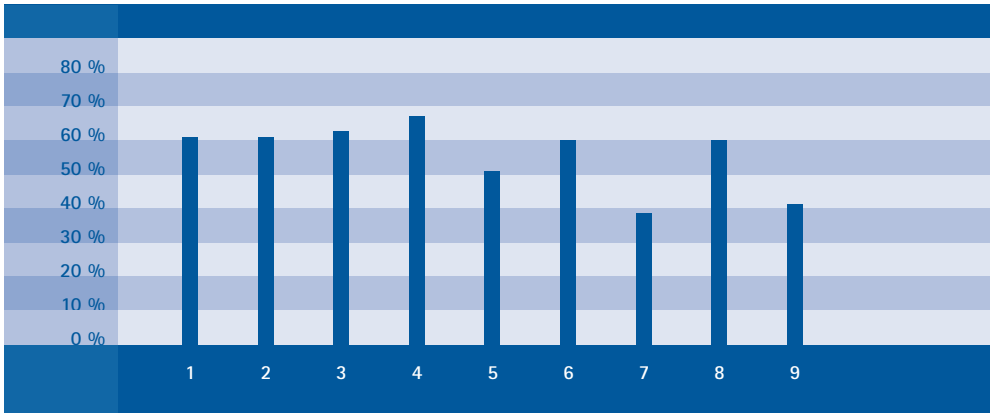
education where there are still agonising delays in appointing appropriately qualified senior managers who can plan and deliver creatively and comprehensively.

In reality and quite apart from HIV/AIDS, education officials and others in the sector are dealing with immense general educational concerns including:

- Their commitment to achieve UPE/EFA
- Their continuing difficulty in providing adequate learning and teaching materials, in the broadest sense, to learning institutions, especially for teachers
- The need to upgrade huge cadres of serving teacher educators and educators (including teachers and officials) in a variety of subjects, including management and planning for educators who are not teaching
- The fragility of most INSET programmes
- The already-substantial demands of the examinable curriculum
- The absence of competency upgrading for teacher trainers and adjustment of PRESET programmes
- The persistent lack of adequate funds applied vigorously and comprehensively throughout the sector
- Insufficient numbers of dedicated senior management experts/leaders among national and international agency partners
- Recent and continuing conflict (Mozambique, Rwanda, South Africa and Uganda) and drought (Malawi, Zambia and Zimbabwe)
- An unrealistic perception of the size of the HIV/AIDS catastrophe.

These factors, among others, constitute a long-term challenge that has not become incrementally less imposing during the four decades of national-international development cooperation and the arrival two decades ago of HIV and AIDS. The uncertain potential of the behaviour change paradigm, given the need to change behaviours not only in institutions but

Creating a Foundation for Action



1 Adequate management base.
2 Prevention *and* mitigation of impact.
3 Committed/informed leadership.
4 Collective dedication.
5 Research; agenda/dissemination
6 Effective senior management.
7 Policy and regulations.
8 Strategic plan.
9 Resources mobilised and appropriately allocated.

among parents and other adults, the community as a whole, and out-of-school young people, in widely varying cultural contexts, has been handed over to already overwhelmed and under-resourced education systems.

The Pandemic's Challenges to Teacher Education

The consultation focused initially on teacher education (PRESET and INSET) and *how best to upgrade the skills and capacities not only of school teachers, but of teacher educators* in colleges and universities who have thus far had few opportunities to improve their HIV skills, knowledge and performance.

Participants reviewed the lifeskills/prevention paradigm in schools that has dominated regional education responses to HIV/AIDS for the past two decades. They reported that formal research has rarely focused on the quality of the content, implementation and outcomes of the lifeskills programmes to allow an informed evaluation of behaviour change programmes' success. They asked: 'In most countries 'lifeskills' is seen as an answer [to the challenges of HIV/AIDS]. But what model is the most effective for changing learner behaviour?'. Even now the answer is not clear.

Participants considered *complementary alternatives to sexuality curricula* that may have potential to achieve quicker success in containing the spread of HIV, providing a modicum of comfort and stability to those infected and affected by the pandemic, and sustaining the quality of the education service.

Ultimately two routes were identified for further strategic planning:

1. A slower, long-term lifeskills *development approach* to prevention, care and counselling in which the target is to change the behaviour of learners – as well as educators, parents, elders and others – so as to save lives and mitigate the consequences of HIV and AIDS for individuals and communities; and

2. A quicker, short- medium-term direct-action *humanitarian approach* to prevention, care and counselling in which the target is to save lives, keep learners safe and in school, and at the same time support the build-up of capacity to deliver lifeskills, care for those at risk and sustain the quality of education over the long-term. (See for example Appendix 3 at end.)

Is the school curriculum the correct place to respond to a crisis, this HIV emergency? We have worked on this now for years, for decades. If there is no – or at best little – evidence that this works, or can work, we can without shame admit defeat and decide what we *could* be doing.

(Ken Longden, Malawi)

Chapter 2

Review of Consultation and Conclusions

Assumptions – and Fallacies

In order to determine what kind of educators are needed to respond to the greater demands of learners and other educators affected by HIV/AIDS in primary and secondary schools, and therefore what teacher educators need to be able to do, it is essential to reconsider the assumptions that underlie current lifeskills/prevention planning in the region's education sectors.

Assumption 1
Teachers (and other educators) need to be able to do three principal things about HIV/AIDS at primary and secondary school levels:

1. They need to help *prevent* the spread of HIV by teaching the HIV curriculum well at primary and secondary levels.

2. They need to identify and seek to *care* (within a circle of care, and within schools that are child-safe) for children who are at risk or who are already orphaned, for they may be the first to see children who are in difficulty.

3. They need to help *manage* the response of their schools – especially those who are school heads, inspectors, supervisors, and district education officials – to the pandemic, working with the community, other educators, school governing bodies and parents in order to help individuals and families, and to sustain an acceptable level of education provision.

> Is it possible for teachers and other educators to take on these additional responsibilities, given the curricular load, the conditions in which they work, their salaries and other conditions of employment, and their own susceptibility to being affected by HIV/AIDS?

Assumption 2
Teachers need to look after *other teachers and educators* as well as the *children* for whom they are responsible. They need to apply prevention, care and management techniques on behalf of their colleagues, as well as learners, to help stabilise the teaching service and sustain morale and performance.

> Have any educators been prepared to consider the needs of their colleagues, in addition to the needs of the learners in their professional care? How much responsibility do they have for the wellbeing of their professional colleagues?

Assumption 3
Teachers, and other educators, need therefore to be trained in (1) delivering *prevention* curricula in cooperation with others, (2) basic *care* and counselling techniques, and (3) how to *manage* the crisis in the school and community, for the benefit of both *learners and educators*.

> Are PRESET and INSET programmes capable of change required to deliver these skills to educators, and are INSET programmes strong enough to deliver subtle sexuality messages to most serving teachers – or at least a selection of them?

Assumption 4
To do this, teachers need to be *trained regularly and systematically* both PRESET and INSET.

HIV curricula need to be inserted in PRESET teacher training programmes, and additional structures and programmes created – through distance education and peer education for example – for developing the skills of serving teachers. Where there is little systematic INSET training of any kind for serving professionals, this will be a particularly difficult objective to achieve with regard to HIV. Is it possible to achieve these goals?

> Is it possible to improve current INSET and PRESET sufficiently? Or are HIV-specific upgrading programmes for new and serving educators, including teacher educators, required?

Assumption 5

Training needs to be done by teacher educators/trainers who are themselves knowledgeable about the aetiology of HIV, the goals and content of schools' HIV curricula, good practice with regard to care and counselling by teachers for children and other educators, and basic HIV management skills, including making HIV school plans. Regular and *systematic training for all teacher trainers* is therefore essential now.

> Has any country given priority to re-tooling teacher training institute staff? Have teacher educators shown themselves willing to take on a new subject – teaching it, researching it, and becoming HIV-competent generally?

The consultation ultimately considered a synthesis of these questions:

1. Identifying the characteristics of capable professional educators.
2. Improving teacher HIV/AIDS-related skills through INSET and PRESET programmes to make them HIV-aware, HIV-competent, and HIV-safe.
3. Improving the HIV/AIDS-related competencies of teacher educators in all teacher

The Planning Levers

1. Where has HIV teacher education been carried out systematically and regularly, PRESET and INSET? Who is responsible? How many educators have been reached and for how long?
2. How are universities and colleges responding to the challenges of HIV/AIDS in terms of their teacher training and educational research programmes?
3. How can existing teacher INSET and PRESET programmes be improved and adjusted to ensure serving and new teachers, and teacher educators, are HIV-aware, HIV-safe, and HIV-competent? Who is responsible?
4. What needs to be done to support universities and colleges in re-tooling their PRESET programmes to incorporate HIV/AIDS concerns? Who is responsible?
5. What needs to be done to ensure that the skills and attitudes of university and college teacher educators are upgraded? Who is responsible?
6. How can an HIV and education research agenda be designed and carried out which speaks specifically to the concerns of educator training? Who is responsible?
7. Who is accountable for developing and sustaining HIV teacher training programmes?

training institutes, to make them HIV-aware, HIV-competent and HIV-safe.
4. Initiating complementary actions to save lives and keep learners and educators healthy and in school at least in the short-term, while longer-term behaviour change interventions take hold.
5. Committing adequate resources to managing this crisis in the education sector.

Teachers and Curriculum

What new skills do teachers need?
The consultation worked around three primary tasks for educators: preventing the further spread of HIV among learners and educators, providing basic care and support within the school context for children at risk and orphans, working to make schools safe and caring communities, and protecting the quality of the education service. (See Appendices 4 and 5.)

What kind of teachers do we have now?
Are teachers and other educators HIV-aware, HIV-competent, and HIV-safe? Responses by participants to a Teacher Assessment Pro Forma (UNAIDS, 2003) provided a snapshot of their confidence in the extent to which educators think they are currently HIV-aware, HIV-competent, and HIV-safe. (See below, and Appendix 6.) [6]

On the whole, respondents felt that educators have a substantial amount of information ('HIV/AIDS is more than a health problem alone'), and are prepared for change. Their capacity to create change is regarded however as relatively modest (most responses fell into the 'average' or median categories'). This may reflect the youthfulness or lack of qualification of many educators in expanding education systems, or the failure of the system to support them through PRE-SET and INSET programmes and the provision of adequate teaching materials, or a very complex set of these and other factors.

What kind of teachers do we need?
All teachers need to be sensitised about the basic facts of the disease and the pandemic: that way they can keep themselves safe, and protect their own families, their communities, and the learners for whom they are responsible. HIV/AIDS must be at the core of the self-identity of the teacher. They must reach deep to be more compassionate, more caring, even in the difficult conditions in which they work.

All teachers must be HIV-aware, HIV-competent and HIV-safe. Despite all the odds, to be effective they must be multiskilled and be able to multitask in order to respond to increasingly complex needs of the school and community. They need to be able to cooperate multisectorally, working 'multicompetently' to support children at risk.

Can we 'think outside the box' about our teachers? Can we do enough 'disciplined divergent thinking' here? For example, do we need people with very different skills in our schools? Can all teachers be HIV/AIDS agents, or do a selected proportion need specialist skills? How can we help teachers cope with their personal burdens as well as their expanded professional responsibilities, the ones we are talking about?

(Ken Longden, Malawi)

6 Ratings suggest a 'mark' out of a possible 5, and sometimes grouped between, say, 3 and 4, or 2 and 3. In the case of 'mobilising resources', responses ranged from lows of 1, to median of 3, to high of 5. (N=25.)

Assessment of Teacher Competence

Factor	Rating	Statement	Statement
Acknowledgement and recognition	3-4	We recognise that HIV/AIDS is affecting us as a group and we discuss it amongst ourselves. Some of us get tested. (3)	We acknowledge openly our concerns and challenges of HIV/AIDS. We seek others for mutual support and learning. (4)
Inclusivity	2	We cooperate with some people who are useful to resolve common issues. (2)	
Care and prevention	2	We look after those unable to care for themselves (sick, orphans, elderly). We discuss the need to change behaviours. (2)	
Access to treatment	2-3	Some get access to treatment. (2)	We can get treatment for infections but not ARVs. (3)
Identifying vulnerability	1	We are aware of general vulnerability and risks. (1)	
Learning and transfer	3	We are willing to try out and adapt what works elsewhere. We share willingly with those who ask. (3)	
Measuring change	1	We are changing because we believe it is the right thing to do but do not measure the impact. (1)	
Adapting responses	3-4	We are aware of the change around us, and we take the decision to adapt because we need to. (3)	We recognise that we continually need to adapt. (4)
Ways of working	3	We work as teams to solve problems as we recognise them. If someone needs help we share what we can. (3)	
Mobilising resources	1,3,5	We have prepared project proposals and identified sources of support. (3)	We use our own resources, access other resources to achieve more, and have planned for the future. (5)

Most of all, educators need to be open and free in talking about HIV/AIDS.

Not all educators can be thoroughly HIV-competent: selected teachers will need to be trained for specialist tasks of care and counselling. In other words, some teachers can *teach* and counsel while others can *counsel* and teach. That means a lower subject load for chosen teachers who are HIV specialists.

Sexuality education and associated life orientation skills can only be taught by teachers who are fully acquainted with all aspects of HIV in school:

- The aetiology of the disease.
- Universal precautions at school (what to do when there is a bloody nose on the playground).
- Stigma and discrimination and the rights of both the learner and the educator.
- The special responsibilities of male teachers for sexual probity.
- Keeping the school a safe, secure and health-caring environment for all.
- How to help others affected by the disease.
- How to plan and manage the impact of the disease on the school.
- How to work with the school governing body, the community and with parents.

HIV-competent specialists will also have bereavement coping skills and basic counselling skills to help those in trauma and children at risk. They will be able to refer those in need to appropriate social or health workers, or to homebased care.

Specially trained teachers will be responsible for an examinable subject and their competence can therefore be evaluated for promotion and other purposes.

Our teachers need good communication skills. They need to know how to integrate AIDS information in class and in co-curricular activities with an eye to balancing today's 'critical issues' including not just HIV but gender, the environment, and poverty inter alia. They themselves should be able to identify and implement strategies that lead to behaviour change. They need to be able to adopt innovative and creative methods of curriculum delivery appropriate to the subject, and in HIV teaching this is particularly sensitive. They need a thorough mastery of the issues related to HIV, and the skills to disseminate this knowledge. They need to be able to work with others in and out of the sector, including their own governing bodies or parent-teacher associations.

(Gabriel Muita, Kenya)

Finally, HIV-competent educators must have access to counselling help themselves, as carers in an increasingly demanding environment. Teachers are faced with regular crises at school as a result of poverty, trauma and HIV: home dumping of chronically ill or terminally ill parents, for example, is particularly difficult for children to cope with, and for a time at least, ends their school career. Burnout is already a reality for some teachers. Carers need carers, and if peers are trained to care for peers, educators will not be forced to cope in isolation.

Let's take account of reality.

It is true that some teachers have 120 children in one shift, and may work more than one shift, often in classrooms that are derelict, and without teaching and learning materials and other basic equipment. It is also true that their salaries and conditions of service generally are poor; that teaching service commissions and public administration have done little or (more often) nothing to ensure their welfare with regard to HIV/AIDS is reflected in pensions and medical boarding, postings and transfers, and

provision for counselling or drug treatment. (The issue of ARV treatment has become important to many teachers and increasingly so for more informed teaching service managers.)

Others have simply been reluctant to become competent in HIV matters because HIV is not an examinable subject, and there is therefore no evaluation or measure of teacher performance.

This means training a 'new teacher' for schools, with a proper curriculum to go with a new vision of what education is. It means deciding realistically what should be included in the curriculum, and finding better ways of delivering it and of being more courageous altogether.

The question was asked: 'What are we doing to help our teachers? Are we asking them to face Genghis Khan and his horsemen simply by changing the plan, engaging in sometimes rather feeble guerrilla warfare, using carthorses instead of warhorses or even tanks? What are we doing to support teachers so they can meet our expectations of them?'. And the question was answered: 'Perhaps we have not had the equipment to face this enemy'.

We have not failed, but we are going as far as we wish to go, as far as we can with what we have.

(John Rutayisire, Rwanda)

Can we do what needs to be done?
If we cannot create the 'new teacher' with a realistically adjusted curriculum, then what are the alternatives for saving lives?

- Make informed choices now about what should and should not be included in an already overloaded curriculum.
- Make arrangements now to appoint trained counsellors in secondary and tertiary institutions to take the load off teachers and teacher educators, and to avoid having to train so many serving teachers.
- Cooperate with other sectors and complementary education sector partners to make significant gains.
- Identify alternatives to school-based taught prevention programmes.

Perhaps Botswana's example is useful, for it combines the strengths of three separate sectors (health, social development and education) to keep children alive and in school, while the lifeskills programmes are being rolled out slowly. Government is committed to (1) registering all orphans and providing food subsidies for them/for the families caring for them; (2) helping to ensure that local home based care groups are available to help child-headed households with schooling (clean uniforms, homework done, some breakfast, and food on return home); and (3) providing all learners with one meal a day at school (pap and relish) so that school is a feeding, caring and more 'normal' environment for disadvantaged children.

Do we need to review the curriculum – again?
The issue of the curriculum is central to planning our response to HIV and AIDS. There are good reasons to review what is being taught, how, and by whom.

- **The school, the street and the home.** We need a curriculum that recognises community needs as well as learner needs, and involves them practically in making decisions about HIV programmes. Learners after all live not only in school, but on the street, and in the home.
- **Curriculum + commitment + resources.** We need a curriculum that includes HIV in the most effective way: as a core, examinable subject; as an infused or integrated and therefore examinable subject; or some other model. There is little so far to indicate

Curriculum development needs to go back to fundamentals: it is not a product of the curriculum developer/writer, but of civil society.

(Vanencia Kabwila, Malawi)

what works best, and all models have been tried. Evidence suggests that no curriculum model leads to behaviour change unless it is underwritten by commitment and resources necessary to implement it comprehensively and intensively over the long term.[7]

- **HIV/AIDS as part of a core, mandatory, examinable subject.** We need to understand the difference between HIV as a broad, core, examinable subject; HIV as an 'infused' or integrated' topic in other curricular subjects like maths and biology; and HIV as a factor in each examinable subject which must be taken into account (we can no longer teach education psychology for example, without taking account of the trauma that millions of children at risk and orphans are enduring; we cannot present a social studies curriculum without reflecting the impact of the pandemic on Africa, on communities and individuals; teaching of economics must take account of the impact of HIV/AIDS on agriculture, mining, manufacturing, and household economy).

The biggest lingering issue for us all is the lifeskills curriculum. If we are bound to it, then do we now continue with integration and infusion, or do we take a bold step and mainstream it? This is the big issue.

(Gabriel Muita, Kenya)

But what is achieved by 'infusing' HIV in the schools curriculum? If by that it is meant that the maths teacher uses HIV-related graphs in her subject, and the science teacher refers to HIV in teaching human biology, and the social studies teacher refers to HIV in teaching about health provision, can we assume that any learner has a holistic understanding of HIV prevention and safe sex thereby? Which parts of the HIV/AIDS/lifeskills puzzle does the individual child get? Can we assume that every teacher in every school is willing and able to 'infuse' HIV in his or her subject? The answer of course is 'no'.

If there are books and materials, they may have some HIV content, which may be taught, for which teachers may be role models for behaviour change, but this may take place in a community where adults have not changed their own behaviours, values and lifestyles, and where learners face the streets and home after school.

(Tania Vergnani, South Africa)

If we want to teach HIV prevention in schools, it can only be done effectively as a stand-alone (preferably examinable) subject: then all learners get all the information they require. It probably needs to be taught by selected teachers who are fully HIV-competent.

7 UNAIDS (2001). HIV Prevention Needs and Successes: A Tale of Three Countries (An Update on HIV Prevention Success in Senegal, Thailand and Uganda). Geneva: UNAIDS.

What is the purpose of the curriculum from the perspective of an educator? Is it to solve all the problems of HIV? Schools are not necessarily best qualified to do the job of fighting this out-of-control fire, and it will take a long time to get them into the position where they are qualified to fight it. The orphans, for example: what prior claim to that responsibility can schools make? In spite of what INSET has been able to do, we are asking people to do things that we do not practice in reality; to do things without teaching them about it; to do things without resourcing them; to be aware of behaviour change throughout their whole community.

(Robert Kamau, Kenya)

- **The curriculum as a weapon of mass salvation.** Is the school curriculum the best tool for responding to HIV as an emergency? Schools and their curricula are being used to solve many social problems. Because of the complex nature of this disease and the context in which it spreads, is the curriculum the best tool for fighting it? That is what educators were asked to do in the 1980s, what was given to them originally. It was perhaps like putting them into a Formula 1 race with a home-built car. What alternatives do they have to the curriculum? These questions, which occupied many participants, are considered later in this report.

Teacher Education: INSET and PRESET Programmes

HIV-related teacher education is not keeping up with teacher needs. INSET and PRESET programmes must be able to train and support new and serving educators in their broader capacities as agents of behaviour change, and front-line carers. Teachers in training need help in internalising and changing their own behaviour. All need to be HIV-aware, HIV-competent, and HIV-safe. But are teachers being reached by current INSET programmes?

After approximately eight years in operation, the Malawi INSET system is stable, but dysfunctions have appeared: PEAs are being attracted by higher salaries as school heads and replacements are not being recruited; their transport, motorbikes initially supplied years ago by The World Bank, have lasted well, but are no longer on the road, and transport for PEAs within many zones has become difficult; TDCs are not being efficiently used to capacity, for a variety of reasons; PEAs have not had upgrading training themselves, although they initially benefited from support by the Malawi Institute of Education, and Canada's Brandon University.

Malawi, after its move to universal free primary education in 1994, has perhaps had more sustained practice in INSET development that other countries in the region. Working together, the Malawi Ministry of Education, UK DFID, The World Bank, and Germany's GTZ reconfigured PRESET and INSET programmes to meet the need for increasing numbers of qualified teachers at all levels of the system. It was decided ultimately that teachers would undergo a preliminary 3-month initial teacher training in colleges, and would after appointment subsequently be supported by Primary Education Advisors (PEAs) working out of 316 Teacher Development Centres (TDCs) to create libraries, and improve the skills of teachers, school heads, education officials and others.

(Hartford Mchazime, Malawi)

The Government of Malawi has given no specific guidelines on HIV/AIDS skills for teachers, so there has been no systematic INSET training for serving teachers. Lifeskills is supposedly being taught in all primary and secondary schools, but books are not available for all grades. NGOs have successfully been involved in school-based programmes, but their contribution has not been evaluated.

We have the INSET structures and TDCs in Malawi, but we do not have HIV/AIDS-aware trainers to do the work, and no way to ensure that pupils get the right message.
(Rosemary Ngalande, Malawi)

Malawi is by no means alone. It is clear that INSET programmes everywhere need to be enlarged and improved – and adjusted to provide for HIV/AIDS services, not just for the curriculum but for care and counselling techniques, planning and management skills, and multisectoral perspectives.

Are we sure that we can improve INSET to an acceptable level and quality of provision?
Long years of experience suggest that it is difficult, almost impossible, to reach large numbers of educators regularly, systematically, and on a scale large enough to make a difference.

It was suggested that

- There needs, first of all, to be a nationally coordinated INSET programme, if HIV/AIDS is to be piggy-backed on it into the schools. (Some countries in the region have no national INSET programme.)
- It must cover the sector, including communities and parents.
- It needs to be national.
- The education sector can only be fully reached if ministries work with other ministries, and with NGOs, CBOs, FBOs and municipalities.
- INSET models need to differ from area to area; the discredited cascade model only exacerbates the flaws of the system and is in effect merely a stop-gap.
- INSET must specifically target HIV issues not just include them in other subject upgrading.
- Upgrading programmes in HIV/AIDS must be complemented by massive distribution of useful materials, media campaigns, magazines and comics, radio broadcasts, TV programmes, 'training ad nauseum', and the active support of senior politicians and policy-makers.
- All institutions should be budgeting for HIV/AIDS, including tertiary institutions, district offices and schools, especially.
- INSET must be financed appropriately; funds must be mobilised and channelled to those who can use them.
- INSET programmes must be evaluated regularly and systematically – ad hoc evaluation of one project here and another there is not acceptable.

It would assist if priorities were identified which were relatively simple and achievable. From the point of view of an experienced Ugandan participant (Uma Agula Francis), there needs to be

- An HIV emergency INSET curriculum.
- Emergency upgrading for INSET tutors.
- HIV-related INSET refresher courses for serving heads of schools, and teachers who have been out of work for some years, but are coming back into the system.
- Appropriate regular and systematic sensitisation courses for heads and deputy heads of schools, district education officers, district inspectors and finance administrators, with appropriate materials.

The experience of Uganda suggests that this is achievable.

How can the ideal be achieved?
It should be possible to act realistically and to reach larger numbers of serving teachers better by proper planning and resource allocation, including:

- Consulting all stakeholders.
- Identifying priority needs (using data and other information).
- Developing strategies to address identified priorities.
- Identifying activities that will promote those strategies – a costed action plan that can attract funding.
- Preparing an implementation plan for each activity (including resources available and required, the type and possible source of resources, time frame, targets, anticipated outputs and outcomes, provision for operations research/monitoring and evaluation.
- Monitoring progress of implementation: setting indicators of achievement; monitoring the process of implementation, possibly by using operations research techniques and personnel; and looking again at the impact assessment where this has been done; promoting formative evaluation of implementation and responsive adjustment.

If we think that HIV/AIDS is that serious, then we should give it top priority even if we have to drop all the other issues for the time being.

(Small group discussion)

Greater commitment at school and district level is required:

- School heads and district officials convening regular seminars for teachers to update themselves.
- Acquiring and distributing as many materials as possible to sensitise all educators on the basics of HIV/AIDS including basic care, counselling and palliative care.
- District officials and heads ensuring HIV/AIDS workplace policy is established in every learning institution and office in the area.
- Teachers undertaking home visits to check on children at risk.
- Heads and district officials involving school committees, school boards of governors, PLWHAs, faith-based and other community organisations in the welfare of the school.
- Headteachers working with the school community create policy and a three-year rolling plan on HIV/AIDS.
- Heads and other officials working to ensure legal protection for affected children and mothers especially in matters of child abuse.
- Heads, teachers and learners working together to describe cultural beliefs and customs that can help to keep them safe, and to identify others that are a threat to their security.

The 'best placed person' can undertake simple and direct interventions alone and by cooperating with others, doing what is known to work. (David Mbetse at Bushbuck Ridge South Africa, and Margaret Ojuando at Highridge Teacher Training College in Kenya for example, are outstanding examples of improvisational and creative HIV-competent leaders.) Individuals and institutions have power: they can step outside the system's lack of urgency, and create centres of action which have a knock-on influence on others. There are various systems operating within the education sector that can be 'hijacked' for sexuality/HIV education: it is not necessary to wait while INSET is improved and scaled up. There is a place within schools and teacher training facilities for more traditional models of care and counselling. In Malawi, for example, nankungwi traditionally provide this kind of support within communities. The idea can be translated into schools and colleges. Spirituality counselling by leaders

of the faith, and peer counselling have also been shown to work.

Who is responsible?
Very simply, all actors at all levels of the education sector are responsible. The ministry of education must take the lead by providing a coordinating policy and action framework.

What are the priorities for PRESET programmes?
If the HIV/AIDS pandemic is as big a crisis as it portends, then the teacher training colleges must give it top priority, and leave out other parts of the conventional curriculum. They must work holistically as change agents to create an ethos among new teachers, and teacher educators, that is informed by the pandemic. Students who are trained at an institute which is a change agent will be change agents themselves.

An HIV-aware institutional ethos
The preservice curriculum must help teachers prepare for HIV-related duties in a holistic way. That means the whole training institution needs to be HIV-competent, -aware, and -safe. The HIV ethos must pervade and permeate the institution.

Practical knowledge and skills
New teachers need to be empowered, but they lack confidence about their skills. If the teacher education programme does not reflect real- life situations, and continues to stress theory and abstract concepts, very basic knowledge, and unrelated practice, then teachers will not be empowered.

Curriculum mainstream
Lifeskills must be mainstreamed in the teacher education curriculum and must also be examinable to ensure that new teachers are committed to learning and teaching the curriculum properly. Only in this way will teacher educators give it its due.

Further, if selected teachers are to specialise in being HIV-competent, then optional courses must be provided for teachers in training who wish to opt for such specialisation.

HIV-competent teacher educators
To achieve these goals, teacher educators must also be knowledgeable and HIV-competent.

Training Teacher Educators

How can we improve HIV/AIDS-related competencies of teacher educators in teacher training institutes, to make them HIV-aware, HIV-competent and HIV-safe?

It is clear that InWEnt, by selecting the theme of HIV and teacher education, has helped to highlight a core group of educators with substantial responsibility for the success of lifeskills programmes but largely ignored in recent HIV/AIDS education policy and action planning.

Teacher training – PRESET and INSET – depends on external aid, and as aid has recently focused almost exclusively on basic education, there has been inadequate attention paid to quality upgrading for new and serving secondary teachers and teacher trainers. (Uganda for example, has a substantial quality differential between primary training institutions, and national/secondary teacher training colleges, reflecting for the most part the priorities of external agencies.)

Have any teacher trainers been upgraded in HIV matters, so they can train new teachers, and help upgrade serving teachers? All teacher training staff must be empowered to be

HIV/AIDS-aware, HIV-competent, and HIV-safe. A clear curriculum policy statement on this might lead to HIV courses as part of a higher education academic qualification. (See draft example from one participating country.) Thus far it is not apparent that any higher education staff in the region have been sensitised to HIV concerns, or that they would be qualified to teach specialist courses for teachers in training.

Tertiary institutes have a prominent role in helping to maintain the quality of education under attack by AIDS, improving lifeskills programmes, and teaching sexuality in a sensitive and effective way, for different communities. They need to broaden the concept of their responsibilities beyond simply prevention for learners, to prevention, care and counselling for students *and* staff, carrying out research to inform the policy, planning and decisions of the education sector, and to help educators reach out across the sector, and to other social sectors to support those in distress as a result of the pandemic.

It is possible that universities and teacher training colleges could act as focal points for the development and distribution of HIV-related materials including guidelines for educators on care and support, and identification of children in trauma and families that are not coping. Education faculties and colleges both might develop capacity to profile and disseminate examples of good practice to teacher development centres and district offices. Together the tertiary institutions can provide a network of knowledge, skills and resources to support teacher upgrading and development, good practice, and further research. HIV/AIDS and education libraries in all tertiary institutions are essential – for staff, students, researchers, postgraduate students and others – and easily available through websites and on CD.

Primary Purposes of this (Draft) Educator Training 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;
- to develop competences in the teaching approaches and styles appropriate to teaching about HIV and AIDS to learners
- to develop the personal capacities and confidence needed by educators in coping with HIV and AIDS responsibly in the daily life in schools; and
- to 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:

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.

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.

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.

Knowing key relevant policies and laws

Qualifiers should have sound knowledge of the following policies and regulations: (a) National HIV/AIDS Policy (1999), (b) HIV/AIDS and STDs – Strategic Plan for South Africa 2000-2005 and (c) the South African Council for Educators' Code of Professional Ethics, and how they are to be adhered to in their own professional practice. They should also have basic knowledge of those laws that regulate professional teacher behaviour and relationships.

Responding to HIV/AIDS in the classroom, school and community

- **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-judgemental 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 affected and infected by HIV/AIDS, and how these impact on learning, teaching and community life. They need to develop the competences 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 affected and infected 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 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.

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.

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

Alternative Complementary Interventions

We must create the right balance between what we *can* do (activism), and what we *should* do (idealism), taking account of our financial and human resources.

Can we initiate complementary actions to save lives and keep learners and educators healthy and in school at least in the short-term, while longer-term behaviour change interventions take hold?
Do we stick with training because we are teachers or teacher educators by profession? Certainly, part of the HIV/AIDS challenge is to improve the way we deliver lifeskills curriculum by setting it properly within the schools curriculum, developing the skills of teachers and teacher trainers – and other educators – and ensuring INSET and PRESET programmes are working efficiently.

This is however a long-term development process. At present, the lifeskills curriculum as currently taught, supported by inadequate INSET/PRESET structures, does not evidently save enough lives: we do not see the results. Evidence worldwide indicates that lifeskills curriculum is a necessary *but not sufficient* response to the pandemic.

First, we must 'get real': we cannot continue with words, jargon, planning and talking, meeting in conferences. We need to be urgent, practical, honest and prepared to deliver.
If we assume that we cannot now rely on the schools' curriculum alone to respond to the

Perhaps the most successful aspect of the [South African] National AIDS Programme has been to improve the quality of STD care and increase the public's access to that care. In fact, it appears to have been a classic example of „getting the small things right', argues Helen Schneider: Ensuring good STD care is simpler than organising peer education or doing outreach with marginalised groupings, and points to the kinds of prevention tasks that are within the capacity of the system to implement...If simple tasks are successfully managed, they will contribute to building an environment which will make more challenging interventions through government possible at a later stage.

(Marais, To the Edge, 2000)

People have been saying the lifeskills curriculum is taking a long time – and will continue to take a long time – to influence behaviour change, and there are other forms of change that can save lives now. What is our readiness to pursue these possibilities, or are we still determined to stay on the behaviour change/lifeskills curriculum track?

(Ken Longden, Malawi)

Are our curriculum and structures adequate or do we need something radically different? The national monolithic education systems are not working: we must look for alternatives.

(Margaret Ojuando and Gabriel Muita, Kenya)

challenge of HIV/AIDS, we can complement the lifeskills curriculum with other methods, alternative interventions. We must be ready to embrace other alternatives, smaller, local but coordinated and informed interventions that can be nurtured at the grassroots level.

Support and Development

- Make sure a policy framework is in place, and that *monitored and costed plans of action* are complete and ready for implementation – and implement if possible - for
  - > creating partnerships for action among social sector ministries of education, among education ministries and (I)NGOs, CBOs and FBOs, and among schools, communities and district offices, and with clearly identified roles for partners.
  - > strengthening INSET through self-study, peer-group study in school clusters, local peer support groups, peer counselling, using the services of local NGOs, FBOs and CBOs as well as volunteers – whatever works systematically, intensively and extensively.
  - > making teacher educators HIV-competent through similar methods plus provision of (virtual) libraries and resource materials which are easily produced locally.
  - > mainstreaming an HIV-awareness curriculum (core, mandatory, and examinable) in college and faculty of education programmes.
- Improve the *HIV-management skills* of heads, deputy heads, senior teachers, and other district officials for implementing school and community HIV programmes.
- Ensure educators are role models for learners, and that schools are safe places, by applying and adhering to a *strict code of conduct* for all learning institutions.
- Create an *ethical and value-laden environment* in learning institutions with regard to discipline, gender safety, non-toleration of violence, abuse, stigma or discrimination.
- Flood the sector with *teaching and learning materials* to ensure that communities, schools and colleges have access to basic knowledge about HIV and have the chance to become HIV-safe, HIV-aware, and HIV-competent, even when there is no one to teach them
- *Be realistic* about resource and capacity issues by designing interventions that take account of workloads at schools, the need to 'zero budget', the mental and social strains that HIV puts on individual educators and the school as a whole, and the value of peer education.

Health

- Establish anti-AIDS clubs or, preferably, paraprofessional youth peer health educator teams for awareness, prevention, care and support for pupils and students; establish similar peer counselling teams for educators.
- Reinstitute school health programmes, or start them where they have not existed before, and guarantee drugs and qualified personnel through the international community if necessary.
- Work with partners in health and social services to create a circle of care for those infected and affected by HIV/AIDS.
- Work to create safe and hygienic conditions in schools: provide potable water and latrines that are clean, gender-separate, and as safe for girls as for boys.
- Identify and guarantee treatment of sexually transmitted infections (STIs) and other HIV-related infections through health care programmes for learners: send a health worker to the school each term and guarantee drugs as required or refer to nearest clinic or hospital.

Condoms, provided in sufficient numbers, *do* make a substantial impact on levels of infec-

tion and should be distributed freely. School feeding programmes, especially in hot-spot areas, can keep disadvantaged and HIV-affected children in school.

Management

We need to manage better, at national, regional, local and schools level. This is perhaps the greatest problem for educators, most of whom are not trained to manage systems or procedures. Yet this is what is required if programmes that challenge HIV/AIDS are to be created and sustained. That this is true has been demonstrated over and over again during the past two decades in the region.

Typically, the consultation left consideration of planning, management and implementation issues to the end of their meeting, and made only outline recommendations.

Plans tend to be 'classical', which bog us down in planning. We need to move faster in response to the pandemic. What is a 'classical' plan? A plan that is never implemented becomes 'classical'.

(Robert Kamau, Kenya)

Planning

We need to be more realistic about our planning, and the fact that resources – human, financial and material – are thus far inadequate to the task. Planning must take account of how to mobilise resources, and the complex process of allocating them appropriately, where they can best be used for change. Planning is rarely matched with resources or management capacity.

It is one thing to have a plan, but if there is no management bases for taking action on it, then implementation will be cruelly slow. Planning must take into account our management capacity, our resources, as well as our priorities.

Mobilisation and allocation of resources

It is essential to ensure that we are making best use of the limited resources available to governments and their partners in the sector for this work, and to do something concrete. We must coordinate the efforts of all actors in the education sector to do this. New and additional resources must be found, especially for increasing numbers of orphans. They need to be kept in school. The greatest part of the education budget (90%+) is spent already on teacher salaries, and there is little left for creating a massive-scale HIV programme through the schools, which also takes account of the needs of learners who have lost their families and have no socio-economic support.

Research

There has been a lot of research undertaken. But we do not know the results, they are not disseminated, or the knowledge is not made available. We need to base what we do on what we learn and know. That means more monitoring and evaluation, operations research, reflection and critical analysis, and broader dissemination of our experience and research findings.

Priorities for managing better

1. Design and establish a *sector framework for action* on HIV/AIDS.
2. Identify and disseminate *models* for grassroots initiatives; develop a rolling matrix of activities in South Africa that effectively address the impact of HIV on education, and maintain information on baselines, benchmarks, and best practice.
3. Help *coordinate* and guide community-based initiatives.
4. Review staffing establishment requirements and *strengthen capacity*, using contracted

additional staff, technical assistance, volunteers, contracted agencies/service providers.
5. *Improve financial flows* at macro-, meso- and micro-levels.
6. Establish *data gathering, analysis and information dissemination* systems at national, provincial and district levels.
7. Develop multisectoral *collaborative structures* and procedures.
8. Regularly reaffirm *political commitment*.
9. *Map flow of funds* to different functions of the state with regard to HIV/AIDS.

Chapter 3

Conclusion

The consultation started with a reference to fighting Genghis Khan in carts and carthorses. It ended with a perception that the mounted, anarchic and flexible fighting horseman – in modern times the cowboy – is perhaps a far more useful model.

The modern cowboy is customarily armed with a revolver with six bullets. They might be compared to levers that, if properly placed, create power. Out of the mass of information available on HIV and AIDS, on teachers and teacher education, on INSET and PRESET, it is possible to identify the six key levers – our bullets or levers in the war against HIV and AIDS:

1. Creating greater awareness among teachers and teacher educators that they and the teacher training institutes/faculties of education have a seminal role in the challenge to HIV/AIDS.
2. Training HIV-aware, HIV-safe and HIV-competent educators for all learning institutions including training colleges, and infusing their environment with HIV/AIDS-awareness.
3. Seeking to balance the importance of lifeskills programmes against more urgent, quicker practicable interventions that can make a difference in saving lives.
4. Identifying and implementing zero-budget or low cost interventions which remove the big resource barrier to action and allow decisions to be made by any creative educator.
5. Moving ahead with practical action after this long period of thinking, planning and digesting what we know, what we think we know about INSET and PRESET and lifeskills education.
6. Using those bullets, and using them well!

Participants requested future opportunities to work together as professionals, 'outside the conventional box', in the search of practical ways to save lives and keep children in school. Workplace policy, the code of conduct, educator discipline, cultural contexts, and the difference between policy, planning and strategic action were issues of particular concern.

Appendix

I Programme

II Pro Forma: Rapid Appraisal of Action on HIV/AIDS and Education by the Sector

III A Humanitarian Response to HIV/AIDS in Education? Short-Term Interventions to Save Lives and Sustain Quality

IV HIV/AIDS and Education: A Conceptual Framework

V Principal HIV/AIDS and Education Themes

VI Assessment of Educators/Basic HIV/AIDS Competence

Consultation papers and supplementary materials

Appendix I

Programme

Consultation on HIV/AIDS and Teacher Education in East and Southern Africa

Kopanong Conference Centre, Benoni, South Africa, 28–30 October 2003

Convened by InWEnt, Capacity Building International, Germany

Programme outline

Day one

Welcome	Representative, Federal Republic of Germany Representative, InWEnt – Capacity Building International, Germany Representative, Department of Education, South Africa
Introduction of participants	
Reflections on HIV/AIDS and educator development	Professor Wally Morrow
Introduction to the consultation	Carol Coombe
Identification of critical issues	Plenary
What kinds of teachers do we need?	Small groups
Interpretation and synthesis	Dhianaraj Chetty

Day two

Characteristics of good INSET and PRESET	Hartford Mchazime, Gabriel Muita
Examples of acceptable practice	Rose Kumwenda
Improving inservice programmes	Lydia Nzomo
Improving preservice programmes	Cosmas Kamugisha
Management problems	Jane Mulemwa
Interpretation and synthesis	Hartford Mchazime, Ken Longden
Examples of commendable practice	David Mbetse Margaret Ojuando

Day three

The role of teacher colleges and faculties of education in fighting HIV/AIDS	Cosmas Kamugisha Wally Morrow
What services should universities and colleges provide?	Small groups
What can be done to upgrade skills of teacher educators?	Small groups
What can be done to retool PRESET programmes?	Small groups
Interpretation and synthesis	John Rutayisire
What alternatives do we have to lifeskills?	Jane Mulemwa, Catherine Barasa
Summary and conclusions	Wally Morrow
Closure	Ulrike Wiegelmann for InWEnt

Appendix II

Pro forma: Rapid Appraisal of Action on HIV and Education by the Sector (Carol Coombe)

Theme 1: Providing Guidance on HIV/AIDS

Teachers and Learners Is there an understanding that HIV and education is a matter for both educators and learners: that teachers need to know too?	
Appropriate Curriculum in all Schools Are learners being guided through the curriculum on safe sex and appropriate behaviours and attitudes (care for those affected, stigma, trauma)?	
Curriculum Mainstreamed Has lifeskills curriculum, including reproductive and sexual health, care and counselling, been mainstreamed in the core curriculum?	
Materials Developed and Distributed (1) Have materials suitable for learners in primary and secondary schools been developed and distributed to most institutions? Are they up to date?	
Materials Developed and Distributed (2) Have materials that can specifically help teachers and teacher educators been developed and are they available to all educators?	
Serving Teachers Prepared Are educators adequately prepared through preservice and inservice to teach life skills curricula and to keep themselves healthy?	
Teacher Educators Prepared Have university, teacher training colleges and local teacher support staff (inspectors etc) been trained in HIV/AIDS issues and curriculum implementation?	
Evaluation Have materials and courses been evaluated in terms of content, implementation and outcomes?	
Alternative Techniques Are peer educator health teams and/or other direct interventions (school feeding, treatment of STDs inter alia) being used to supplement curriculum?	
Partnerships Are other partners helping with prevention programmes?	

Give one, two or three points for performance (one is low, three is high) or zero if action has not yet been taken on this issue. Make notes to clarify your grading if you wish.

Theme 2: Care and Support for Affected Learners and Educators

Teacher Competencies Is it recognized that basic care and counseling for other educators and for learners affected by HIV/AIDS is a teaching responsibility?	
Safe and Secure Environment Have steps been taken to ensure every learning institution is a safe and secure place, especially for girls?	
Coping with Trauma – Learners Have preparations been made to prepare educators to help children who are in distress – because of poverty, orphaning or HIV-related trauma.	
Coping with Trauma – Educators Have preparations been made to help educators who are HIV+. Have VTC, drug, or coping regimes been set up to help them?	
Stigma and Discrimination Have steps been taken to reduce levels of isolation, stigma and discrimination associated with HIV infection within the education sector?	
Codes of Conduct/Ethics Have educators been given guidance on professional codes of conduct and are cases of abuse, harassment or violence rigorously dealt with?	
Supporting Orphans (1) Does the sector have links with health and social welfare to create a network of support for orphaned children?	
Supporting Orphans (2) Does the sector have a policy on education's responsibility for increasing numbers of orphaned children who may be forced out of the school system?	
Partnerships Are other partners helping with care and support programmes in a systematic and sustainable way?	

Give one, two or three points for performance (one is low, three is high) or zero if action has not yet been taken on this issue. Make notes to clarify your grading if you wish.

Theme 3: Creating a Foundation for Action

Management Base Is there an adequate base for driving HIV and teacher education programmes within the education sector?	
Dual Approach Is equal consideration given to (1) preventing spread of the disease and to (2) reducing the anticipated impact of the pandemic on education?	
Leadership Are political leaders, senior officials, unions, the teaching service, school governing bodies knowledgeable and committed to action?	
Collective Dedication Are partners outside government involved in the fight against HIV/AIDS? Do mechanisms exist for partnerships?	
Research Agenda Is information about HIV/AIDS being collected, analysed, stored and spread? Is there an HIV/AIDS and education research agenda for the education sector?	
Effective Management Has a full-time senior manager been appointed? Does a standing structure exist which includes partners in and out of government?	
Policy and Regulations Are HIV/AIDS sector policies and regulations in place? Are there appropriate codes of conduct for teachers and learners, and are they applied rigorously?	
Strategic Plan Is there an education sector HIV/AIDS strategic plan which covers some or all sub-sectors of the education system, have priorities been identified, and is it funded?	
Resources Are plans being funded adequately? Are funds being channelled to various levels of the system, and to partners outside government who can use them?	

Give one, two or three points for performance (one is low, three is high) or zero if action has not yet been taken on this issue. Make notes to clarify your grading if you wish.

Appendix III

A Humanitarian Response to HIV and AIDS in Education? Short-term Interventions to save Lives and Sustain Quality[8] Carol Coombe

The Inter-Agency Working Group (Unicef, UNDP, UNESCO inter alia) has proposed long-term strategies for improving child well-being and changing behaviours. Taking this development route will require many years before observable differences in behaviour appear. In the interim there are things that can be done by agencies, governments and communities working together with will, competence, and commitment, taking a humanitarian, rather than a development route, to alleviating distress among affected and often impoverished populations.

Limiting Spread by Decreasing Risk

(a) **STDs:** Offer to make it possible for every post-secondary institution, secondary school, upper primary school and school hostel to be visited by a health worker twice each month, to identify and treat young people with STDs, providing the correct medication and assisting with medical advice according to established protocol. Appropriate drugs will be available for distribution to those with STDs through the international community and whatever procedures it takes.

(b) **Condoms:** Offer to provide every post-secondary institution, secondary school and school hostel condoms for learners and educators. They will be provided in sufficient numbers to meet demand, they will be available in places which are easily accessed by students and educators, and information will be available on their use from the health worker who visits the school and from student and staff health volunteers.

(c) **Student health volunteers:** Offer to provide training – or to see that someone does it – for every post-secondary institution, secondary school and school hostel for a voluntary student health team, with support from local health and social workers, along the lines of well-established models from Zambia and Botswana, in the aetiology of HIV, safer sex practices, STD symptoms and treatment, physical care for those who are sick, counselling for those affected, and the use of condoms.

Supporting Vulnerable Learners

(a) **School feeding scheme:** Offer to provide every secondary and primary school which is vulnerable or at high risk with a feeding scheme for all learners, irrespective of their individual socio-economic condition. In

8 This paper is written within the context of education sector planning and action.

some cases a feeding scheme which covers all schools can be justified. Special provision must be made in school hostels to upgrade nutritional levels. School feeding schemes will be linked to **homebased care**, and **orphan supplementation schemes** as much as possible.

(b) **Potable water:** Offer to ensure that every school has a supply of potable water: a borehole, well or piped water.

(c) **Latrines:** Offer to ensure that every school has sufficient and well-maintained latrines, separate for boys and girls.

Water and latrines are basics, and should have been guaranteed by governments years ago. They have not. Their presence will create an orderly and hygienic environment in which nutrition is guaranteed, and health messages can prevail. School becomes a normal place for children who would otherwise drop out of school.

Managing the Impact of HIV on the Sector

(a) **Executive management team:** Offer to provide high profile, full-time, senior executives to support the ministry of education, to drive the education sector's HIV campaign.

(b) **Volunteers and technical assistance:** Offer to provide contract and volunteer staff (national or international) as required. Technical assistance will be required from both the global and national pools of expertise.

(c) **Impact assessment:** Offer to get the impact assessment underway, and to provide staff to set up TORs, supervise it, analyse it, and see that it is factored into planning and action.

We must be thinking of hiring on managers from the private sector, from the military, from international bodies, and from other countries. There are not enough people with the right skills in government, and they have to be commandeered from wherever, on contract. It is time to offer to do this as a matter of urgency.

Notes

Management issues lie at the heart of whether we can make a difference or not to limit the progress of this pandemic, and stabilise our already derelict education systems. We have some idea of what needs to be done over the long term, BUT how will long-term development-oriented behaviour change be made to happen? If little of real merit has not happened yet, there are perhaps reasons for this – that is, a lack of capacity to make things happen.

It will take at least 30-50 years to get the ideal framework (like that proposed by the Inter-Agency Working Group on AIDS) into place so that lives can be saved. Development plans aimed at behaviour change are good in theory and concept, but cannot, for many reasons which can be elaborated, work in order to meet the immediate crisis.

So what will work?

Education System Resources: First of all, what educational resources do we have? I think that the only resource many *schools* can offer at the moment is that they host large numbers of children and young people in various places for several hours every day. This means that messages and help can reach them there. I don't think that schools can offer much more - if we are brutally frank.

I think that there are some wonderful *teachers* and principals around, but there are not enough of them, and those there are cannot be relied on systematically because they are either redeployed or overloaded. Teachers are not going to make good *mediators* in part because, like parents and other adults, they are culture-bound not to talk about death or sex with children. They don't talk to children about these matters; children don't talk to them. So will they really carry the message of safe sex and behaviour change to children in their charge?

We don't have *books and teaching materials* distributed to schools. NGOs and FBOs have developed materials but they are used locally rather than nationally.

Our *universities and colleges* are not even starting to think about training teachers of the kind we need, or in the numbers we will require. They are not working on curriculum for sexuality education or HIV planning; they are not setting a research agenda on HIV; and they are not doing research in support of government or even their own institutions. Turning these institutions around is going to take decades unless there is a miracle: I know because I am trying to get one to turn.

These are the facts, and they will not be changed because we wish they would, much as we might wish things to be otherwise.

Other Resources: What we do have is (1) governments getting more worried because they are starting to think they should do something; (2) international agencies hoping that something will happen, and starting - not fast - to find ways to make funds flow; (3) communities of mothers, social workers, officials, and teachers, homebased care volunteers, ordinary people who are seeing people dying, who are losing people in their own families, and who are caring for orphans, and (4) NGOs, CBOs, and FBOs, mothers and young people's groups developing (often ad hoc and underfunded) programmes of merit.

So I thought about Helen Schneider's principle of simplicity and viability (from Marais: To *the Edge*, University of Pretoria, 2000).

'Perhaps the most successful aspect of the [South African] National AIDS Programme has been to improve the quality of STD care and increase the public's access to that care. In fact, it appears to have been a classic example of „getting the small things right". Ensuring good STD care is simpler than organising peer education or doing outreach with marginalised groupings, and points to the kinds of prevention tasks that are within the capacity of the system to implement...If simple tasks are successfully managed, they will contribute to building an environment which will make more challenging interventions through government possible at a later stage.'

Principle 1: To me this means keep it simple, stick to things that we know can work. STD prevention is demonstrated to cut incidence of HIV infection drastically (Brundtland Commission report, December 2001).

Principle 2: We must look to cooperative community processes that harness the compassion of a lot of people, including young people, PLWAs, churches, NGOs and development agencies and ensure that they participate in one way or another without big administrative hassles and new mechanisms. I have seen this at work, and I know it is possible.

Principle 3: These proposals must be applied universally, in every school, and they must be mandatory. It will be up to parents, teachers, elders or other adults to make final decisions about condoms, for example – and they will be accountable for the outcome.

Principle 4: They will be applied collaboratively, with cooperation from MOH, NGOs, FBOs and agencies, etc, because that is the only way they can work in practice.

Principle 5: There can be no application of the affordability and sustainability criteria for development agency assistance in these areas, because they have no place in these circumstances of life and death.

Principle 6: We must be thinking of hiring on managers from the private sector, from the military, from international bodies, and from other countries. Affected governments can no longer excuse themselves by saying they do not have established public service posts for HIV staff. TAs, volunteers etc, have to be assigned to contract posts. Many African governments don't have, will not have, or have already lost, enough people with the right skills to make things happen.

Principle 7: Many education management systems are in such difficulty that there is no way they can sustain an HIV programme on top of the responsibilities with which they are already struggling. I am talking black and white here - no more pretending. *Plagues and Peoples* (McNeil, 1979) demonstrates that where plagues have struck in the past, it was often strong (sometimes military) administration that tackled a disease among soldiers and civilian populations. We don't require military administration, but it does say to me that we need absolutely rigorous management appropriate to the level of infection. The historical messages are clear: this is not the first time that humankind has been hit by a plague. (See also Barbara Tuchman *A Distant Mirror*, on the 14th century plagues.)

Principle 8: I keep thinking that South Africa's apartheid regime was overthrown by a coalition of people and the international community. And I wonder if, where governments are unable, unwilling or too corrupt to act swiftly to save lives (passive genocide?), this 'parallel government' model for action can be mobilised once again to overthrow the evil that is HIV and AIDS?

Appendix IV

HIV and Education: A conceptual Framework Carol Coombe (2003)

This is a Crisis. Increasing numbers of countries, especially in Sub-Saharan Africa and the Caribbean, are facing one of the great crises of human history. Other countries in Eastern Europe and the Asia and Pacific regions will confront similar challenges as the pandemic spreads. Despite the difference in the nature of HIV and AIDS pandemics in the Americas and Europe, Africa, and Asia and the Pacific, it should be possible to extrapolate common ideas about what works and what doesn't in the fight against AIDS.

HIV/AIDS the Virus and HIV/AIDS the Pandemic. The *virus* known as HIV/AIDS has been around since the late 1970s. Responses to it have been largely biomedical, focused on preventing the spread of the disease. Rising prevalence rates worldwide indicate that strategies to contain the virus have not been effective. As HIV/AIDS spreads, individuals, families, communities and nations have to learn to live with the disease. But HIV/AIDS is no longer just a disease. It is now a *pandemic*, an entirely different though clearly linked phenomenon that needs understanding in far broader geographical, demographic, environmental, economic and social terms. The full complexity of this phenomenon is not yet understood. Governments and communities are only starting to define its social, economic and cultural characteristics. The fight against 'HIV/AIDS the virus' will continue while the battle with 'HIV/AIDS the pandemic' is joined.

The Education Sector. As the pandemic snowballs, health-driven national strategies are being replaced by multisectoral strategies in which ministries of education are now taking responsibility for identifying and driving education's response to HIV, as in Botswana, Namibia, Rwanda and South Africa, for example. Ministries of education alone do not have the capacity to respond to the challenges HIV/AIDS poses for education. It is clear they can only achieve their strategic goals in partnership with others. The capacities of partners within the education sector as a whole need to be strengthened, and policy and regulatory frameworks established for effective collaboration.

The Role of the Education Sector in Fighting AIDS. HIV/AIDS is raising four principal questions for the education sector for which answers are only starting to emerge:

1. What is the role of the education sector in preventing the spread of HIV/AIDS among young people?
2. How can the sector ensure that all young people, especially orphans and other vulnerable children, achieve their full potential?
3. How can the sector, which is the biggest employer in most countries, protect the viability of the education service, and therefore the quality of education provision?
4. How can the education sector continue to improve access to and quality of education services in the face of HIV/AIDS?

General agreement has emerged over the past three years (USAID, 2001; Coombe and Kelly, 2001; Inter-Agency Working Group, 2001, for example) that there are three principal areas of concern for sector partners:

1. **Prevention:** helping prevent the spread of AIDS

2. **Social Support:** working with others to provide a modicum of care and support for learners and educators affected by HIV/AIDS, and
3. **Sustaining Education Quality and Provision:** protecting the education sector's capacity to provide adequate levels of quality education – by stabilising the sector, and responding to new learning needs.

In addition, an effective response will require *capacity in the sector to manage* this crisis.

Clearly the education sector cannot be responsible for 'solving' the immense challenges raised by this pandemic. The sector can, in a very focused way, define exactly what educators can and should be responsible for doing in support of the nation's fight against HIV/AIDS, and then take effective action on defined short- medium- and long-term strategic priorities.

What do we mean by 'HIV and Education'?

Education can no longer be 'business as usual'. Our understanding of curriculum development will never be the same again. Our educational support services can no longer focus narrowly on children with special learning needs while ignoring those of vast numbers of orphaned, abused and suffering children affected by HIV and AIDS. The lack of school-based support systems will now cost lives, rather than merely perpetuating inadequate teaching and learning. Our managers cannot rely on the models of the past to drive education into the future.

The paradigm of education is shifting, and we must change our concepts and planning principles, or watch the achievements registered by EFA being steadily undone. We must move from a narrow 'HIV education' curriculum campaign towards a broader 'HIV and education' paradigm.

What does 'HIV and education' mean? The pandemic-as-phenomenon is vastly complex, and individual educators, researchers, policy makers and analysts, planners and funders each confront this plague from a different perspective.

A broad multidisciplinary approach by educators to the pandemic is essential. The following 'HIV and education' construct is a work in progress. It attempts to set out particularly significant issues for education practitioners and researchers coming to it from different perspectives. There are clearly more facets to be added.

General issues: Learning to contend with the pandemic's impact on the education sector; identifying (1) the nature and extent of education's responsibility for fighting HIV/AIDS and caring for those affected; (2) at what point educators should transfer responsibility for learners in difficulty to social services; and (3) the extent to which schools and other educational institutions are (or should be) part of communities' response to the pandemic.

Education and training subsectors: In higher education (for example), protecting learners and staff as well as the institution itself; understanding within the university community how the pandemic will affect national and community life, and revising taught curricula in all faculties appropriately; creating a knowledge bank about the pandemic capable of serving national development and security; training for predicted labour shortages starting with teachers, health workers, and social welfare staff; undertaking research in priority areas, on orphanhood and thanatology for example, on the psycho-social roots of the pandemic, on economic impact.

Management, policy and planning issues: Understanding and predicting the pandemic's implications for management and development within the education sector; managing the pandemic in a way that protects learners, educators and institutions; developing appropriate policies and strategic plans, and implementing them; systematically collecting and disseminating information and data as a basis for informed decision-making; establishing partnerships for action; mobilising and allocating resources effectively within the sector.

Pedagogical issues: Mainstreaming lifeskills curricula in all learning institutions, and developing and evaluating appropriate materials; improving educator knowledge and skills; providing appropriate support to educators; evaluating content, implementation and outcomes of lifeskills curriculum; developing teacher competencies in care and counselling.

Psycho-social and care issues: Learning to be more sensitive to learner wellbeing, including children of trauma – those who are abused, harassed or victims of incest, who are vulnerable and at-risk, who are orphaned, who are heading households, or are caregivers; understanding adolescent sexuality, customary and imported behaviours, homosexuality and bisexuality and HIV/AIDS-related sexual behaviour; understanding 'orphanhood' and responding to it; learning from our past experience with school hostels, institutional care, and home-based care; analysing and planning for home-based care and school feeding schemes; defining the school's links with the community's response to the pandemic.

Educator development and support issues: Establishing HIV workplace policies in all learning institutions; supporting educators infected or affected by HIV; creating and applying appropriate codes of conduct; understanding the limitations of teachers as mentors, caregivers and guides and supplementing their efforts from social and health sector resources; reconstituting a culture of care and respect in learning institutions.

Gender concerns: Keeping issues related to the girl-child at risk at centre stage; recognising schools as unsafe places for girls and taking action; closely linking gender and HIV programmes for maximum efficiency; continuing advocacy, research and action on violence, abuse and rape in learning institutions.

Values, and moral and ethical issues. Understanding how values and customary and religious beliefs can either profoundly inhibit our understanding of this pandemic, or empower educators and learners to challenge the pandemic.

HIV and international agreements, legislation and application of the law, regulations, codes and human rights issues: Reviewing existing international and national conventions, education legislation and policy; establishing an appropriate legislative and regulatory framework; analysing issues of testing; identifying and protecting the rights and responsibilities of teachers; dealing rigorously with harassment and abuse, stigmatisation and discrimination in learning institutions; establishing codes of conduct and applying them.

Training, manpower and economic implications of HIV: Understanding the ramifications of HIV/AIDS for the teaching service including teacher attrition, replacement and deployment; identifying new teacher competencies required to cope with complex cohorts of learners; enabling training institutions to produce appropriately qualified teachers; helping to mitigate HIV's consequences for economic growth through education and training.

This broader concept of HIV and education means in practice that each educator is responsible in his or her own domain to make sense of what is happening, and to react appropriately. We are moving into unknown territory here, for few of the right questions and answers have as yet been tabled.

Appendix V

Principal HIV/AIDS and Education Themes (Carol Coombe, November 2003)

Principal objective: to determine how the education sector should be responding to the challenges of the HIV/AIDS pandemic.

Concerns lie principally within

- **four substantive areas:** prevention, social support, education quality, and strategic management
- **various cross-cutting issues:** gender, violence and abuse, ethics and values, teaching service management, and strategic cooperation, and
- **all education subsectors from early childhood development to higher education:** HIV/AIDS is not a schools issue but a matter for all sites of learning, all educators – teachers and officials – and all learners.

Principal Themes

Discussions will focus on the four principal responsibilities of the education sector:

1. **Preventing infection:** containing the spread of HIV through lifeskills curricula, peer health educator teams, and other activities.
2. **Providing social support:** mitigating the impact of HIV and AIDS on educators and learners, and providing multisectoral support for orphans.
3. **Protecting education quality:** stabilising the system – the teaching service and teacher education – and responding to new and more complex learning needs.
4. **Managing the response to HIV/AIDS:** creating capacity to respond to the pandemic effectively.

Theme 1: Preventing Infection
The principal need: an intensive and extensive programme which limits the spread of HIV among young people.

1. What should the education sector be doing to limit the spread of AIDS? Is it possible to limit and define what it should do, and what it is able to do effectively?
2. What are the principal responsibilities of schools, universities and other learning institutions within the sector for saving lives of learners and educators?
3. What about young people who are out of school, for whatever reason? Who is responsible for their wellbeing with regard to

HIV/AIDS? What role should the education sector play? Is this a nonformal education issue, or a lifelong learning issue? Who is responsible?

4. How effective are current lifeskills programmes in terms of content, delivery, and the way they change adolescent – and educator – behaviour? Do educators understand the psychological, sociological and cultural complexities of behaviour change? Are they reflected in lifeskills programmes?
5. To what extent are schools and other learning institutions promoting safer sex messages
   - through the learning environment and a policy of zero tolerance for discrimination harassment, abuse or violence
   - by ensuring staff provide models of appropriate behaviour
   - by mainstreaming AIDS in curricula
   - by creating institutional plans for limiting HIV/AIDS' impact on learners and educators
   - by developing peer education programmes
   - by providing counselling and mentoring support
   - by promoting the principles of respect, tolerance and protecting basic human rights?
6. Are behaviour-change programmes the best way to save lives? What is the potential for saving lives in very direct and immediate ways by
   - treating sexually transmitted infections among learner populations on a regular basis, and combining treatment with counselling and testing where requested
   - guaranteeing a supply of contraceptives to all learners and educators
   - improving health and nutrition of learners, and promoting health messages, by providing school meals, clean water at each learning site and improving sanitation in all schools
   - keeping learners in school by providing a meal for every learner of school-going age?
7. What do parents and community leaders need to know about how they can support and complement the work of learning institutions and educators? What adult education programmes are there about HIV and AIDS that make homes and streets, as well as learning institutions, safe places for children and young people?
8. What skills and knowledge do educators need to have in order to keep learners in their care safe? Can all educators deliver safer sex messages? Should they be expected to? What responsibility do young people themselves have within the learning environment for teaching and helping other learners who are at risk or affected by HIV/AIDS?
9. How are teacher educators responding to the pandemic? Are they knowledgeable? Are preservice and inservice curricula reflecting HIV/AIDS concerns? Are universities creating a body of knowledge about what kind of teachers will be needed by the end of the decade when there are over 2 million orphans in the system?
10. What are other government departments and nongovernmental organisations doing to assist educators and learners to prevent the spread of AIDS? Is there coherence in what is being done by cooperating stakeholders?

Theme 2A: Social Support for Affected Learners and Educators

The principal need: to provide a safe and secure environment for all learners and educators, especially those affected by HIV and AIDS.

1. Is every learning institution a safe and secure environment? If not why not? What needs to be done to ensure that all learning

institutions are places of safety for children and young people and their teachers, that there is zero tolerance for violence and abuse, and that educators are guardians of learners' safety?

2. What are the principal behavioural, values and human rights issues highlighted by the pandemic? What is the role of educators with regard to gender abuse, violence, and lack of security for children? How can they be assisted to play their part in creating a culture of care in all learning institutions?
3. How are educators responding to the emotional and complex learning needs of children and young people affected by HIV and AIDS? What do educators understand about the ways in which young people and children cope with grief and trauma?
4. What techniques can educators use to decrease levels of stigma and discrimination in learning environments? Do they know the law and policy on stigma and education? How can they be helped to know what role they should play?
5. How can educators provide basic support for learners at risk of infection by HIV/AIDS? How can they empower survivors of family loss and discrimination due to HIV/AIDS?
6. How can the education sector integrate its response to the needs of learners and educators with the programmes of other agencies in and out of government to create a circle of care for those affected and at risk?
7. Learners work and play at school, on the street and at home? What role do educators play in keeping them safe when they are out of school?
8. What is the role of the school within the community, in helping parents and other adults to understand and cope with the impacts of HIV/AIDS, and to protect their children?
9. What is the role of parents, government departments, CBOs, NGOs, FBOs and other agencies in creating a culture of care, and providing support for those affected by AIDS in all learning institutions? Is there a way of formalising their participation as part of a circle of support?

Theme 2B: Responsibilities for Orphans and Vulnerable Children

The principal need: to create a caring and supportive environment for children who are orphaned or otherwise affected by HIV and AIDS.

1. What responsibilities do educators have for identifying orphans and children at risk of HIV infection, ensuring access to education for children affected and infected by HIV, and providing alternative learning opportunities for those whose education has become more random?
2. How is the sector planning to respond to the emotional, material and physical needs of two million children likely to be orphaned by AIDS, and those who are already otherwise disadvantaged by the pandemic either directly or indirectly? What responsibilities do educators have?
3. What support can educators give to children, young people, and other educators in need, and how can they be supported in providing such support?
4. What provision will likely be required in terms of homebased care, income support, orphan registration and subsidies, school feeding, counselling and mentoring for learners and educators?
5. What potential does school-based support and management have for improving care for children in need, and reconstituting a culture of care in all learning environments?
6. What practical action needs to be taken to make all learning institutions caring institutions?

Theme 3: Educators Supply, Demand and Quality

The principal need: to protect the viability and quality of the education service.

Three principal areas:

1. education supply and demand
2. educator quality, upgrading, preservice and inservice programmes
3. management of the education service

(1) Education Demand, Supply and Quality

Demand

1. What do we know about how HIV/AIDS is likely to affect the demand for education in terms of
   - the size of learner populations
   - growth rates of learner populations in schools and tertiary subsectors
   - more complex learning needs among orphaned and other vulnerable children
   - traumatized, vulnerable or stressed children?
2. Have Education for All (EFA) or UPE targets been reviewed in the light of the impact of HIV/AIDS on the sector? What are the demand, supply and financial implications of the pandemic for achieving EFA/UPE goals? Restated: Have Education for All (EFA) and UPE targets been reviewed in the light of the impact of HIV/AIDS on the sector? What are the resource (human, financial and other) implications of the pandemic for achieving these goals?

Supply

3. What do we know about changing supply of education services in terms of
   - educator morbidity and mortality
   - HIV's influence on educator performance, absenteeism, morale
   - costs of provision
   - other effects of the epidemic?
4. How can future educator requirements be satisfied in the light of shortages anticipated as a result of the impact of HIV/AIDS?

Quality

5. How will the pandemic affect the capacity of the sector to continue to provide education of appropriate quality? How can the viability of the teaching service be secured given
   - rising rates of absenteeism for funerals, illness etc
   - lower productivity of educators who continue to work while ill
   - disruption of instructional time and work schedules
   - lack of provision for cover or medical boarding for educators who are ill
   - failure to provide alternative learning opportunities for learners forced out of education because they are affected or infected
   - possibilities of increasing shortages of educators in certain areas (maths, science) and older, more experienced staff including managers
   - trauma, lack of morale, and stress?
6. What alternatives to formal learning exist for those who are forced out of the formal system by economic, health or social circumstances?

(2) Management of the Education Service

1. What specific provisions need to be made for the management of the education service affected by HIV/AIDS to make sure that teachers are teaching and learners are learning, in terms of
   - deployment and cover for absenteeism
   - training, recruitment and retention, attrition and deployment
   - medical boarding
   - testing and counselling

- retirement benefits
- provision of antiretroviral drugs
- workplace policies
- regulations and codes of conduct.

2. What can be learned from private business sector's response in protecting their investment in human capital in order to keep productivity and profits high, and sustain the viability of the company?
3. Who is accountable for sustaining the quality of education provision under the onslaught of HIV/AIDS?

Theme 3B: Educator Upgrading

What kind of educators are needed who can respond to the greater demands of learners and other educators affected by HIV/AIDS?

1. How are universities and colleges responding to the challenges of HIV/AIDS in terms of their teacher training and educational research programmes?
2. How can teacher inservice and preservice programmes be improved, adjusted and enlarged to keep numbers of qualified teachers up, particularly in view of EFA/UPE targets?
3. What needs to be done in practice to provide a sustainable, coherent and viable national inservice programme for educators including elements of HIV, sexuality, lifeskills as well as counselling and mentoring?
4. What needs to be done to support universities and colleges in re-tooling their preservice programmes to incorporate HIV/AIDS concerns?
5. How can an HIV and education research agenda be designed and carried out which speaks specifically to the concerns of educator training?
6. Who is accountable for sustaining the quality of education provision under the onslaught of HIV/AIDS?

Theme 4: Managing the Response to HIV/AIDS

The principal need: to create and sustain management capacity to respond to the threat of HIV/AIDS appropriately.

1. What provision have departments of education made for creating a foundation for action on HIV/AIDS in terms of

    - informed leadership at national, provincial, district and institutional levels
    - effective partnerships among education and training sector stakeholders
    - information collection and analysis as a basis for planning
    - management capacity to harness resources and take action
    - policy, coherent planning for action, and priorities for action
    - allocation of resources where they can be used to best effect and
    - evaluation and monitoring techniques to measure real progress.

2. What potential exists within the sector for creating collaborative management capacity appropriate to the task?

Cross-cutting Concerns

- Human and legal rights, international conventions and the constitution
- Gender, violence, abuse and harassment; social and cultural values
- Management of the workplace – all learning institutions and other education sites
- Collaborative structures and procedures

Education Subsectors

- Early childhood development
- Primary school
- Secondary school
- Post-school education and training
- Educator development and support
- Education management development
- Special needs
- Private sector training
- Alternative learning opportunities
- Hostel and institutional accommodation
- School health services
- Guidance and counselling
- Lifelong learning

Appendix VI

Assessment of Educators' Basic HIV/AIDS Competence (Eastern and Southern Africa, October 2003) [9]

	1 Basic	2	3	4	5 High
Acknowledgement and Recognition	We know the basic facts about HIV/AIDS, how it spreads and its effects	We recognise that HIV/AIDS is more than a health problem alone	**We recognise that HIV/AIDS is affecting us as a group/ community and we discuss it amongst ourselves. Some of us get tested.**	**We acknowledge openly our concerns and challenges of HIV/AIDS. We seek others for mutual support and learning**	We go for testing consciously. We recognise our own strength to deal with the challenges and anticipate a better future.
Inclusivity	We don't involve those affected by the problem.	**We co-operate with some people who are useful to resolve common issues.**	We in our separate groups meet to resolve common issues (e.g. PLWA, youth, women).	Separate groups share common goals and define each member's contribution.	Because we work together on HIV/ AIDS we can address and resolve other challenges facing us.
Care and Prevention	We relay externally provided messages about care and prevention.	**We look after those unable to care for themselves (sick, orphans, elderly). We discuss the need to change behaviours.**	We take action because we need to and we have a process to care for others long term.	As a community we initiate care and prevention activities, and work in partnership with external services.	Through care we see changes in behaviour which improve the quality of life for all.
Access to Treatment	Other than existing medicines, treatment is not available to us.	**Some of us get access to treatment.**	**We can get treatment for infections but not ARVs.**	We know how and where to access ARVs.	ARV drugs are available to all who need them, are successful procured and effectively used.
Identify and Address Own Vulnerability	**We are aware of the general factors of vulnerability and the risks affecting us.**	We have identified our areas of vulnerability and risk. (e.g. using mapping as a tool).	We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach.	We implement our approach using accessible resources and capacities.	We are addressing vulnerability in other aspects of the life of our group.

9 Participants were asked to rate (individually) how HIV/AIDS-competent educators are in their country. The first column is the lowest or basic competence, while column five represents the highest score, the one which educators might strive to achieve. Boxes in bold represent most common responses.

	1 Basic	2	3	4	5 High
Learning and Transfer	We learn from our actions.	We share learning from our successes but not our mistakes. We adopt good practice from outside.	**We are willing to try out and adapt what works elsewhere. We share willingly with those who ask.**	We learn, share and apply what we learn regularly, and seek people with relevant experience to help us.	We continuously learn how we can respond better to HIV/AIDS and share it with those we think will benefit.
Measuring Change	**We are changing because we believe it is the right thing to do but do not measure impact.**	We begin consciously to self-measure.	We occasionally measure our own group's change and set targets for improvement.	We measure our change continuously and can demonstrate measurable improvement.	We invite others' ideas about how to measure change and share learning and results.
Adapting Our Responses	We see no need to adapt, because we are doing something useful.	We are changing our response as a result of external influences and groups.	**We are aware of the change around us and we take the decision to adapt because we need to.**	**We recognise that we continually need to adapt.**	We see implications for the future and adapt to meet them.
Ways of Working	We wait for others to tell us what to do and provide the resources to do so.	We work as individuals, attempting to control the situation, even when we feel helpless.	**We work as teams to solve problems as we recognise them. If someone needs help we share what we can.**	We find our own solutions and access help from others where we can.	We believe in our own and others capacity to succeed. We share ways of working that help others succeed.
Mobilising Resources	**We know what we want to achieve but don't have the means to do it.**	We can demonstrate some progress by our own resources.	**We have prepared project proposals and identified sources of support.**	We access resources to address the problems of our community, because others want to support us.	**We use our own resources, access other resources to achieve more and have planned for the future.**

Complementary consultation papers

> Coombe, C (2003). HIV and AIDS in Context: The Needs of Learners and Educators. Pretoria.
> InWEnt (2003). HIV/AIDS and Teacher Education: Synopsis of Observations and Principal Conclusions. Bonn: InWEnt
> Kelly, MJ (2003). Preventing HIV/AIDS Transmission Through Education. Perspectives in Education, Vol 20, No 2, July 2002. Pretoria: University of Pretoria Faculty of Education.

Supplementary materials

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The conference members from Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda and Germany.

The author

Carol Coombe has worked in Africa since arriving in Zambia as a Canadian volunteer in 1968. From 1985-1994 she was based at the Commonwealth Secretariat in London, latterly as Chief Programme Officer (Education Management), and first Convenor of UNESCO's Working Group on the Teaching Profession, part of the Association for the Development of Education in Africa (ADEA). Based in South Africa since 1994, she has worked as an independent education advisor, primarily on educator development and support, capacity building, international cooperation, and education management issues. As education planning and management are increasingly compromised by HIV/AIDS in the SADC region, she refocussed more specifically on HIV and education. Carol has completed a two-year appointment as Research Associate: HIV and Education at the University of Pretoria Faculty of Education, and as a member of the Southern African Mobile Task Team on HIV and Education. Since 2003 she has continued to research, write and speak about the impact of HIV on education globally as an independent adviser.

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