REPORT ON VISIT TO SOUTHEAST ASIA REGION
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ADDITIONAL DOCUMENTS

South-East Asia Reports (Carol Coombe)

(1) REPORT ON A VISIT TO CAMBODIA 28-30 MARCH 2002
(2) REPORT ON A VISIT TO MYANMAR (1) MANAGEMENT 3-9 APRIL 2002
(3) REPORT ON A VISIT TO MYANMAR (2) HIV AND SOCIAL SECTOR RESPONSE 3-9 APRIL 2002
(4) SPEAKING NOTES UNICEF VIET NAM 15 APRIL 2002

Support Documents (Various)

(5) UNICEF DRAFT PROGRAMME PLANNING PRINCIPLES FOR ORPHANS AND OTHER VULNERABLE CHILDREN (DECEMBER 2001)
(6) COOMBE *MITIGATING THE IMPACT OF HIV/AIDS ON EDUCATION SUPPLY, DEMAND AND QUALITY: A GLOBAL REVIEW* FOR UNICEF FLORENCE, INNOCENTI RESEARCH INSTITUTE (JANUARY 2002)
(7) COOMBE AND KELLY *EDUCATION AS A VEHICLE FOR COMBATING HIV/AIDS* FOR UNESCO PROSPECTS, SEPTEMBER 2001.
(9) SMART *RAPID APPRAISAL OF CHILDREN INFECTED WITH AND AFFECTED BY HIV/AIDS* FOR SAVE THE CHILDREN UK (SOUTH AFRICA)
(10) SOUTH AFRICA DEPARTMENT OF EDUCATION *HIV EMERGENCY GUIDELINES FOR EDUCATORS.*

TERMS OF REFERENCE

The mission was carried out principally to consider how to establish MTSP policy, programme, and advocacy targets relating to HIV and education, with particular reference to education systems, educators and teacher educators, and learners – particularly those affected by HIV/Aids. Current MTSP targets emphasise

For children
- expanding care and support for children and families living with HIV/Aids
- expanding care, protection and support for children who are at risk and vulnerable to HIV infection
- expanding access by young people to HIV/Aids-related information and services

For Unicef
- completing assessment of the HIV/Aids situation in each country, its potential impact on children and young people
- developing country programme strategies to respond appropriately
- supporting development of national policies and prioritised strategies to guarantee protection and care for children in distress, reduce the vulnerability of young girls

- supporting implementation of national plans.

The short-term goal of the mission was

- to stimulate country office responses (principally in Cambodia, Myanmar and Viet Nam) to achieve these HIV-related targets
- to share Africa's experience in coping with a pandemic which is now out of control in many countries, and learning from the South-East Asian experience and
- to identify and prioritise feasible options for meeting the needs of orphans and HIV/Aids-affected children and their families.

The following questions focused the interviews and presentations of the mission:

- How effectively are Unicef country offices currently helping to contain the spread of AIDS and mitigate the impact of country epidemics (current and anticipated) on systems and individuals?
- What might be the role of education systems, individual schools and educators, in mitigating the impact of HIV/Aids on children who are orphaned, HIV-infected, or otherwise affected by the pandemic? (An assumption is made here that it is not strategically advisable to separate out children who are AIDS-affected, and children who are otherwise in distress.) What about adolescents and children and young people who are not in school?
- What HIV-directed activities might be best suited to South-East Asian conditions and sero-prevalence levels? How can current low levels of prevalence be kept low? Are special strategies required for this?
- What are some of the managerial and logistical problems which inhibit the agency's current response to the pandemic?

Unfortunately, it was not possible to discuss education issues at length during the mission: Unicef education personnel were either not in post or away; only in Cambodia was a senior official available to discuss policy although a good practical discussion of lifeskills was held with departmental officials in Myanmar; and no visits were scheduled to schools, colleges, universities, or daycare centres; no appointments were made to discuss HIV/Aids matters with young people in or out of school. This can be rectified in future, when education-focused strategic support is required. What follows are generic propositions for South-East Asia, based on experience of so-called best practice in the sub-Saharan Africa region.

It is difficult to comment generally on so large and complex a region. Country papers have been prepared for Myanmar (two) and Cambodia (one). Unfortunately it was not possible to prepare a report for Viet Nam as the visit was truncated because of visa problems. This paper relies heavily on the draft proposals made in the two Myanmar reports.

GENERAL OBSERVATIONS

Balancing the response: Some countries have tried to take a vertical, top-down, government-directed approach to fighting HIV/Aids. Experience has suggested that over twenty years this approach has not worked well in Africa, while it seems to have worked reasonably well – up to now at least – in Thailand and Cambodia. Globally, many agencies and governments are moving towards a community-based approach, although it is not clear just how local programmes can be managed, funded, evaluated and sustained. In Myanmar, agency and grassroots interventions have proved effective, in a situation where government has delayed its response. In Viet Nam on the other hand, mass action campaigns and civil action seem to have significantly delayed the onset of higher rates of prevalence. (This observation is based on intuition and discussion, rather than on any rigorous data or systematic investigation.) *It would seem that a balanced approach which combines systematic mass action driven from national and provincial government and*

parastatal offices, combined with sustained community care and support programmes, can make a difference in low prevalence countries. Both are necessary if prevalence is to stay low.

Keeping low prevalence countries low: There is some indication that Thailand is experiencing a resurgence of higher prevalence rates, perhaps because it has had to cut HIV/Aids budgets, has not kept up the pressure, or for any one of a variety of other reasons which government appears reluctant to discuss. High prevalence countries are fighting not just the disease but the epidemic. Low prevalence countries may become complacent, failing to keep up pressure on the disease, and not anticipating the impacts of a potential epidemic. *It is clear that there may be special strategies required to keep prevalence in a low prevalence country low, which differ from strategies appropriate for high prevalence countries, and those countries in which HIV/Aids has not yet taken hold.(See Appendix 2)*

Finding leverage points: At the moment, Unicef responses to HIV/Aids – and related child protection concerns – in the region seem fragmented, unfocussed, not particularly hardy, and rather fragile for such a large problem. Despite the fact that prevalence rates in the region's countries are relatively low, the potential for disaster is high among such large and youthful populations. The lack of focused and prioritised strategies is particularly noticeable in education sector programmes, although one must argue that HIV/Aids is not a single-sector matter: like gender it is a cross-cutting concern which must engage all Unicef sections. Street children's programmes for 300 kids, or condom cafes for 200 kids may have local usefulness, and save some lives, but Unicef should expect to achieve much more. *Interventions by Unicef country offices need to be focused not just on supporting local community activities, but on creating an environment in which large-scale safety nets can be secured – through information, policy formation, direct action, and education. Unicef is known for working the levers – as it did in its girlchild programmes. At a time when the girlchild should be at the front in a big way because of the vulnerability of this group to HIV/Aids infection, this concern is barely visible in current programming. Of similar concern is the fact that the region has not identified the critical leverage points that can influence change, and where it will concentrate its resources – managerial, technical, professional, financial and time – for fighting HIV/Aids.*

Time-awareness and funding. The characteristics of the HIV/Aids pandemic require that commitment to funding be made for not less than 10-15 years at a minimum. In several cases, projects were seen which had lost funding after one year (CARE International HIV Project Mandalay with AusAID; Condom Café Ho Chi Minh City with Medecins du Monde) or two years (Condom Café HIV VTC centre with San Francisco funders), and this problem was confirmed by SFC UK in Yangon. Agreeing to accept funding for a short period of time, or offering funding for such a period condemns people to death or extreme hardship, and is no longer acceptable development practice as far as HIV/Aids is concerned. *Great care must be taken to ensure that HIV/Aids is fought hard over time, with funding commitments guaranteed. Those funders that cannot commit for at least five years should not be entertained because the consequences are too dire.*

Programmes not projects: Long-term commitment makes it possible to move from a relatively limited one off, ad hoc or pilot project approach (although it is true that projects as part of programmes may be useful and viable). Training 'workshops' and 'projects' should only figure as part of a coherent programmed strategic response which can tackle a big problem on a large scale. and should be complemented by other activities including materials development and dissemination, discussion fora, policy development and related action. *This does not of course mean that Unicef should not fund local community projects, but it will need to do so by using carefully selected criteria, and evaluation procedures, looking for sustainability over the long-term, with funding if necessary.*

Moving away from 'sustainability and affordability' to 'sustained intervention'. Development agencies have for years insisted they were in a project for the short-term, assuming that ultimately government could and should sustain the programme. As far as HIV/Aids is concerned, at least, the criteria of sustainability and affordability are no longer useful or humane. Agencies, NGOs and others must work with government,

using whatever resources are available and required, to create a coherent and collaborative *sustained* response to HIV/Aids. The epidemic in one country will affect other countries; this is a global crisis for which all are accountable. *It is essential that Unicef work with partners, including governments, to ensure a flexible and sustained response is planned for the next two decades, with adequate resources to keep up the pressure on HIV/Aids.*

Understanding individual and community coping mechanisms.

> *The AIDS-orphaned child is not just another orphan, but a child who suffers from unique pressures and influences which may lead to depression, hopelessness and psychological trauma later in life. Because the concept of 'orphanhood' is relatively new in African communities where children who have lost parents have customarily been incorporated into extended families, we need to know much more about 'orphanhood' and the material, psychological and social deprivation that accompanies it. We need to know more about AIDS orphans in particular, and how educators can work with social and health workers, sociologists and psychologists, and behavioural scientists and managers to comprehend and address their needs* (Coombe, 2001b).

Too little is understood about how individuals and communities cope with HIV/Aids, even in Africa, where research and analysis of community coping techniques and individual psychological response to grief, anger and loss is only is only just beginning. Although counselling and care projects are already underway in South-East Asia, and although the debate on community care vs institutionalisation for orphans and other children affected by HIV/Aids has been joined, it is based on a fairly high degree of ignorance about local perceptions of coping and emotional response. One psychologist in Yangon is running workshops for parents on whether they perceive their children have feelings, and how they can respond to their emotional needs. Other counselling techniques seem to depend heavily on western perceptions of appropriate emotional support. *Unicef has a responsibility to broaden and deepen the psycho-social discussion involved in assisting those in despair, particularly because of HIV/Aids.*

HIV/Aids Support Community. Unicef, and its partners - (I)NGOs including CARE International, World Vision, MSF, and SCF for example - are making significant, if sometimes fragmented, time limited and/or superficial, contributions to containing the spread of HIV/Aids, providing care and support for those affected by HIV/Aids (is it a virus, is it yet a pandemic?) within the context of general social support to civil society. Their work is often characterised by commitment, sensitivity to government policy, careful interpretation of their agreements with government and other partners, and a relatively high – if occasionally narrowly focused – understanding of the potential impact of HIV/Aids. On the other hand, their management staff may be young and inexperienced in strategic planning, they may be disempowered in significant ways by government strictures – and to some extent by funders' conditionalities – and they might be said (through little fault of their own) to be trying to damp a potential conflagration by spitting on it.

HIV/Aids programming in now needs senior executive managers and planners in Unicef and in partner agencies to drive HIV/Aids interventions. This is not work for young volunteers.

EDUCATION/.SOCIAL SECTOR RESPONSE

Specific proposals have been made for Myanmar (*REPORT ON A VISIT TO MYANMAR (2) HIV AND SOCIAL SECTOR RESPONSE 3-9 APRIL 2002*). It is difficult to make generic proposals for the region, but there are some distinct strategic priorities that recommend themselves.

ASSUMPTIONS

Distinguishing between 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 clearly 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' starts. Unicef and government officials need to be aware of the texture of the fight against the pandemic, and to move more clearly to a social sector response to mitigate and contain its consequences.*

Identifying at-risk populations: Interventions in the region have concentrated principally on visible at-risk groups: IDUs, CSWs, MSMs, and the children of PLWHAs. In fact, the largest at-risk group, and the one with the most potential to push prevalence rates to frightening levels, consists of ordinary young people between the ages of 15 and 24 years. They are the ones most at risk in Africa, and it is clear that in the South-East Asia region, they are ripe for infection:

> *Young people are waiting longer to marry and have children for social and economic reasons (Care International and MOH). Together with migration, this trend increases the likelihood of premarital sex and multiple sex partners. According to one study about 15 per cent of adolescents aged 15-19 in Harnoi and 25 per cent in Ho Chi Minh City engage in premarital sex (Youth Union). In rural Viet Nam, it is estimated that 30-70 per cent of unmarried couples have sex before marriage (Care International Viet Nam). Though many unmarried adolescents and young adults are sexually active, family planning information and services target married women primarily and do not ensure confidentiality and privacy. Young people generally lack knowledge about human reproduction and sexuality because they have no effective source of information on these subjects. Sex education is not offered in schools (UNFPA). Similarly young people do not have access to sex information at home. (*Unicef Viet Nam, *Viet Nam Children and Women Situation Analysis, 2000.*)

Identifying orphans and vulnerable children: Current programming tends to separate children infected by HIV/Aids from children affected by HIV/Aids (sometimes the distinction between these two is not made clearly in programming or project documents, and in discussion) from other children, and particularly from other children in distress. Numbers of children infected and affected by Aids is still very small, and it is perhaps not yet time to be as concerned, at national level, with caring for Aids orphans (93 in Viet Nam) as it is to activate the debate in all countries about institutionalisation vs foster care. This means looking at the social paradigm of government officials trained in the former Soviet Union, examining more closely family care models, fostering provision, orphan registration and feeding schemes, and coming down clearly and consistently on the side of home-based care. Too much concentration on children coming into institutions at this point might suggest a flutter of approbation. *Unicef is concerned about the wellbeing of all children and should continue to act on children – especially girls – in distress. It must work on developing strategies for reaching children at-risk – children and young people who are vulnerable to infection – rather than those who are already infected as the numbers of the latter are miniscule, and will continue to be so for some years.*

Taking steps to confront stigma and discrimination: These issues are of singular importance to many throughout the region particularly with regard to Aids-infected children, some of whom may also be orphans. It is possible to argue that discrimination derives from ignorance. This was evidenced by the fact that staff in a children's care centre asked for special chemicals to clean a bedspace in which an HIV-children had died; by the separation of HIV/Aids orphans and children infected from others in care centres; by a number of implied references to the dangers of contracting HIV/Aids in the general course of day-to-day living; and by the experience of PLWHAs, and those caring for them. Defeating ignorance requires sustained provision of knowledge on all aspects of the epidemic, not just the transmission details, and would include: transmission, universal precautions, legal and ethical considerations, practical guidelines for caring for those who are ill, and psycho-social guidelines for carers and those who care for carers (the Women's Union in Viet Nam for example, CSFP staff, Friend to Friend carers – who themselves have the capacity to teach others to learn). Messages about HIV in the past may have been overwhelmingly frightening (the Viet Nam case), and may have created fear leading to discrimination when only the negative rather that positive messages about living

with HIV (as individuals and as a collective) were disseminated. *Unicef needs to be at the forefront of reducing ignorance, and through its IEC mechanisms sustaining those responsible for creating a more positive environment for HIV/Aids work. At the moment, discrimination is skewing the official response to HIV/Aids.*

Keeping prevalence low: It is not possible to know where on the continuum of break-out to the general population countries in the region are at present, but it is best to assume that the spread through to the general population is higher than official statistics suggest. (Thailand shared statistics from 1992 and 1994, and projections by Tim Brown from 1995).) Certainly anecdotal information and soft information from communities indicates that HIV/Aids is already in communities and homes, families and schools, and that its threat is well recognised by local people. *There is a window of opportunity – of perhaps two to three years – during which government and its partners (or Unicef and its partners) can define a strategic response to HIV/Aids which has an improved chance of confining the disease to high-risk areas, and containing the spread of the infection through the general population.*

Understanding the nature of HIV/Aids: While there is a moderately high Aids-awareness in Unicef country offices, there is little detailed understanding of the aetiology of the disease, potentially effective responses, or how to implement such responses. A note on the character and texture of HIV/Aids is attached (Appendix 1). *If lower prevalence rates are to be sustained through Unicef's work, then staff need to be more fully engaged with, knowledgeable about, and aware of HIV/Aids issues.*

EDUCATION'S RESPONSE

What is the role of education in preventing the spread of HIV/Aids among young people? How can the sector ensure that all young people, especially orphans and other vulnerable children, achieve their full potential?

Prevention is more than lifeskills in the curriculum – it means disseminating correct information including how to use condoms, developing skills in educators AND teacher educators, develop skills among peer educators, get teaching materials into the hands of educators and peer health educator teams, putting women and girls first, creating a safe and clean environment in schools, retaining learners and going for EFA goals (education this is the only 'vaccine' we have against HIV right now), monitoring and evaluating.

***Care and social support*:** Little is being done in practice – there is urgent need for counseling both learners and educators, creating a culture of care in schools, observing zero tolerance for violence or abuse in the school setting. We need to learn much more on orphans and children in distress – how they cope, how they live, how they can stay alive, how they die, how they are socialised, how they learn, how they grow up to be citizens, how they process grief, anger and loss, and the stigma associated with being affected by HIV and Aids.

This note is based on the assumption that education and the education sector have significant roles to play in helping to contain the spread of HIV/Aids among children and young people, and to mitigate the impact of the pandemic on them.

By determining the responsibility of the education sector – government and nongovernment stakeholders – for containing the impact of HIV/Aids on learners and their families it is possible to

- establish strategic priorities for the sector and subsectors within it including early childhood development, primary and secondary schools, and tertiary institutions and
- improve the skills and understanding of teachers and teacher educators through improved preservice and inservice programmes.

- identify who is responsible for the wellbeing of young people who are, for a variety of reasons, not in school

Mainstreaming lifeskills curricula in all learning institutions is a *necessary* but not *sufficient* response to HIV/Aids. It is essential that it be done well and to take other strategic actions while education-driven behaviour change strategies are slowly being crafted and implemented. Education-driven behaviour change requires

- developing, evaluating and adjusting curriculum materials regularly
- systematically upgrading educator and teacher educator skills
- developing and sustaining programmes of support for educators and teacher educators, including care and counselling
- evaluating the content, implementation and actual outcomes of lifeskills programmes
- understanding the limitations of teachers as mentors, care-givers and guides, and supplementing their efforts from social, health and nongovernment resources, and
- constituting a culture of care and respect in all learning institutions.

STRATEGIC PRINCIPLES

Unicef can identify a set of criteria for selecting education/social sector interventions which have the capacity to make a difference to the lives of children and young people at risk, keeping prevalence levels relatively low, and which make best use of Unicef's professional capacity, global programmes, and current regional commitments.

The three fundamental criteria, based on UNAIDS analysis of global experience, are:

Rapid: Is the action capable of reaching target groups rapidly?
Intensive: Does it keep the pressure on key levers – knowledge, behaviour, and attitudes?
Extensive: Can it reach large numbers of people, preferably entire populations?

Strategic experience suggests a number of additional strategic criteria:

Commitment: Are staff, funds, management capacity and time appropriately committed to HIV/Aids strategies?
Coherence: Does the country programme, across all sections and through partnerships, represent a coherent strategy for containing Aids and mitigating its consequences?
Consistency: Is there consistency of understanding and intent within the programme, among sections, between partners?
Cooperation: Does the programme make best use of existing and potential resources by including collaborative operations on a broad scale? Can cooperative structures be formalised through theme groups, other structures, or even formal contracts?
Comparative advantage: Does the strategic action make best use of Unicef's existing experience, knowledge, staff capacity and does it fit within the context of the agency's global programmes?
Manageability: Is the intervention manageable, is it congruent with Unicef staff's technical, professional, planning and managerial capacity?

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.' (Helen Schneider in Hein Marais, To the Edge: AIDS Review 2000, University of Pretoria, Centre for the Study of AIDS, p. 7).

Finally, it is essential that the programme be

Considered: based on adequate research and analysis. Is there a research agenda in place, nationally and regionally, on which to make planning and management decisions?
Focused and prioritised: pulling selected levers that can make a difference. Has an attempt been made, in consultation with government and nongovernment partners, to select effective priorities and concentrate resources on them, in the short- and medium-term?
Direct and indirect: making short-term indirect interventions that can save lives immediately (STI control, condom distribution, school feeding schemes, orphan registration and subsidy), while long-term behaviour change kicks in. What direct or indirect actions can be taken now, while planning for the medium- to long-term takes place?

In Botswana, teachers and schools have developed a range of responses to vulnerable children's needs, including recognition and referral of such children for grants and other support, providing supplies, monitoring orphan well-being, interacting with households and homebased care teams to reduce stress on children, helping with psychological needs and behaviour disturbance, and developing school HIV/Aids plans. Botswana already has an established culture of schooling and high female enrolments. There is less reliance on child labour for subsistence tasks, and relatively good prospects of work after completion of school. Government may have reduced the potential adverse affects of orphaning on learners by creating three complementary support programmes which together seem to keep many children in school, and help them perform adequately. The package is not a technically difficult one and includes school feeding, home based care, and orphan registration and subsidy (Abt Associates, 2001).

OPERATIONAL CONCERNS

The following principals need to inform any strategy to improve the efficiency of HIV/Aids programmes in the region. They can be applied to Unicef, they can be used to design national as well as local programmes, and they are suited to individual agencies as well as to the collective.

Leadership: Leadership of (I)NGO HIV/Aids initiatives is currently fragmented among UN agencies, including UNAIDS, UNDCP, UNDP, Unicef, and various partners. The establishment of the HIV/Aids Theme Groups and development of joint plans of action in Myanmar and Thailand may begin to make a difference in creating a coherent response to HIV/Aids. It is essential for leadership to be committed, informed and confident about collaboration.

Collective dedication: Headway will only be made if better working arrangements (systems and structures) among partners are created. Fragmentation of understanding, focus, and effort currently means the HIV/Aids jigsaw puzzle is lying in bits and pieces. Strong leadership would help to put the pieces together in a recognizably more coherent framework for action with a better chance of making a difference.

Research, analysis, information and dissemination: Unicef's support for research on the impact of HIV/Aids on children and their families will make a significant contribution to understanding difficult issues in the region, and globally. The situation analyses are particularly useful, as is the study of alternative forms of care – although the latter needs to be extended to include a consideration of community care.

There is a profound need for additional research and analysis to be undertaken:. Research topics that particularly suggest themselves include the extent to which children in various geographical areas are at risk of (1) abuse and (2) being infected; the relationship between child trafficking, migration of women and children, and the spread of HIV/Aids; (3) the links between socio-economic deprivation, child welfare and vulnerability to infection; (4) a review of customary child welfare and individual trauma coping devices; (5)

psychosocial deprivation and coping mechanisms among people of the region, with particular focus on orphans and other vulnerable children.

Dissemination of information is the responsibility of Unicef's Communications Sections. It is possible to construe a number of new ways of getting analysis and information out to where it can make a difference: *nationally* through advocacy books and briefing notes; *internationally* through the agency and HIV networks; *locally* through practical modules for field staff; and to *educators and health workers* through government communication channels where possible.

Management appropriate to the crisis: There are not enough international or local Unicef or (I)NGO technical staff to (1) respond to the crisis, (2) support government initiatives, and (3) design, implement and manage strategic interventions. There are not enough staff, and there are not enough senior staff.

The problem is how to acquire senior technical and managerial skills for the work that must be done. This should be possible in a number of ways: (1) hiring local expertise; (2) hiring individual international and local experts on long and short contracts; (3) linking programmes with programmes in other countries; (4) establishing a Mobile Task Team on HIV and Children, similar to the Task Team on HIV and Education in the SADC region, supported by USAID, based at the University of Natal in South Africa and serving the needs of governments and agencies in the region; (5) contracting partner agencies to scale up their own operations to provide services agreed between the contractor and contractee, over a specified and sustained period of time; and (6) contracting regular support from a specialist HIV/Aids consulting service.

Policy, planning and priorities: The UN Theme Group in Myanmar has made important progress in identifying the characteristic features of a planned response to HIV/Aids (see A3 chart Joint Plan of Action, April 2002). The construct provides an opportunity to identify those levers for change which have the best chance of making a difference on a large scale. It allows for a set of common understandings and a focused response within agency, by agencies in partnership with government, and within the NGO community. Most important it will allow the collective to identify priorities for action: what can be achieved within the management competence of the community, which is likely to make a difference in the short-term while waiting for long-term behaviour change initiatives to take place, and what contextual issues need to be addressed in addition to those specifically related to HIV/Aids.

Funding mobilisation and allocation: The critical issue here is to ensure that funds, once mobilised, are allocated to those who can use them. Much is known in practice about the difficulties of decentralising funds to communities, but little is understood about how to make it work to the satisfaction of the donor community. Studies exist in Mozambique and Thailand, and another has recently been prepared by Save the Children, for example. More work is required to ensure that money gets to those who can best use it at community level. A fundholding system, at national and local levels, can take much of the burden of accounting and auditing away from local NGOs, CBOs and FBOs, so they can get on with the substantive programmes.

PREVENTION

It is now a global principle that lifeskills curriculum is a *necessary* but *not sufficient* HIV/Aids prevention mechanism. Given that lifeskills programming is a prerequisite of any national prevention programme, it must be done well. It has the capacity, at least, to save lives of thousands of children and educators through all subsectors of the education system, to keep a generation of children AIDS-free, and to protect the viability of the education service. It responds to the need to protect each nation's young people, and its expensively-skilled workforce. In Myanmar for example, the client population would include:

- 6 million children and young people between the ages of 5 and 24. Young people between 15 and 24 years old are by definition high risk/vulnerable groups whether or not they are IDUs, CSWs, MHM, CNSP or trafficked. Younger children are so far relatively AIDS-free and provide government and agencies with an opportunity to keep them so: an AIDS-free generation. These clients are found in all subsectors of the education system: HIV/Aids is not just a schools issue, but is of concern from the ECCD level to tertiary training and education.
- 250,000 educators (ECCD to tertiary institutions) who have access to learners as well as to their own families and communities.
- an unknown number of teacher educators, who have responsibilities for preservice and inservice preparation of educators (teachers and managers), and who should also – to some extent at least – be responsible for action research and evaluation.

Lifeskills programmes, designed effectively, will reach learners *as well as* educators and parents. The latter is significant for it is necessary to look beyond learners to what parents need to know: children live in schools, on the street and at home, and the values for one environment may not be same values as for the other. We think that at the moment, education is the only effective 'vaccine' to prevent infection by HIV: the longer children stay in school, statistics show, the less likely they are to become infected (Coombe and Kelly for *Prospects*, 2001).

The goal: To provide information to educators and learners about the disease, and how to live safely at a time when HIV/Aids is spreading rapidly, and many young people and skilled professionals are at risk.

The problem: HIV/Aids infection rates among learners and educators are likely in future to be rising unless effective action is taken and sustained.

The purpose:
- Improve the knowledge of learners and educators about HIV/ AIDS.
- Change the social behaviour of young people and educators to reduce risk of infection.
- Reduce infection rates among learners and educators.

Anticipated short-term outcomes
- Educators are introducing learners to HIV-related information across the curriculum.
- Educators have access to gender-sensitive materials and INSET support.
- All education and training institutions have trained peer health educator teams.
- Teacher education programmes reflect the HIV emergency.
- Lifeskills interventions are being monitored.

Anticipated medium-term outcomes
- Infection rates among educators and learners start to flatten out and/or fall.
- Acceptable levels of educator and learner performance are sustained.

PRIORITY ACTIONS

Medium- to long-term actions

1. ***Good-quality lifeskills programme.*** Introduce lifeskills teaching in upper primary and secondary schools, and in post-secondary institutions. The lifeskills materials developed under SHAPE in Myanmar, for example, have been adopted by government, but there is lack of focus about what can be done with them, and how. The materials need further review and adjustment (*through Unicef's Communication Section)*.

Additional modules may be required for educators who must use them (helping to improve their knowledge of the disease in particular), and making1 proposals for how educators can improve their HIV message-dissemination skills through self- or peer-group study.

Support for teacher and teacher educator development needs to be extended to include provision for adjusting materials (from other countries wherever possible, in the interests of cost and time), and developing techniques for upgrading the skills of teachers and teacher educators (not all teachers, but selected teachers who show they have the capacity for this kind of work). Some of this work can be done by mainstreaming HIV/Aids in existing area focus programmes.

Training strategies need to be reviewed to reduce dependence on workshops, and increase the use of distance education, self- and peer-group study in systematic, regular, highly visible, accessible and sustainable ways.

2. ***HIV media campaigns for young people:*** Design and promote value-based national media campaigns targetting young people.

In South Africa, Soul City is a multi-media 'edutainment' project now extending into Botswana, Namibia and other countries in the region. It integrates health and development issues into prime- time television and radio dramas, backed up by full-colour easy-to-read booklets, posters and other materials. HIV/Aids has been one of its core topics. Evaluation of the programme during 2001 shows that programmes reach more than 16 million people, many of them youth, and that personal values seem to be shifting towards greater acceptance, inclusion, and support for people who are HIV positive. Qualitative and quantitative evidence shows that Soul City has played a significant role in increasing accurate knowledge about HIV/Aids and in shifting youth attitudes and subjective social norms, as well as directing practice towards sustained safer sexual behaviours. Future work is expected to focus on care (counselling, treatment and care of the ill) and a social climate that minimises discrimination and stigmatisation through social mobilisation and advocacy for human rights (University of Natal, 2001).

It should be possible to determine what it is acceptable to do for young people who are out of school through the written and other media. *Unicef Communications Sections have a responsibility for determining what might be possible.* It is essential to move to a paradigm of lifelong learning – as opposed to conventional nonformal education – and to concentrate on what educators can do for learners out of school as far as HIV is concerned. That focuses the problem, and narrows the range of activities and commitments required. *Unicef's Education Sections need to make decisions about what nonformal education for out-of-school youth really means, in the new millenium.*

3. ***Institutional plans:*** Instruct all learning institutions to develop an HIV/Aids plan, and monitor its implementation. It should not be beyond the capacity of every institution, particularly at post-primary level, to make a plan about how it can combat HIV/Aids: preventing its spread, helping learners and educators who are affected by the disease, fighting stigma, teaching universal precautions. Some heads will find it difficult, and will need help; others are fully capable of taking on this civic responsibility, and working with PTAs to do so. *This responsibility should be mainstreamed through national and area initiatives, with close cooperation from Unicef in preparing plan guidelines, and helping heads to understand what is required.*

4. ***Research:*** Establish research priorities; commission investigations; disseminate findings: cultural values; violence and abuse against women and children (outside the trafficking paradigm); parental roles and responsibilities, and the extent to which PTAs can deal with HIV issues; factors that make learners and educators vulnerable to infection; how young people learn about safe sex in reality; proposals for a condom distribution programme.

Countries in Sub-Saharan Africa are undertaking assessments of HIV's impact on education and on learners and educators, and its long-term ramifications for the education service. In the case of Myanmar, it might be appropriate at this stage to

undertake, not full-dress impact assessment (for which TORs are available), but rather a situation analysis which addresses the following:

- *factors relating to prevention: information on gender, age, ethnicity, literacy, risks, STI and pregnancy rates, age at first sexual intercourse, substance use, condom use, number of partners, availability of condoms and services, safety and security in learning institutions, social and cultural aspects relevant to risk, attitudes to lifeskills education, sexual and reproductive health services, discrimination in schools and community*
- *factors relating to vulnerability: numbers and percent of children living at home, children not attending school, numbers of children in and out of school, orphans, health status, economic pressures, poverty, security issues; projections for future trends relating to risk-related factors*
- *factors relating to management: surveillance data, qualitative and quantitative information about AIDS and the education system, attitudes to AIDS, stigma, staffing levels, teaching capacity affected by illness, loss of organisational and management capacity, macroeconomic and household costs related to AIDS.*

Priorities must be to evaluate what is currently being done, to develop skills (teachers, health workers, school heads and youth), scale up curriculum development and adjustment, get materials to educators and learners, and provide support through education offices. Ad hoc support is not enough: it must be regular, dependable, sustained and systematic.

It is essential to focus on upgrading knowledge and capacity of educators and teacher educators, while understanding their limitations as mentors, guides and teachers of lifeskills. They have often untapped potential to help children in improving self-esteem, decision-making, values clarification, cooperation, coping and stress management, as well as their critical and creative thinking. It is necessary to provide systematic professional support to educators from education centres and supervisors, education officials, teacher training centres, and headteacher training programmes.

Little is currently being done in this regard. There do not seem to be plans to help teachers understand HIV/Aids the virus, nor the HIV/Aids the pandemic. Educators need material specifically designed for them, with the knowledge they need. The problem of systematic support for educators and teacher educators is difficult and requires further discussion among partners. Much more work needs to be done on the matter of developing capacity of teacher training colleges to provide conceptual and developmental support through inservice and preservice programmes.

Short-term rapid response actions

5. ***Guidelines for educators:*** Provide all educators with HIV emergency guidelines (aetiology, universal precautions, care for the terminally ill and those in distress, human rights and stigma, care and counselling, workplace policy) for discussion and self-study. *South Africa's HIV emergency guidelines can be adapted throughout the region, and disseminated nationally and regularly to all educators, in all subsectors through Unicef's Communications Sections.*

6. ***STIs:*** Find ways 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 STIs, provide the correct medication and assist with medical advice according to established protocols. Appropriate drugs must be made available for distribution to those with STIs through the international community and whatever procedures it takes. *Unicef's Health and Nutrition Sections will need to extend STI prevention and treatment schemes and avoid mistakes like the Condom Café in HCMC.*

7. ***Condoms:*** Wherever possible, offer to provide every post-secondary institution, secondary school and school hostel condoms for learners and educators, in sufficient numbers to meet demand, available in places which are easily accessed by students and educators. Information will be available on their use

from the health worker who visits the school and from student and staff health volunteers. *This is a task for Unicef Health and Nutrition Sections.*

8. ***Youth out of school:*** Start to meet the needs of young people who are not in school – for whatever reason – by training peer educator health teams (patterned on PSI models in other regions, see below), using the media, developing books and materials for lending libraries, making progress on a values-driven media campaign.

   Any 'nonformal' programme aimed at 'out-of-school' youth, must move away from the 1970s conventional perception, to one of lifelong learning which anticipates that learning will become more random, especially for those affected by HIV/Aids, that formal schooling is only part of the learning continuum, and that people must continue to learn wherever and whenever they wish to access learning.

   Alternative learning provision is the model here, rather than nonformal education, and can make use of distance education, self-study, and peer group techniques, as well as new technologies which are spreading quickly to more and more users. Above all, it is essential not to get sucked into the bottomless attempt to provide extensive nonformal opportunities, but to do what is required for addressing HIV/Aids rather than for changing the quality of the lives of all young people. *Unicef's education and HIV staff must work together, and also with the Communications Sections to create an effective national campaign.*

SOCIAL SUPPORT

The goal: To make learning institutions places that are sensitive to the material, psychological and social needs of learners and educators, especially those affected by HIV/Aids, so that they continue learning and teaching. All institutions need to be places of safety and security for staff and learners.

The problem: Learners and educators are suffering from the traumas of orphanhood, chronic or terminal illness and loss, which influence education quality and overall performance of both learners and educators.

The purpose:

- To create an environment in all education and training institutions that is safe and caring for all learners and educators.

Anticipated short-term outcomes

- There is a peer health educator team in every institution.
- Learners have access to health and counselling services.
- Educators have someone who can advise them personally and professionally.

Anticipated medium-term outcomes

- A culture of care is established in institutions.
- Learners remain in school because of improved care and nutrition.
- All institutions are safe places, especially for girls and the very young.
- There is zero tolerance for violence or abuse in any institution.

PRIORITY ACTIONS

Medium- to long-term actions

1. ***Network of support at community level including schools:*** Develop the 'circle of care' approach (see Appendix 3, from Namibia) that involves educators, health workers, community workers and parents and in so doing improve liaison among professionals in the social sector in support of schools. *Unicef's area focussed programmes, where they exist, provide excellent opportunities for mainstreaming HIV/Aids in the social support networks of communities.*

2. ***Codes of conduct:*** Establish a human rights code for the education service and disseminate it. Issues of stigma and discrimination are clearly a dominant concern in the region. Educators can start to campaign for de-stigmatisation if they are helped to understand the difficulties, and if they have materials and regulations which promote human rights in every institution. *Unicef's Communications Sections must work with CNSP to develop guidelines on human rights for educators in all institutions, and see that they are distributed through departments of education wherever possible, or locally*

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3. ***Research:*** Establish research priorities; commission investigations; disseminate: rapid appraisal of the condition of orphans and other vulnerable children; how Myanmar children cope with trauma; the particular traumas associated with HIV and Aids; developing care and counselling programmes which are school-based but community driven; and the capacity of educators to undertake care and counselling responsibilities.

Short-term rapid response actions

4. ***Hygiene and sanitation:*** Guarantee acceptable levels of hygiene and sanitation in all learning institutions, including potable water, enough separate latrines, humane hostel conditions. *Extend Unicef's programme for schools' water and sanitation provision as rapidly and as far as possible.*

5. ***School hostels:*** Adjust, or at least review, hostel conditions, supervision, and administrative guidelines. Too many learners live in conditions of distress in hostels, or in private homes away from home. *A Unicef-led situation analysis is required here to determine levels of nutritional and hygiene risk, personal security, and vulnerability of learners living away from homes and communities.*

6. ***Peer educator health teams***: 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 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. *Through area programmes, and mainstreaming HIV in other programmes, Unicef has the possibility of training and supporting paraprofessional peer heath educator teams: groups of young people who are trained by health workers and can be professional effective in helping communities and individuals cope with the epidemic.*

7. ***Direct support for children affected by HIV/Aids.*** Examine the consequences and financial implications of providing (1) school feeding schemes in high risk or particularly vulnerable areas, (2) orphan subsidies, to keep children in families or with foster carers and (3) scaling up education provision to meet EFA targets. *Unicef needs to undertake an analysis of the cost of feeding children to keep them in school ('education is the only vaccine we have at present to combat AIDS': Coombe and Kelly, September 2001 for UNESCO). Fiddling about with small-scale community response is a long-term priority. In the shorter term it is essential to understand better whether it is possible or impossible to develop rapid-response mechanisms to protect children: food and nutrition, orphan subsidies, and more school places. Unicef needs to lead the discussion on these issues, and commission hard-nosed studies of costs and implications.*

It will only be possible to pass on messages about safe sex and health if the learning environment itself embodies the basic elements of decency by ensuring every school has potable water, separate male/female latrines, and guidance on universal precautions. The whole issue of school hostels needs to be unpicked: how are they supervised; what guidelines have been received on child security; what nurturing learners receive; levels of STIs; what guidelines there are on condom distribution and use. There are many other students living on their own in rooms or boarding houses, or with guardians. What is known about them, the conditions in which they live, and what needs to be done to help them?

WITHIN UNICEF

The following adjustments to the way Unicef works merit attention:

1. ensure a workplace policy is in place for Unicef Myanmar
2. mainstream HIV/Aids in all Unicef's work by allocating 20% of time in any workshop, on whatever theme, to HIV/Aids issues
3. mainstream prevention and care messages through all Unicef programmes in particular, communications, health and nutrition, education, CNSP and area programmes
4. train and sensitise *all* staff regularly (once each month)
    - aetiology of HIV/Aids
    - universal precautions
    - care and support for those affected and infected
    - human and civil rights issues
8. ask for a commitment to action on HIV by individual staff members
9. identify an action research agenda within the agency
10. factor HIV/Aids into all development planning
11. factor HIV/Aids into management capacity building
12. develop standards monitoring capacity
13. acquire additional executive staff for HIV implementation and contract management
14. establish contracting and monitoring procedures for joint/partner HIV interventions.

Carol Coombe
Bangkok
17.04.02

APPENDIX 1

UNDERSTANDING THE NATURE OF HIV/Aids

It is essential, as quickly as possible, to review what is known about the extent and nature of the character, spread, social texture, and potential impact of HIV/Aids in Myanmar. HIV/Aids is understood principally as a *prevention issue*, and to a further extent as a disease that will have impact on the *social wellbeing of children and their families*. This perception reduces to a narrow focus on prevention curriculum, and social support programmes for those affected. In fact, the full construct of the potential of HIV/Aids to terminally damage the social fabric of this society must take into account matters such as:

(1) ***General issues*:** Learning to contend with the pandemic's impact on civil society; identifying (a) the nature and extent of various stakeholders for fighting HIV/Aids and caring for those affected; and (b) the extent to which schools and other educational institutions, for example, are (or should be) part of communities' response to the pandemic.

(2) ***Education and training subsectors*:** Determining the responsibility of the education sector – government and nongovernment stakeholders – for containing the impact of HIV/Aids on learners and their families; identifying who is responsible for the wellbeing of young people who are, for a variety of reasons, not in school; creating a strategic focus for the sector and subsectors within it including early childhood development, primary and secondary schools, and tertiary institutions; improving the skills and understanding of teacher educators and improving preservice and inservice programmes.

Mainstreaming lifeskills curricula in all learning institutions – a necessary but not sufficient response to HIV/Aids; taking other critical steps while education-driven behaviour change strategies are being slowly crafted and implemented: developing, evaluating and adjusting curriculum materials regularly; regularly upgrading educator and teacher educator skills; providing programmes of support for educators and teacher educators, including care and counselling; evaluating the content, implementation and actual outcomes of lifeskills programmes; understanding the limitations of teachers as mentors, care-givers and guides and supplementing their efforts from social, health and nongovernment sector resources; and constituting a culture of care and respect in all learning institutions.

(3) ***Management, policy and planning issues*:** Understanding and predicting the pandemic's implications for management and development within the social sector; proactively managing the pandemic in a way that protects children and their families as effectively as possible; developing coherent policies and strategic plans – at least for the nongovernment sector – 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 to stakeholders.

(4) ***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 past experience with about national capacity to provide institutional care for affected children; understanding the potential of homebased care; analysing and planning for homebased care and school feeding schemes; defining the school's links with the community's response to the pandemic.

(5) ***Gender concerns***: Keeping issues related to the girl-child at risk at centre stage; recognising where there are particularly unsafe places for girls and taking action; closely linking gender and HIV

programmes for maximum efficiency; continuing and scaling up advocacy, research and action on child protection programmes.

(6) ***Values, and moral and ethical issues***. Understanding how values and customary and religious beliefs can either profoundly inhibit understanding of HIV/Aids, or empower communities, individuals and agencies to challenge the pandemic.

(7) ***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 policy and regulatory framework at least for the agency and NGO community; analysing issues of testing and confidentiality; creating strategies for dealing rigorously with harassment and abuse, stigmatisation and discrimination in especially in learning institutions and communities; establishing codes of conduct and applying them.

APPENDIX 2

FIGURE LOW PREVALENCE INTERVENTIONS

APPENDIX 3

FIGURE ABT ASSOCIATES CIRCLE OF CARE