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IIEP – UNESCO

THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR IN UGANDA

Study 1

EXAMINING POLICY, LEADERSHIP AND ADVOCACY RESPONSES IN THE EDUCATION SECTOR

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FOREWORD

THE COLLABORATIVE ACTION RESEARCH PROGRAMME

IIEP and its partner ministries of education launched the collaborative action research programme in 2003. This initiative is designed to contribute to mitigation and prevention of the impact of the HIV/AIDS pandemic in three countries – Malawi, Tanzania and Uganda. The focus of the research activities is essentially needs assessment. This, in turn, will help to prioritize options for the development of policy, training and other measures to enable the education sector to strengthen its internal capacity in two critical areas. These are to respond to the impact of the epidemic on its staff at all levels and to maintain progress towards EFA goals.

Objectives

The collaborative action research programme is designed to achieve the following objectives:

- to identify problems related to the impact of HIV/AIDS on the education sector and to prioritise areas for action;
- to formulate responses to gaps identified in current policy, leadership practices and management capacities;
- to develop a database to track patterns and trends in HIV/AIDS-related teacher and student absence, abandonment and mortality;
- to formulate effective mitigation and prevention measures based on a qualitative assessment of the impact of HIV/AIDS on selected schools and their surrounding communities.

Expected results

The programme is expected to produce results on two levels. Initial activities will produce five diagnostic studies and recommendations for specific responses to the impact of the epidemic on the education sector. The first two studies will be carried out in all three countries. The final three studies will be implemented selectively. The studies will examine the impact of HIV/AIDS on the following areas: educational leadership and policy; educational governance; enrolment, attendance and instruction in district schools; selected schools and communities, and tertiary educational institutions. This phase will also lead to the production of a handbook of research tools, policy recommendations and best practices, to facilitate replication of the research programme in other countries.

As the research progresses, the needs identified in the diagnosis stage will be used to formulate policy frameworks and recommendations, and training and organisational development strategies. The ministries of education of the co-operating countries will implement, monitor and evaluate these strategies, in partnership with IIEP and other technical and financial partners in the donor community.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
BoG	Board of Governors
CAO	Chief Administrative Officer
CBO	Community-Based Organization
CSO	Civil Society Organization
DAC	District AIDS Committee
DAT	District AIDS Taskforce
DEO	District Education Officer
EFA	Education for All
EMIS	Educational Management Information System
ESC	Education Service Commission
ESIP	Education Sector Investment Plan
FGD	Focus group discussion
FPO	Focal Point Officer
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IIEP	International Institute for Educational Planning
ILO	International Labour Organization
LSPE	Life Skills Planning Education
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoPS	Ministry of Public Service
NGO	Non-Governmental Organization
NSF	National Strategic Framework
PEAP	Poverty Eradication Action Plan
PIASCY	Presidential Initiative on AIDS Strategy and Communication to the Youth
PLWHA	People living with HIV/AIDS
SRH	Sexual and reproductive health
STD	Sexually Transmitted Disease
TA	Technical Advisor
TASO	The AIDS Support Organization
UAC	Uganda AIDS Commission
UACS	Uganda AIDS Commission Secretariat
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children’s Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
VAT	Village AIDS Taskforce
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization

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EXECUTIVE SUMMARY

The HIV/AIDS epidemic in Uganda has had far reaching consequences not only for individuals, families and communities, but also for the country as a whole. In the education sector, the epidemic has emerged as a major threat to achieving Education for All (EFA) goals. The *national* success in the fight against HIV/AIDS in Uganda has been attributed to good and committed leadership, open policies and sustained advocacy. Policy confers legitimacy, sets priorities and goals and establishes accountability for the different partners operating in the area. Leadership provides the desired vision, mobilizes both human and financial resources, and forms the driving force for implementation, monitoring and evaluation. Advocacy, on the other hand, provides the energy necessary for mobilization and action. However, according to the findings of this research, the education sector in Uganda does little to document or analyse policy, leadership and advocacy issues as critical responses to HIV/AIDS, with respect to the welfare of teachers, education managers, support staff and learners. This study seeks to investigate those factors.

The overall study objective was to analyse the existing policy, leadership and advocacy responses to the impact of the HIV/AIDS epidemic in primary and secondary education in Uganda. Specifically, the study seeks to:

- assess the existence of sectoral policy on HIV/AIDS and how it is being implemented;
- examine the roles of different actors in the sector in providing leadership for advocacy in HIV/AIDS issues, and
- explore the roles of different actors in providing leadership for implementation of HIV/AIDS programmes at all levels.

The study was conducted in eight districts: Mukono; Kasese; Gulu; Mubende; Iganga; Kumi; Kyenjojyo; Rakai, and Kampala. Purposive sampling was used to select these districts. Study participants included commissioners of education, HIV/AIDS focal point officers (FPOs) at Ministry of Education and Sports (MoES) headquarters, members of parliament (i.e. policy makers), district education officers (DEOs), members of school boards of governors (BoGs), headteachers, members of Non-Governmental Organizations (NGOs) and Community-Based Organizations (CBOs), religious leaders, pupils, teachers, support staff, representatives of the teachers' union and teachers living with HIV/AIDS. Data were collected using key informant interviews, focus group discussions (FGDs), case studies, and document reviews. Interviews were tape-recorded, transcribed and typed. The contents and narrative were coded in themes. The themes and trends were then analyzed.

The literature reviewed indicates that although HIV/AIDS prevalence is declining in Uganda, it has stabilized at high levels, implying that the impact of the epidemic will be felt for a long while to come. Areas of armed conflict, like Gulu District, have prevalence rates that are much higher than the national average. The information available on the impact of HIV/AIDS in the education sector is fragmented, insufficient and lacks a clear chronology. Current information is based on the prevalence of HIV/AIDS on the general population and does not reflect the peculiarities of the education sector with respect to demand and supply. Estimates from Education Management Information System (EMIS) data are also not reliable, because HIV/AIDS has yet to be mainstreamed in the system.

Although some steps have already been taken towards the development of a comprehensive sector policy, the process has been slow, due to limitations such as the absence of a fully developed national policy on HIV/AIDS to serve as a basis for a sector policy and the non-commitment of financial resources to facilitate the process. This ‘policy vacuum’ has led to the development of ad hoc micro-policies that are being used at different levels of the education sector. Some of these policies could contribute to a comprehensive HIV/AIDS education sector policy.

The effectiveness of AIDS co-ordination structures and mechanisms at different levels of the sector is constrained by structural and conceptual problems that impinge on the dynamics of HIV/AIDS programmes in the sector. It is apparent that issues of power and authority in the sector bureaucracy are yet to be clearly streamlined. The fact that HIV/AIDS roles are frequently ‘add-ons’ to routine responsibilities has weakened the success of HIV/AIDS initiatives. The study also revealed that education sector leaders focus more on the needs of learners and pay little attention to teachers, managers and support staff, despite the fact that they are essential for the system’s long-term sustainability. HIV/AIDS is not viewed as a systemic issue in the sector.

In order for policy and leadership on HIV/AIDS to be effective, there is a clear need for an advocacy strategy to mainstream HIV/AIDS both inside and outside the MoES. Operational structures must be designed to influence positive change in policies, rules and procedures in response to the impact of the epidemic. Findings show that several advocacy tools have been developed within the framework of the ministry, the decentralized districts and Uganda AIDS Commission (UAC). However, as yet, there is no comprehensive advocacy strategy for the education sector. As a result, commitment and follow-through of ideas are frequently lacking, thereby causing ‘AIDS fatigue’.

The report also discusses other responses to HIV/AIDS in the education sector, such as curriculum interventions, condoms, personnel issues, orphans, stigma and discrimination, guidance and counselling and the role of the teachers’ union. HIV/AIDS has been integrated into the primary school curriculum and is now going through the same process for the secondary curriculum. However, it is not enough to simply direct teachers to deliver instruction on HIV/AIDS issues: teachers must be re-trained to improve their capacity to deliver this new curriculum, especially when tackling sensitive subjects. For example, the issue of promoting condoms in schools has raised a lot of emotional sentiments amongst teachers and other stakeholders. The general view is that a moralist, rather than a pragmatic approach should be adopted to deal with the subject. As a result, condoms are generally discouraged in primary and secondary schools.

The MoES is currently using public service personnel policies. These policies are not responsive to personnel issues relating to education and HIV/AIDS. Lacking clear guidance, education managers have developed unwritten modalities and practices to respond to the plight of teachers and learners affected and infected by HIV/AIDS. These informal arrangements take the form of job security, transfers, workload sharing, hiring extra-budgetary resources, special leave arrangements, etc. However, under the civil service reform exercise, the Ministry of Public Service (MoPS), in collaboration with other stakeholders, is now reviewing personnel policies, specifically to integrate HIV/AIDS concerns.

Counselling and guidance services for learners and teachers are inadequate. Senior teachers perform general counselling duties, coverage of which includes HIV/AIDS and other

sexual and reproductive health (SRH) issues. However, most of them do not posses adequate knowledge or skills. Anti-HIV/AIDS clubs now exist in a number of schools; although some clubs were found not to be functional due to a lack of effective leadership and guidance. For example, the clubs do not receive direct financial support either from schools or the MoES. Club patrons and peer educators are poorly trained and unmotivated to assume management responsibilities.

This report recommends a number of actions for the MoES and its partners to consider when addressing policy, leadership, advocacy and other concerns identified with regard to HIV/AIDS in the sector. Key recommendations include that:

- a well organised system of policy formulation and monitoring should be developed for the sector, which does not depend on individuals, but rather is self driven;
- a comprehensive HIV/AIDS policy should be developed for the education sector;
- a clear budget line should be established for HIV/AIDS activities at all levels;
- the current HIV/AIDS co-ordination structure should be reviewed to make it more effective;
- an AIDS-sensitive EMIS is needed to identify needs and monitor the impact of policy implementation on attendance and overall educational quality;
- the vision of the sector leadership on HIV/AIDS should be broadened, so that it also takes in the needs of teachers, managers and support staff in relation to HIV/AIDS. Leadership and policy initiatives must address these priority issues:
    - stigma, silence and discrimination related to HIV/AIDS, which are still problematic in the education sector;
    - special approaches to HIV/AIDS prevention and mitigation needed in areas of armed conflict;
    - special approaches to the educational needs of orphans, including support from trained counsellors and protection from discrimination and exploitation.

1. INTRODUCTION

1.1 Background to the study

HIV/AIDS is a global phenomenon, which has hit Africa with particular severity. It was estimated that by 2001 African countries accounted for 74 per cent of new HIV infections and 78.5 per cent of AIDS-related deaths. With approximately 28.5 million people currently infected with HIV in sub-Saharan Africa, HIV/AIDS continues to constitute a grave health burden and impact negatively on all aspects of the region's development (UNAIDS, 2002).

By the end of 2001, it was estimated that 1,050,555 Ugandans, out of a total population of about 24 million, were living with HIV/AIDS. Of them, 105,055 were children under 15 years of age. Approximately 947,552 Ugandans have died of AIDS-related causes since the beginning of the epidemic (MoH, 2002). There are approximately 2 million orphans in Uganda, constituting 19.7 per cent of the child population (Wakhweya, 2003).

1.2 Overview of the education system in Uganda

Formal education in Uganda began in the 1890s, when the first Christian mission schools were established. Religious organizations have continued to play a major role in Ugandan education up to the present. In 1924 the government opened its first secondary school, although by 1950 it still ran only three of the 53 secondary schools in the country. After independence, communities came together, with government assistance, to build and operate their own local schools. Up to 1974, the curriculum followed the British syllabus for most subjects; the government proposed a new curriculum in 1975. The education system suffered during the political and economic turmoil of the 1970s and 1980s: the infrastructure was destroyed and many teachers fled the country. However, in the late 1980s improvements were put in place that meant that by the early 1990s, the overall literacy rate had increased to 61.8 per cent (Byrnes, 1992). Although the administration of educational institutions was taken over by the government, the influence of founding bodies continues today, through the support of school boards of governors (BoGs) and founding religious organizations. As a result, school life guidelines and other aspects of school culture still largely subscribe to the faith of the founding organizations. Approximately 60 per cent of secondary schools are either church-run or have church-affiliated BoGs.

The educational system in Uganda consists of pre-primary, primary, secondary and post-secondary, or tertiary, education. Pre primary (nursery) is for children aged 3 to 5 years. About 10 per cent of the total school-going children pass through pre-primary schools (Education in Uganda, 2003). Pre-primary is the only level of the system that is completely under private control. So far, there has been a notable lack of government regulation, resulting in questionable trends regarding the content and quality of the curriculum, teaching methods, facilities, age of entry, quality of teachers and school charges.

Primary education typically lasts seven years (Primary 1 to Primary 7) and is for children aged 6 to 12 years. The demand for primary education has radically increased, with the introduction in 1997 of Universal Primary Education (UPE). This saw school enrolment

increase from 2 million pupils in 1986 to over 7 million pupils in 2002 (MoES, 2002*a*). There are variations, however, between urban and rural areas, with the former having more permanent schools and better teaching and instructional materials than the latter. On completing primary school, pupils may enter Ordinary Level or alternatively, a small proportion may go on to Business, Technical, Vocational Education and Training institutions. In 2001 there were only 29 state Technical Secondary Schools taking primary school leavers (there are also a number of private vocational centres, but not all of these are recorded in EMIS statistics). Overall, transition rates to secondary level are slowly increasing (from 38.6 per cent in 1997 to 54.6 per cent in 2001), although demand still far outstrips supply (Bennell and Sayed, 2002).

Secondary education is divided into Ordinary Level (Senior 1 to 4, ages 13 to 16) and Advanced Level (Senior 5 and 6, ages 17 and 18), although not all students follow this progression. After Ordinary Level, as an alternative to studying for Advanced Level, students have the option to go to a Business, Technical, Vocational Education and Training institution (the post-Senior 4 intake to state-run Technical Vocational Institutes have generally poor final examination results), or primary teachers' college. Over the last 10 years, secondary education has witnessed growth of over 20 per cent in the number of government-aided secondary schools and 15 per cent in the number of registered private secondary schools. Even despite this increase, the sector is yet to attain the necessary capacity to cope with the large number of primary school leavers (Education in Uganda, 2003).

Those students completing Advanced Level have the option to enter post-secondary, or higher education. This covers universities, national teachers' colleges, national business colleges, national technical colleges and medical institutions. Every year, between 9,000 and 12,000 students qualify to join post-secondary education. However, only about 25 per cent have the opportunity to take up places at post-secondary institutions. This is partly due to the limited number of places. Tuition fees have also been introduced (tertiary education was formerly free and scholarships were available), acting as a further disincentive to young people, especially those from poorer backgrounds, remaining in education.

1.3 Statement of the problem and justification for the study

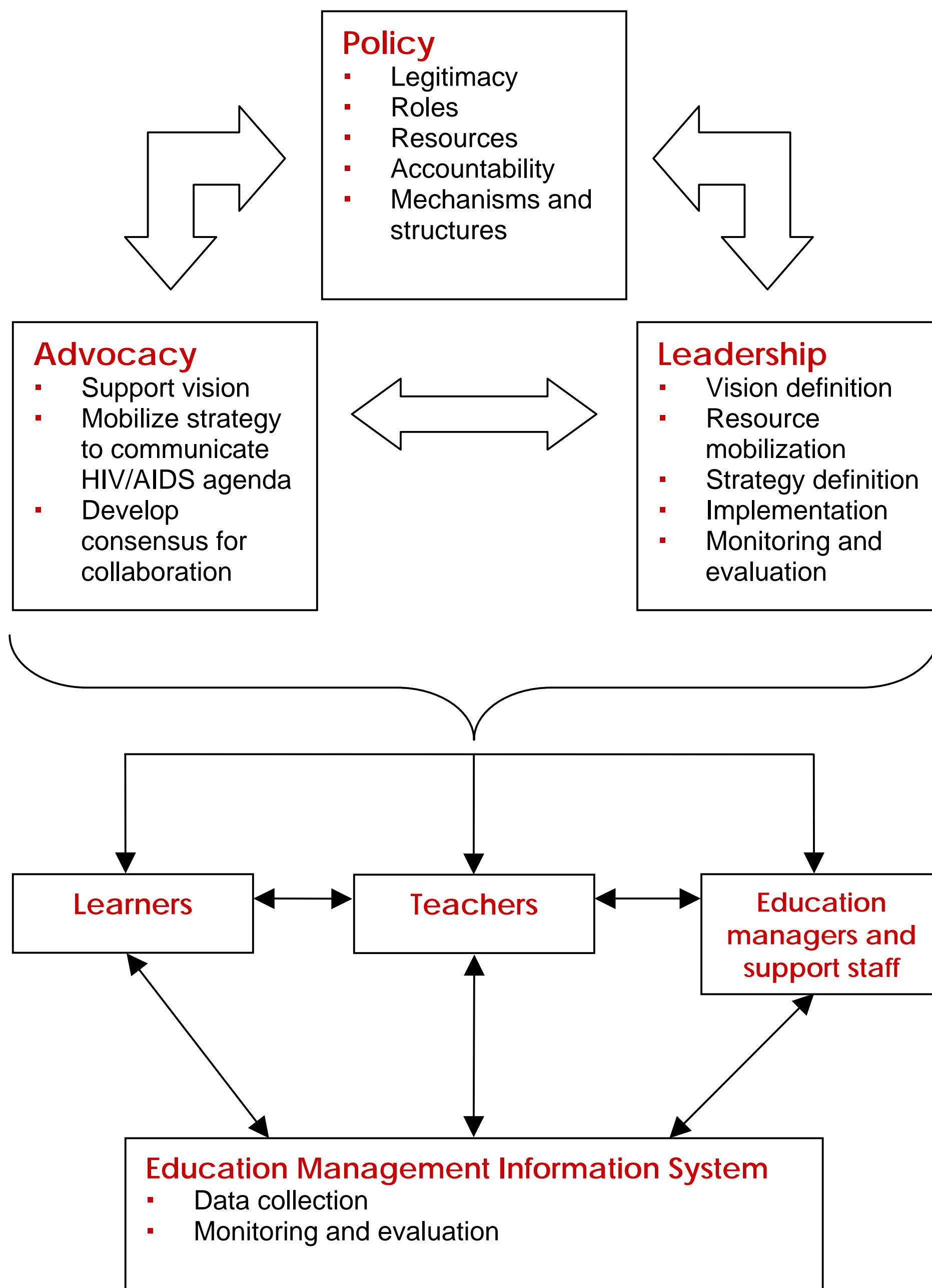
In Uganda, education is ranked among the top priority sectors of government. The vision of the Ministry of Education and Sports (MoES) is to provide quality education and sport for all. More specifically, its mission is to provide, support, guide, co-ordinate, regulate and promote quality education for all persons in Uganda, to promote national integration and individual and national development (MoES, 2002*b*).

The HIV/AIDS epidemic has affected all sectors in Uganda, including that of education, especially in terms of educational demand, supply and quality. This constitutes a major threat to the achievement of UPE and Education for All (EFA) goals.

National success in the fight against HIV/AIDS is attributed, among other aspects, to good and committed leadership, effective policies and sustained advocacy. These elements form a strong foundation for a successful response to the epidemic. The education sector information that is available suggests that policy, leadership and advocacy issues are not documented or analysed with respect to the welfare of teachers, managers, support staff and learners living with HIV/AIDS, mainstreaming and co-ordination of HIV/AIDS in the sector,

curriculum reviews and personnel issues. Policy provides legitimacy for integrating HIV/AIDS in the education sector, and committing resources through the usual budget allocation, as well as providing a mechanism for ensuring that actors are accountable to the wider community. Leadership forms the driving force for implementation, monitoring and evaluation, through inspiring the desired vision and mobilizing both human and financial resources to implement that vision. It is the view of the authors that no significant innovation or major institutional change can come about without sustained and committed leadership. Advocacy, in the context of this action research initiative, is an organised form of energetic communication, lobbying or active promotion of specific principles or practices. In the context of HIV/AIDS sector-specific needs, advocacy provides the necessary energy for articulating those needs, whilst also putting in place a framework for collaboration, both within and without the sector. Since all three are critical to the success of HIV/AIDS responses, this investigation is felt to be both necessary and timely.

Figure 1.1 Conceptual framework for the implementation of effective responses to HIV/AIDS in the education sector



1.4 Objectives

The general objective of the study is to analyse the leadership, policy and advocacy responses formulated to date, to facilitate the formulation of strategies that will enhance the capacity of the education sector to address the HIV/AIDS epidemic more effectively. More specifically, the study will:

- investigate the existence of a sectoral policy on HIV/AIDS and assess how it is being implemented;

- examine the role of different actors in the education sector in providing leadership for advocacy in HIV/AIDS issues;
- explore the role of different actors in providing leadership for the implementation of HIV/AIDS programmes at central, district and institutional levels.

1.5 Methodology

1.5.1 Areas of study

Purposive sampling[1] was used to select nine districts: Mukono; Kasese; Mubende; Gulu; Iganga; Kumi; Kyenjojyo; Rakai, and Kampala (see Figure 1.2). Kampala was selected because it is urban and cosmopolitan and has more access to services; Kasese represents an area that has experienced insurgency and civil strife. Rakai and Mubende were among the first districts to experience the epidemic, Mukono was selected for proximity and because it was used for the pre-testing of the research concept and tools, and finally, Kumi, Iganga and Kyenjojo provide a wider regional context for comparison of findings.

1.5.2 Study participants

These included four commissioners of education, five HIV/AIDS focal point officers (FPOs) at ministry headquarters, seven members of parliament (i.e. policy makers), eight district education officers (DEOs), three members of school BoGs, and sixteen headteachers of both primary and secondary schools. Others participants were members of Non-Governmental Organizations (NGOs) and Community-Based Organizations (CBOs), religious leaders, learners, teachers, support staff, teachers' union and association representatives and teachers living with HIV/AIDS.

1.5.3 Data collection techniques

Data were collected using the following techniques:

- Key informant interviews were conducted with district leaders and education officials to explore their views on the role that leaders play, the existence of policies and the advocacy strategies currently used on HIV/AIDS in the education sector.

- Focus group discussions (FGDs) were used to gather information from pupils and teachers.

- The case study approach was employed mainly to illustrate the experiences of teachers living with HIV/AIDS. This method was also used to study the evolution of HIV/AIDS policy in the education sector.

Other techniques used include participant observation and a review of relevant HIV/AIDS literature.

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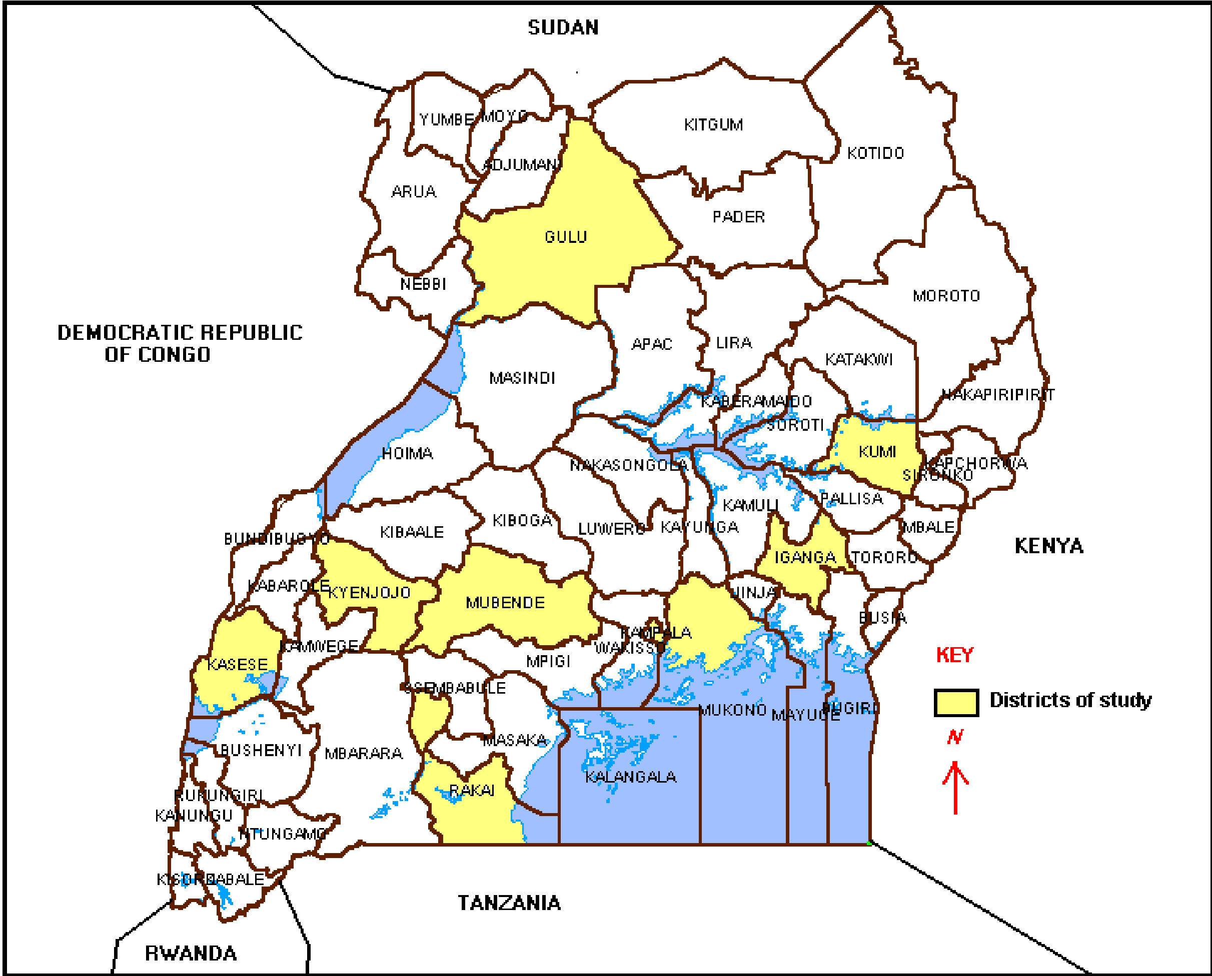
[1] A technique common in qualitative research where the sample is selected by human choice, following the objectives of the study to ensure that certain specific characteristics are selected, rather than at random.

Figure 1.2 Map of Uganda, showing regional boundaries and study areas



Source: MoH geographer.

1.5.4 Data processing and analysis

All interviews were tape-recorded, then transcribed and typed. The contents and narrative were coded in themes. These included policy issues, the role of district leaders and education officials in HIV/AIDS prevention and advocacy responses. The themes and associated trends were then analysed to identify the various activities that took place over the years and at the different levels of the education sector.

1.5.5 Ethical considerations

A Memorandum of Understanding was signed between the International Institute for Education Planning (IIEP-UNESCO) and the MoES. The research proposal was presented to Advisory Board appointed by the MoES. This was followed by presentation to the National Council of Science and Technology for approval. The purpose of the study was explained and consent obtained from the respondents, before any of the interviews were conducted.

1.5.6 Dissemination of findings

A validation workshop was conducted with participants drawn from the MoES, NGOs, the Uganda AIDS Commission (UAC), the Education Service Commission (ESC), the public service, district officials, members of the advisory board, and researchers from academia. The final report was submitted to both the MoES and IIEP-UNESCO.

2. MAGNITUDE OF HIV/AIDS

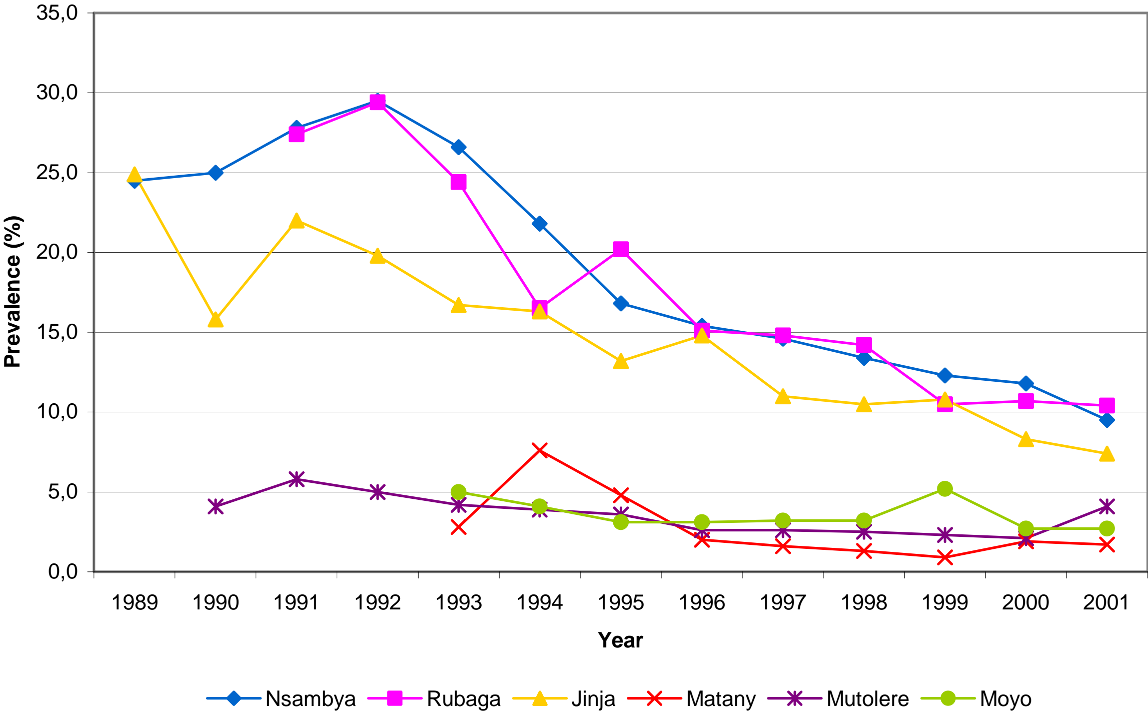
2.1 HIV/AIDS in Uganda

The first AIDS case in Uganda was identified in 1982. At the peak of the epidemic, in 1992, some urban areas were registering prevalence rates of more than 30 per cent. In 1995, adult national HIV prevalence had declined to 18.5 per cent and continued to decline to 14.7 per cent in 1997, 9.5 per cent in 1998 and 8.3 per cent in 1999. At the end of 2001, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated HIV prevalence among the adult population to be at 5 per cent, although Ministry of Health (MoH) estimates were somewhat higher, at 6.5 per cent overall: 8.8 per cent in urban areas, and 4.2 per cent in rural areas (MoH, 2002; UNAIDS, 2002).

There is a high degree of variation in HIV/AIDS trends between districts. In 2001, at selected antenatal sites, the prevalence rates varied from a low of 1.7 per cent at Matany Hospital in Moroto, which is one of the most rural districts, to a high of 11.3 per cent in Lacor Hospital in Gulu district, which is currently experiencing insurgency (see Appendix 1 for full set of results). Besides Gulu, other districts with relatively high rates of HIV/AIDS, which may be attributed to war situations or insurgency, include Kitgum, Luwero, Kiboga, Kabarole, Kasese and Mpigi. The large numbers of cases in Kampala and Jinja are attributed to the high concentration of urban residents; while in rural Masaka and Rakai it is mainly due to the fact that the epidemic occurred earlier in these districts (UNDP, 2002).

As stated earlier, overall HIV prevalence in Uganda has been falling since 1992 – a trend that Figure 2.1 demonstrates graphically. Figure 2.1 also clearly shows the difference in prevalence rates between rural and urban centres. It compares selected sentinel sites at Nsambya and Rubaga in Kampala City and Jinja Hospital in Jinja District, which represent urban centres, with the more rural sites of Moyo Hospital in Moyo District, Matany Hospital in Moroto District and Mutolere Hospital in Kisoro District. The urban centres have a markedly higher rate: the lowest city rate – 7.4 per cent – is roughly on a par with the highest rural rate – 7.6 per cent. Even within rural districts, for example, Rakai or Masaka, where the epidemic was first reported and where HIV prevalence rates range between 10 per cent and 13 per cent, rates are higher in the more densely populated zones (e.g. in trading centres along major roads), than in the truly rural areas. However, it is important to note that the trend of infection is changing, with faster declining rates being experienced in urban than in rural areas (UNDP, 2002).

Figure 2.1 HIV/AIDS infection prevalence rates among antenatal clinic attendees at selected sites, 1989-2001

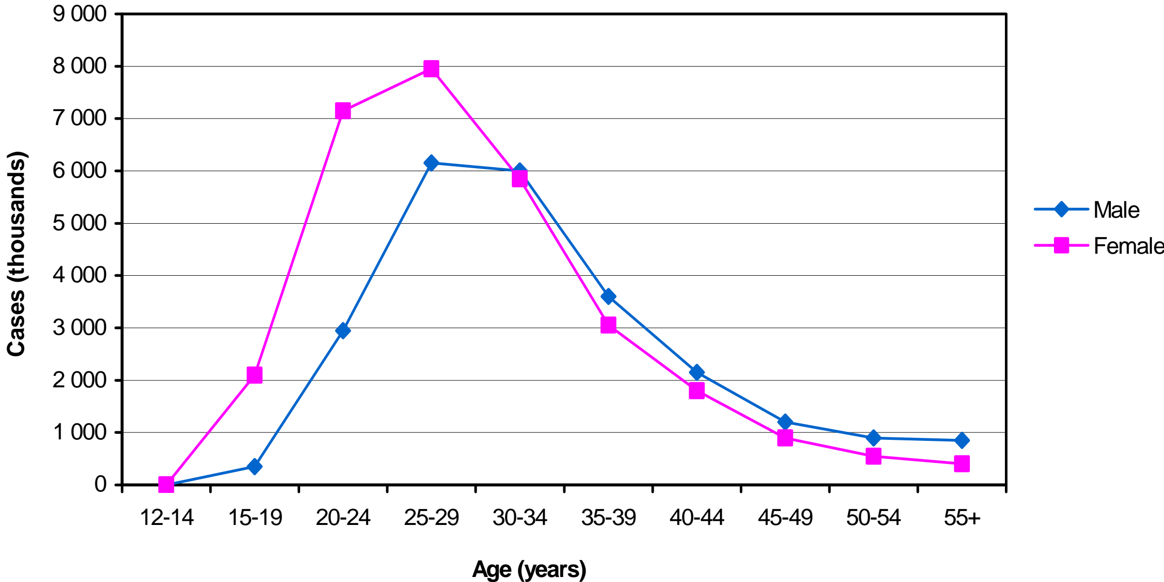


Source: Adapted from MoH, 2002.

In Uganda, the overall mean age for adults living with AIDS is 30.9 years. Stratified by sex, the mean ages are 33.0 and 29.1 for males and females respectively (MoH, 2002). Figure 2.2 shows the distribution of AIDS cases by age and sex. It also shows that the most affected age group (15-44 years) occupies a very critical position in society, encompassing as it does, learners in higher level institutions, teachers, education managers, parents or heads of households and the labour force in general. Labour shortages due to HIV/AIDS-related morbidity and mortality have also been experienced in the agricultural sector, which forms the backbone of Uganda's economy, education, health and industry (UAC, 2003*a*).

The high prevalence and incidence rates of HIV/AIDS have a lot of bearing on the education sector. The supply of experienced teachers and education managers is being reduced by AIDS-related illness and death, since most sector workers fall within the most highly affected age group. Parents are similarly affected, which has implications for learners, as they may be kept out of school to take care of sick family members. Learners also drop out of school if their families cannot afford fees due to reduced income as a result of AIDS illness or death. All of these social and economic processes have a potentially devastating impact on the education sector in terms of demand for the supply and quality of education (Domatob, 2000).

Figure 2.2 Distribution of AIDS cases in Uganda by age and sex



Source: MoH, 2002.

2.2 HIV/AIDS in the education sector

HIV/AIDS has inflicted a heavy toll on learners, parents and teachers, thus seriously affecting education, which forms one of the great pillars of development. HIV/AIDS affects learners by increasing dropout rates and absenteeism, leading to poor school performance. The teachers who die are frequently experienced, possessing leadership and enterprise qualities, as well as specialist skills, such as the ability to teach science subjects. They are not easily replaceable (UNDP, 2002).

The MoES (2003*a*) reported that prolonged illness and deaths (resulting from all health conditions) account for 9 per cent of all teacher loss. The central and northern regions show higher rates of teacher loss through death and prolonged illness than the national average for the primary sector, while the south-west region has the highest rates for the secondary sector. Primary rates are highest of all (21 per cent) in Pader District in the north of the country (see Figure 1.2). In both primary and secondary schools, on average 8 per cent of all teacher loss is due to death and prolonged illness. The district of Lira showed the highest percentage of attrition (25 per cent), while Kitgum District experienced an overall teacher loss of 19 per cent. These losses have had an impact on the supply side of the education sector and the quality of education. However, the paucity of data means that losses of teachers due to death and prolonged illness cannot be directly attributed to AIDS. HIV/AIDS is not yet mainstreamed in the Education Management Information System (EMIS) of the MoES, so few firm conclusions can be drawn.

According Hyde, Ekatan, Kiage and Barasa (2002), in 1998 16.5 per cent of primary teachers in Uganda, both trained (13.9 per cent) and untrained (24.3 per cent), left their respective schools. These figures include transfers, promotions and teachers who left to pursue further training. Between 1995 and 1998 attrition ranged from 3.9 per cent to 5.4 per cent. The highest contribution of mortality (from all causes) to these rates was in 1997, when

it accounted for 25 per cent of all primary teachers and 31 per cent of all secondary teachers leaving the sector.

One of the most immediate social impacts of the epidemic has been the large and increasing numbers of AIDS orphans. The UAC (2003*a*) estimates that there are 1,650,000 orphans in Uganda, whilst according to the *Uganda demographic and health survey, 2000-2001* (Uganda Bureau of Statistics and ORC Macro, 2001), 14 per cent of Ugandan children are orphans, representing one child in every four families. Hyde et al. (2002) reported that 37 per cent of the students questioned had lost at least one parent and 10 per cent had lost both. Among students, personal sickness was cited as the most frequent reason for being absent. However, school interruption shows the clearest impact of the effect of parental death on education: 26.9 per cent of primary and 42.9 per cent of secondary students who had lost both parents had their schooling interrupted, compared with 13.5 per cent and 16.2 per cent respectively for students whose parents were both still alive. An analysis of the 2000-2002 MoES EMIS data revealed that in 2002, 6 per cent of the Primary 1 enrolment was orphaned. This rose to 9 per cent for both Primary 7 and Senior 1, dropping down to 7 per cent for Senior 6.

Though HIV/AIDS prevalence is declining in Uganda, it has stabilized at high levels. This implies that the impact of the epidemic will continue to be felt quite a while to come. Education sector information on the impact of HIV/AIDS is fragmented, lacking in structure (e.g. there is no clear chronology) and insufficient for many policy and management purposes, creating an information vacuum. Current information is based on the prevalence of HIV/AIDS in the general population and does not reflect the peculiarities of the education sector with respect to issues of demand and supply. Estimates from EMIS data are also unreliable because HIV/AIDS indicators and data have not yet been mainstreamed in the EMIS.

3. EVOLUTION OF HIV/AIDS POLICY

Policy is a key element in any effective HIV/AIDS strategy. It provides the mechanism for the prescription of roles, issuing of directives and allocation of resources. Policies can be formal, semi-formal or informal. One of the objectives of this study is to assess the existence of a sectoral policy on HIV/AIDS – how it evolved and how it is being operationalized. This chapter will examine the evolution of policy responses to the HIV/AIDS epidemic at the national and sectoral levels. It will note the shifts, changes in focus and challenges encountered, along with other sources of mandate applicable to the education sector.

3.1 Evolution of policy at the national level

In view of the severity of the effects of the HIV/AIDS epidemic, the Ugandan government adopted an open policy of admitting the seriousness of the problem. The government began to address the problem of HIV/AIDS in 1986; their initial efforts culminating in 1987 with the formation of the first National AIDS Control Programme in the MoH. The focus was on blood safety, prevention of infection in health care settings and the dissemination of information, education and communication (IEC) materials. At that time, HIV/AIDS was viewed as a health problem, rather than an inter-sectoral, cross-cutting development concern.

Between 1987 and 1991, following the government's realization that the impact of the epidemic reached far beyond the health sector, numerous consultations took place concerning the development of a multi-sectoral approach to the control of HIV/AIDS. In 1990, a national task force was appointed to work out the modalities for this multi-sectoral AIDS control approach. In 1992, the Multi-sectoral Approach to the Control of HIV/AIDS was adopted as a policy and strategy for responding to the epidemic. The UAC was consequently established by Statute No. 2 of 1992, to co-ordinate the multi-sectoral effort and unify the different responses to the epidemic. The UAC was mandated to take a leadership role in co-ordinating the development of the first multi-sectoral National Operational Plan for HIV/AIDS activities, 1994-1998, which reflected the priority needs and roles of each sector involved in addressing the epidemic.

In 1997, the National Strategic Framework (NSF) 1998-2000 was developed for HIV/AIDS activities in co-operation with partners from various sectors, both at national and district levels. This was revised in 2001, becoming the NSF 2000/1-2005/6. The second NSF was developed as a guide for action against the HIV/AIDS epidemic at all levels, with the purpose of relating HIV/AIDS concerns to national development goals and priorities, and actively involving all stakeholders in the national response. It was also intended to serve as a tool for mobilizing human, technical and material resources for HIV/AIDS work in the country. The NSF has three principal goals:

- to reduce HIV prevalence by 25 per cent by 2005/6;
- to mitigate the health and socio-economic effects of HIV/AIDS at the individual, household and community level, and

- to strengthen the national capacity to respond to the HIV/AIDS epidemic.

The NSF is also closely related to the Poverty Eradication Action Plan (PEAP), for purposes of mainstreaming sectoral development plans through policy and resource allocation (UACS, 2000; UAC 2003*a*).

The draft national policy on HIV/AIDS for Uganda, developed in 2001 and revised in 2003, mandates the MoES to integrate HIV/AIDS education into all levels and institutions of education, following the broad principles of a human rights-based approach, greater involvement of people living with HIV/AIDS (PLWHA) and the promotion of prevention, treatment, care, support and gender sensitivity.

Other sources of mandate for the MoES at the national level include Vision 2025, which provides an overview of long-term goals and aspirations for the year 2025 and the PEAP – the national planning framework on which detailed sector strategies are developed (MoES, 2003*b*). The PEAP closely relates to the Poverty Reduction Strategy Paper , which provides unconstrained costing for AIDS programmes implemented by the education sector. The PEAP is developed and reviewed periodically through a consultative process involving all stakeholders, including those in the education sector. One of the main goals of the PEAP is to enhance the quality of life of the poor. It also specifically calls for activities to ensure that further spread of the AIDS epidemic is halted and provides a framework for focusing on HIV/AIDS activities, on policies for the actual mainstreaming of HIV/AIDS in sectoral development plans and on resource allocation (UAC, 2003*a*). The PEAP provided the framework on which the HIV/AIDS strategic plan for the education sector was developed and operationalized.

Table 3.1 Summary of evolution of policy at the national level

Year	Event	Remarks
1986	▪ The President of Uganda announces the existence of HIV/AIDS.	Broke the silence and marked the beginning of the fight against HIV/AIDS in Uganda. This emerging political openness created a conducive environment for the mass campaigns spearheaded by President Museveni.
1987	▪ The first AIDS control programme is established in the MoH.	HIV/AIDS was viewed as a health problem.
1992	▪ The government adopts a multi-sectoral approach for the control of AIDS.	The multi-sectoral approach was used as a policy and strategy response to the epidemic.
	▪ The UAC is established by Statute No. 2 of 1992.	The UAC provided leadership in co-ordinating the multi-sectoral efforts.
1993	▪ The UAC leads and co-ordinates the development of the first multi-sectoral	This was a consultative process involving UNAIDS, the UAC and other HIV/AIDS

		National Operational Plan for activities targeting HIV/AIDS and other sexually transmitted diseases (STDs), 1994-1998.	stakeholders.
1997	▪	Development of the 1998-2002 NSF for HIV/AIDS activities.	
2001	▪	Revision of the NSF, 1998-2002 and development of the NSF 2000/1-2005/6.	The HIV/AIDS problem was adapted to a broader context of national development goals.
	▪	Development of a draft national policy on HIV/AIDS.	This draft policy is being reviewed.
2003	▪	Revision of draft of the National HIV/AIDS Policy for Uganda, 2001.	
	▪	Development of draft National HIV/AIDS Policy for Uganda, 2003.	

3.2 Evolution of policy in the education sector

There is no formal comprehensive sector policy on HIV/AIDS. Instead, a combination of related formal and informal 'policies' or practices is being followed. However, the need for a formal policy is evident and has been acknowledged by the ministry, as the following quote illustrates:

> *"Uganda as a country has some guidelines, which can be [viewed as] policy. There is no written policy but somehow the policy is there. We need a sector specific policy of course. What we are doing is to 'build the boat as we sail it'. This is because AIDS is not waiting for policy."*
>
> Senior official, MoES

In the absence of a comprehensive policy, some instruments have been developed and used by the sector to address issues related to HIV/AIDS. These include the following measures.

3.2.1 The Education Strategic Investment Plan (ESIP), 1998-2003

The ESIP 1998-2003 constitutes an action-based approach to implementation of the education policies formulated in 1992, following publication of the Government White Paper on the Education Policy Review Commission Report of 1989 (MoES, 1998). The ESIP framework objectives for the planned period are to:

- make significant and permanent gains in achieving equitable access to education at all levels;
- improve the quality of education;
- enhance the management of education service delivery, and

- develop the capacity of the MoES to plan, programme and manage an investment portfolio that will effectively and efficiently develop the education sector (MoES, 1998).

Although the ESIP lays a good foundation for policy formulation in the education sector, HIV/AIDS issues do not stand out clearly enough. There is a need to clarify or incorporate more precise guidelines on HIV/AIDS issues with a view to strengthening the focus.

3.2.2 The HIV/AIDS Strategic Plan for the Education Sector, 2000/1-2005/6

The MoES has designed a five-year HIV/AIDS strategic plan to address the internal and external impact of the HIV/AIDS epidemic. The HIV/AIDS Strategic Plan for the Education Sector 2001 was designed to intensify the response to the HIV/AIDS epidemic in the education sector. Its major policy aims are to

- formulate a clear and binding policy that will promote prevention and mitigation of HIV/AIDS in the sector;
- develop and distribute guidelines and standards for the protection of school children against all forms of abuse, and
- enforce the existing policies and regulations regarding HIV/AIDS (MoES, 2001).

Implementation of the strategic plan has begun and is progressing satisfactorily, not withstanding the difficulties of creating and operationalizing a sector strategic plan in the absence of a comprehensive sector policy.

3.2.3 The Presidential Initiative on AIDS Strategy for Communication to the Youth (PIASCY)

In early 2002, His Excellency the President of Uganda, Yoweri Museveni, proposed a strategy to improve communication on HIV/AIDS to young people. The concern was that Uganda's past success in containing HIV/AIDS would be reversed if children and young people did not receive enough information. Under PIASCY, headteachers should address school assemblies on AIDS issues every two weeks. Other teachers then take the discussion into classrooms and clubs. This strategy takes advantage of UPE, through which almost all eligible children are enrolled in primary school and are, in theory, constantly available for HIV/AIDS education (MoES, 2003*c*).

The objectives of PIASCY are to:

- increase and sustain HIV/AIDS education for school children and other young people;
- increase the capacity of parents, teachers, and health service providers to engage in constructive debate with young people on HIV/AIDS;
- increase public debate on HIV/AIDS to support youth HIV/AIDS initiatives;
- identify, engage and increase the capacity of communities to assist young people in modifying behaviour that may increase the risk of contracting HIV/AIDS;
- engage law and policy instruments to support HIV/AIDS prevention initiatives for youth;
- foster networking among youth service organizations;
- train core personnel from different sectors on youth HIV/AIDS prevention;

- improve the delivery of services to young people, in collaboration with partners through 'youth friendly services', and
- mobilize resources for PIASCY.

PIASCY is a positive development towards the formulation of a sector policy on HIV/AIDS, as it provides a nation-wide strategy tailored to enhancing awareness and building the capacity of key actors in the education sector to respond to HIV/AIDS prevention issues. It directly targets pupils who are between the ages of 5 and 13 years (who, if reached early enough, may be seen as a 'window of hope' for the goal of achieving an AIDS-free generation), most of whom are enrolled in the UPE programme and also complements other initiatives, such as the School Health Education Project, which introduced life-skills-based HIV/AIDS education into the primary school curriculum. However, the content of the PIASCY handbook is still being reviewed in order to resolve the technical and administrative conflicts over the first edition.

3.2.4 The draft School Health Policy, 2003

The MoES developed the draft School Health Policy in collaboration with the United Nations Children's Fund (UNICEF) and the Ministry of Health (MoH). One component of the policy lays down strategies that can be used in controlling the spread of the epidemic among learners and staff. It also addresses the rights of learners and staff living with HIV/AIDS (MoH and MoES, 2003*a*; 2003*b*). However, this draft policy is still under review.

3.2.5 Circular Number 5, 2001

Circular Number 5 of 2001, from the Permanent Secretary of the MoES, directed all heads of educational institutions to initiate the formation of health or HIV/AIDS clubs as a means of addressing HIV/AIDS in the sector through peer education programmes. These clubs are aimed at empowering young people with information and knowledge about HIV/AIDS and equipping them with life skills for a positive change in attitudes, behaviour and practices. The circular also instructs the heads of educational institutions to support clubs in developing plans for addressing HIV/AIDS, which should then be submitted to the local authorities for funding. However, this directive has not yet been operationalized in all schools, with the result that support to the clubs is still inadequate.

3.3 Challenges to policy formulation in the education sector

Study findings indicate that the policy formulation process in the education sector has been slow because of a number of factors, which will be described below.

3.3.1 The project approach

Reviews of ministry reports indicate that SRH and HIV/AIDS activities in the school system have been underpinned by the project approach. Available literature and primary data from interviews indicates that since 1986, the MoES and its partners have designed and implemented several projects directed towards addressing the impact of HIV/AIDS. These projects include the School Health Education Project (1986), the Population and Family Life Education Project (1990-1996), Adolescent Reproductive Health Guidance and Counselling

(1997-2000), the IEC in support of Reproductive Health in Schools Project (1998), the Life Skills Initiative (1995) and the Curriculum Review (2000).

While such an approach undoubtedly has many points in its favour, it also has weaknesses, which should not be overlooked (MoES, 2001*b*). The major liability of the project approach is that it favours the implementation of disjointed, piecemeal activities that lack adequate coverage and, above all, lack continuity. It has also failed to foster an enabling environment for the development of a comprehensive policy framework. By focusing on single project achievements, technocrats and leaders at the ministry send the message that they are more interested in short-term gains than in laying down the foundation for long-term, sustainable policy development. As a result, capacity building has been a very slow process in the units mandated with policy development and analysis in the education sector.

3.3.2 Absence of a national policy on HIV/AIDS

In Uganda sector policies are developed on the basis of national policies. The absence of a national HIV/AIDS policy has therefore contributed to the slow progress towards the formulation of a sector specific policy.

> *"There is no national policy. So on what basis can you therefore formulate a sector policy?"*
>
> Senior official, MoES

3.3.3 The mask of unwritten informal policies

Interviews with officials at the central and local levels reveal that a number of informal policies and by-laws have been used to respond to the HIV/AIDS epidemic. These undocumented policies sometimes seem to work so well with the existing systems that the institutions responsible for policy development reach the point where they do not see any pressure or urgency for the development of formal policy instruments. Informal policies delay the formal policy formulation process by reducing the perceived urgency for policy development.

3.3.4 Difficulty in gaining consensus from other actors

Study findings clearly indicate that the process of policy development is consultative, participatory and bureaucratic. As a result, the policy-making process may seem daunting, requiring elaborate preparation and long-term, large-scale inputs of personnel, time and other resources. Sometimes it takes a long time to gain consensus on key policy concerns, which further stalls the process.

3.3.5 Inadequately developed systems

Interviews with study participants revealed that in a number of cases, it is individuals, rather than the entire system that drive the policy-making process. It follows that in the absence of such individuals, the whole process will stall. Structures need to be developed so that the system is less dependent on individual commitment and can sustain initiatives beyond the initial period of high interest and motivation.

3.3.6 Technical and resource constraints

There is insufficient technical, human and institutional capacity to undertake the task of policy formulation efficiently. The ministry unit in charge of policy formulation is under-staffed, under equipped and under-funded.

In conclusion, a comprehensive sector policy is required, whether on a stand-alone basis or supported by a national multi-sectoral framework, to address HIV/AIDS issues. Some steps have already been taken towards the development of a comprehensive sector policy, but this process has been slow due to limitations such as inadequate sector technical capacity, the absence of a fully developed national policy on HIV/AIDS to serve as a basis for the sector-specific version and the non-commitment of financial resources. In the resulting policy vacuum, various micro-policies have been developed and are being used, with varying degrees of success, at each level of the sector.

4. LEADERSHIP

President Museveni's admirable example of commitment and leadership in the national fight against the HIV/AIDS epidemic has led to efforts to integrate HIV/AIDS concerns into development plans in all sectors (UACS, 2000). This chapter will consider the role of leadership as an essential ingredient for the creation of a supportive policy environment to fight the effects of HIV/AIDS in the education sector. It is necessary to inspire a vision, articulate needs, and attract and mobilize vital human and financial resources.

4.1 Uganda AIDS Commission (UAC)

The UAC was established by Statute No 2 of 1992 to provide leadership in co-ordinating the multi-sectoral effort against HIV/AIDS in Uganda. Its priorities for intensifying action against the epidemic include stepping up political and civic leadership at all levels, by mobilizing and sensitizing leaders in government sectors, NGOs and CBOs, religious and cultural institutions, and the private sector to take up their rightful roles in combating the epidemic (UACS, 2000).

The UAC is a corporate body, presently composed of 18 members appointed by the President of Uganda. Members are drawn from government and non-government sectors, and include PLWHA and individuals who have been selected for their outstanding expertise and commitment to the HIV/AIDS struggle. It is located in the Office of the President, chaired by a full-time chairperson and serviced by a full-time secretariat.

The Uganda AIDS Commission Secretariat (UACS), established in 1990, is the technical and implementing arm of UAC. The UACS is headed by a director general who acts as the chief executive and secretary to the UAC and who is appointed by the President of Uganda. The structure of the UACS hinges on three directorates: Policy, Research and Development, which incorporates HIV/AIDS Information and Documentation; Planning, Monitoring and Evaluation, and Finance and Administration.

4.2 Ministry of Education and Sports (MoES)

The MoES has an HIV/AIDS sector co-ordinator, who is appointed by the Permanent Secretary to provide technical leadership on HIV/AIDS matters affecting the sector. The Commissioner for Secondary Education, who doubles as the HIV/AIDS Sector Co-ordinator, co-ordinates all sectoral initiatives, mobilizes the ministry and liaises with the UAC and other HIV/AIDS stakeholders.

HIV/AIDS FPOs – one for each of the eight departments of the ministry – assist the sector co-ordinator. The departments are: Pre-Primary and Primary Education; Secondary Education; Teacher Education; Business, Technical and Vocational Education; Special Education and Career Guidance; Higher Education; Education Planning, and Finance and Administration (see Figure 4.1). Each head of department appoints the HIV/AIDS FPO from

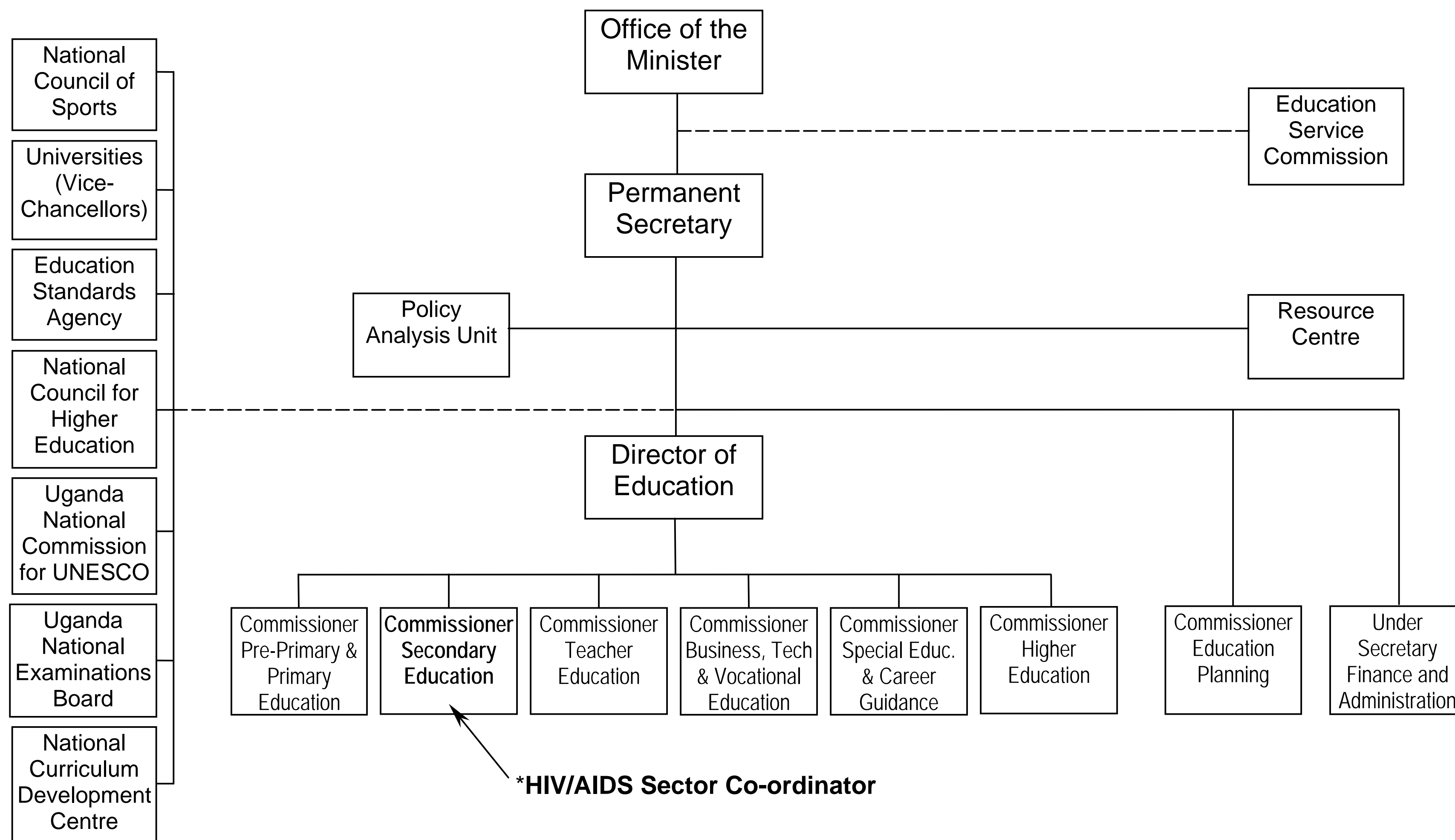
among the existing staff members, who then assumes the additional responsibilities of representing the department on any HIV/AIDS forum at the ministry and facilitating the integration of HIV/AIDS activities into the work plans of the department. FPOs also act as peer educators for their respective departments. Although FPOs meet when called upon, there is no clear indication that they function as a regular committee. It is also unclear whether the training that ministry and district level focal points receive is adequate in view of the tasks involved.

The relationship between the HIV/AIDS Sector Co-ordinator and the FPOs is critical for efficient HIV/AIDS leadership in the ministry. Since the HIV/AIDS Sector Co-ordinator and the Commissioner for Secondary Education are one and the same person, co-operation from fellow commissioners and FPOs, especially from other departments, depends more on goodwill than anything else. FPOs tend to deal first with their own commissioner's assignments, since they report directly to him or her, before attending to the HIV/AIDS Sector Co-ordinator, who they may simply view as a commissioner from another department. The missing link in the chain of command coupled with the 'add-on' nature of HIV/AIDS roles, weakens the sector leadership and, consequently, the success of HIV/AIDS initiatives.

With assistance from Irish Aid, the ministry has set up an HIV/AIDS unit of three full-time staff members, namely the Technical Advisor (TA), a secretary and a driver. The TA, who reports to the Permanent Secretary, provides support for policy, strategic planning, resource mobilization, and designing effective HIV/AIDS interventions for the education sector. If strengthened, this unit could provide the co-ordination office with more reliable support.

Study observations also reveal that there are gaps in the information management system. Although the MoES operates an EMIS, HIV/AIDS information is not being systematically collected or inputted. As a result, the current EMIS has a limited utility for planners attempting to incorporate HIV/AIDS concerns into the system. However, a strategy intended to rectify this situation is in the process of being designed.

Figure 4.1 Organizational chart of the Ministry of Education and Sports (MoES)

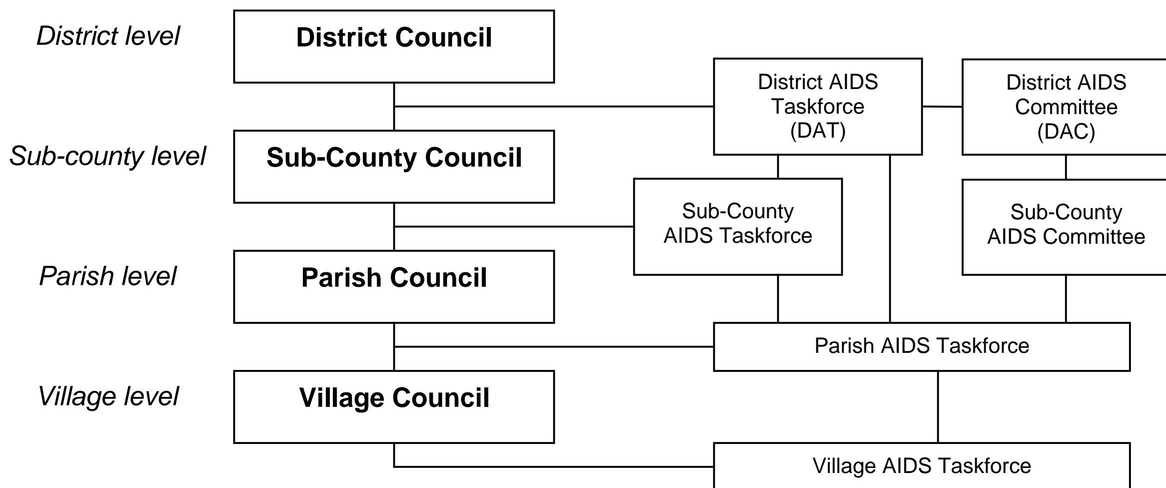


Source: MoES, 2002*b*.

4.3 Leadership at the district level

The district HIV/AIDS structure corresponds to the decentralized governance system and takes into account the political and technical aspects of operations at each level. The taskforces represent the political wing, while the committees provide technical support. Figure 4.2 shows the linkages at each level of the district HIV/AIDS structure.

Figure 4.2 Linkages in the district HIV/AIDS leadership structure



Source: UAC and National HIV/AIDS Partnership, 2002.

At the district level, political leadership is provided by the District AIDS Taskforce (DAT), of which the District Chairperson is the chair and the Chief Administrative Officer (CAO) provides the secretarial role. The DAT is composed of all of the members of the District Executive, the Resident District Commissioner, the Council Speaker and representatives from Civil Society Organizations (CSOs) and the private sector. DAT membership is variable but does not exceed 23 people.

The District AIDS Committee (DAC) is responsible for all HIV/AIDS activities in the district. It provides technical leadership and co-ordination through the monitoring and regulation of the activities of the key players in the district. DACs were formed as sub-committees of the existing District Technical Planning Committees, at the request of the UAC. The DAC is also chaired by the CAO, thus ensuring that the DAT and DAC (which acts are secretariat to the former) are strongly linked together on a human, as well as systemic level. The District HIV/AIDS FPO, who is selected by the CAO, acts as DAC secretary. The DAC is composed of all of the heads of directorates in the district government structure, including the DEO, and technical representation from CSOs and the private sector. DAC membership is limited to 23 people (UAC and National HIV/AIDS Partnership, 2002). The DAC reports to the district council, who then act on their recommendations.

The Sub-County AIDS Taskforce provides political leadership at the sub-county level. The Sub-County Chairperson chairs the taskforce and the Sub-County Chief acts as secretary. Membership is limited to 15 people. Responsibility for technical leadership at this level is assumed by the Sub-County AIDS Committee, which the Sub-County Chief chairs, mirroring

the organizational linkages outlined for the district level structures. The DEO nominates HIV/AIDS focal points from the pool of district inspectors of schools in charge of sub-counties, to ensure that the interests of the education sector are adequately represented at the committee. The composition of the sub-county committee is similar to that of the DAC, although it is slightly smaller, membership being limited to 15 people only.

The Parish AIDS Taskforce ensures leadership at the parish level. This is composed of 15 members, drawn from the executive of, and representatives from, the Parish Development Committee, CSOs and opinion leaders. It is chaired by the Parish Chairperson.

The Village AIDS Taskforce, which is chaired by the Village Chairperson, is the body responsible for political leadership at the most local level. It is made up of an executive council and opinion leaders. Membership is limited to 15 people.

4.4 Leadership at the institutional or school level

The headteacher assumes leadership on all HIV/AIDS issues arising in school. He or she nominates senior teachers to provide a guidance and counselling service to pupils and also nominates a staff member whom the BoG or School Management Committee appoints as HIV/AIDS Focal Point for the school. They then facilitate the formation and running of school health clubs. According to the MoES (2003*d*), an HIV/AIDS or health club is an association of learners, who come together under the guidance of teaching staff to carry out activities to prevent and mitigate the impact of HIV/AIDS, as well as to address other health-related issues.

Given the inter-linkages between health and education, the process of forming HIV/AIDS or health clubs calls for the involvement of a wide selection of participants. Involving many stakeholders in this way ensures that everyone understands, accepts and abides by the guiding principles set to facilitate the smooth implementation of the planned activities of these clubs. The clubs are diverse in nature – some are fully concerned with HIV/AIDS activities, whilst others integrate HIV/AIDS into more varied programmes, seeking to use practical activities as an entry-point for discussing the epidemic and its effects. The clubs are known by various names, including anti-AIDS clubs, health clubs, music, dance and drama clubs, debate clubs, Straight Talk clubs, first aid clubs, peer clubs, Youth Alive clubs, Interact clubs, Young Christians' Society, Red Cross clubs, readers' clubs, scripture clubs, writers' clubs, life skills clubs, Scouts and Girl Guides etc. (MoES, 2003*d*).

Highlighting the diverse nature and activities of school clubs, a study participant had this to say:

> *"We have the writers' club, which advises us on the dangers of HIV/AIDS through writing and gives career guidance education on issues related to HIV/AIDS. The debating club sometimes introduces a motion on HIV/AIDS awareness. The Christian group within the school emphasizes spiritual values geared towards changing our behaviour."*
>
> Secondary school student, Mubende District

Many clubs were formed in response to the MoES directive contained in Circular 5 of 2001, while those already in existence incorporated HIV/AIDS activities. Some clubs,

however, were not functional in some schools, due to ineffective leadership and guidance (see Tables 4.1 and 4.2). In this regard, a study participant observed:

> *"We have an AIDS club but it is not active. It was formed last term. This term we have not done anything about AIDS. Teachers did not tell us what to do. We need a teacher to come and tell pupils to join the club and the things to be discussed."*
>
> Primary school pupil, Mukono District

Lack of leadership and guidance was particularly common in primary schools, which on the whole boasted fewer clubs in general (see Tables 4.1 and 4.2).

Table 4.1 Types of HIV/AIDS-related programmes in the primary schools visited

District	Primary schools visited	Guidance and counselling?[2]	Other HIV/AIDS activities
Gulu	▪ Kirombe Primary School	Yes	
Iganga	▪ Kasokoso Town Council Primary School	Yes	
Kampala	▪ Makerere University Primary School	Yes	Music and drama club
Kasese	▪ Base Camp Primary School	Yes	
Kumi	▪ Mary Macleese Primary School	Yes	
Mubende	▪ Kaweeri Demonstration Primary School	Yes	Music and drama club
	▪ Mityana Public Primary School	Yes	Debate club; writers' club; Scouts; music and drama club.
Mukono	▪ Bishop's East Primary School	Yes	Anti-AIDS club
	▪ Kazinga Moslem Primary School	Yes	Music and drama club

[2] In all cases, guidance and counselling services are provided by senior teachers.

Table 4.2 Type of HIV/AIDS-elated programmes in the secondary schools visited

District	Secondary schools visited	Guidance and counselling?[3]	Other HIV/AIDS Activities
Gulu	▪ Layibi College	Yes	Straight Talk club; Scouts; debating club; Young Farmers club.
	▪ Sacred Heart Secondary School	Yes	Interact club; Youth Alive club; Straight Talk club; Girl Guides; debating club; drama club.
	▪ Gulu Central High School	Yes	Red Cross club; writers' club; wildlife club; Straight Talk Club.
Iganga	▪ Bukoyo Secondary School	Yes	Anti-AIDS club; drama club.
Kasese	▪ Bwera Secondary School	Yes	Debate club; drama club; anti-AIDS club; Straight Talk club.
	▪ Kilembe Mines Secondary School	Yes	
Kumi	▪ Wiggins Secondary School	Yes	Anti-AIDS club; first aid club.
Mubende	▪ Kasenyi Secondary School	Yes	Music and drama club; life skills club; Programme for Enhancing Adolescent Reproductive Life .
	▪ Mityana Secondary School	Yes – counselling club	Writers' club; debate club; drama club; teachers' welfare scheme.
Mukono	▪ Mukono Bishop Secondary School	Yes	Anti-AIDS club; scripture club.
	▪ Nagalama Secondary School	Yes	Peer-to-peer club; anti-AIDS club; drama club; Youth Alive club; Interact club; Young Christians' Society; Red Cross club; Mary Teresa club; Generation Next club; Righteous club; readers' club.

In almost all of the schools visited senior male and female teachers perform general counselling duties, including dealing with HIV/AIDS and other SRH issues. The choice of the senior teachers is not in effect based on any kind of seniority (e.g. teaching experience or age), but rather on the perceived competence of the teacher to help learners with their psychosocial needs.

[3] In all cases guidance and counselling services are provided by senior teachers.

The study revealed that counselling and guidance tasks are often additional responsibilities, for which there is no extra remuneration. Findings also show that senior teachers frequently do not posses adequate counselling and guidance skills, especially in relation to HIV/AIDS and other SRH issues. This trend was evident across the districts and schools visited, as highlighted by the following quotes:

> *"We put up senior female and male teachers but their services are inadequate and inefficient. They do not know what to do and how to do it. They need a lot of capacity building to be able to deliver.*"
>
> Headteacher, Mubende District

> *"We don't have the basic skills in counselling. We are just gambling. It makes it hard to help these young children."*
>
> Teacher, Mukono District

> *"We do not have qualified counsellors, especially in that area of HIV/AIDS. We just use our general knowledge about what may be counselling and guidance."*
>
> Headteacher, Kasese District

Some districts are aware of the inadequacy of counselling and guidance services. As a result, they have taken steps to mobilize resources towards improving them.

> *"We are soliciting a training package of about 15 million [Ugandan] shillings . We have 14 sub-counties and one town council. So if each sub-county got a counsellor trained by [The AIDS Support Organization] TASO at a cost of about 1 million [shillings], then we would have counselling as a strategy in the department."*
>
> District Education Official, Kyenjojo District

Therefore, HIV/AIDS is an additional responsibility for officials at all levels of the education sector. Sector leadership has focused more on learners; very little has been done to date to address the needs of infected and affected teachers. Though the current EMIS does not produce comprehensive HIV/AIDS information, the process is underway to incorporate HIV/AIDS information into the system.

5. ADVOCACY RESPONSES

This chapter will examine the advocacy mechanisms and practices that are employed at the central and local school levels, and the bureaucratic challenges faced in the art of advocacy for HIV/AIDS prevention, mitigation, care and support in the education sector. In order for policy and leadership on HIV/AIDS to be effective, there is a need for a strong advocacy strategy.

5.1 Advocacy at the ministry level

In response to the impact of the HIV/AIDS epidemic on the education sector, the MoES has developed a number of advocacy tools to enhance policy and leadership interventions. Directives, circulars and 'loose minutes' (i.e. occasional announcements) are used to channel policy information and administrative decisions relating to HIV/AIDS. Circulars are regularly posted on MoES notice boards and loose minutes are used as an iterative communication mechanism to facilitate dialogue between ministry staff on issues of concern. Much as circulars and loose minutes are instrumental in the pursuit of the HIV/AIDS agenda, delays in their dissemination can be encountered, thus reducing their efficacy and impact. At times they reach officials too late for timely action, as this quote from a senior management official illustrates:

> "*We inform them of the relevant circulars issued, but there could be some communication gaps between the ministry and the schools, and the headteachers, teachers and learners in the school. In practice, headteachers pick [up] these circulars themselves from the ministry, but of course others do not.*"
>
> Senior official, MoES

IEC materials are used by the MoES as a mechanism to disseminate information and create awareness on HIV/AIDS-related issues in the education sector. Efforts have been made to produce IEC materials, which include the PIASCY handbooks, booklets on facts and myths about HIV/AIDS, the Youth Survival Kit (composed of seven booklets) and posters conveying basic facts about HIV/AIDS. These are supplemented by videos, which are shown to staff and learners.

The production and distribution of IEC materials is an integral part of the MoES response to the impact of HIV/AIDS. However, although the benefits of using IEC materials as an advocacy tool can be seen in some schools, not everyone can access them as the distribution of these materials is inadequate. For example, only 30 PIASCY handbooks have been distributed to each primary school throughout the country. This is a very small quantity, when compared with the number of teachers and pupils involved. Furthermore, some schools in Gulu district reported that they did not even have the basic survival kit.

> *"There are some handouts that were issued from Lacor hospital and [the] Straight Talk Foundation. They are not adequate but we reproduce them from here. We have never received the youth survival kit from the ministry."*
>
> Headteacher, Gulu District

In addition to these distribution issues, some district officials have pointed out that there are more fundamental problems with some of the IEC materials: the messages that they contain are sometimes misleading on basic facts on HIV/AIDS.

> *"We have ... stopped some printed IEC materials from circulation because the messages were misleading."*
>
> Participant, Validation Workshop

Some DEOs and headteachers have intervened to verify the contents of materials before they are disseminated. Doing this on a larger scale, however, to ensure countrywide parity in the quality of production, distribution and dissemination of IEC materials, creates many co-ordination challenges.

Some NGOs, like the Straight Talk Foundation, work in partnership with the MoES and are instrumental in the production and distribution of HIV/AIDS IEC materials. For example, the Straight Talk Foundation produces *Young Talk*, *Straight Talk* and *Teacher Talk*, all of which promote different awareness messages and tackle different themes. These newsletters are distributed to schools for the benefit of both staff and learners.

Workshops and seminars organised by the MoES are used as tools for consultation, sensitization, training and dissemination of information on a wide variety of subjects of relevance to the education community. HIV/AIDS constitutes a new phenomenon in educational planning, so many workshops and seminars with a variety of objectives and targets have had to be organised to address issues arising from the effects of the epidemic on the sector. Interviews held with ministry officials indicate that although workshops can be a very effective tool for approaching the HIV/AIDS problem in the education sector, the content and coverage of the sessions create many challenges. For example, to date workshops have catered more to sector managers; little attention has been paid to the support staff, teachers and learners who have such an important contribution to make and who are so vital to the sector.

5.2 Advocacy at the district level

At the district level, a number of different forums have been launched to promote advocacy for the mitigation of the effects of HIV/AIDS in district structures and in schools and institutions. The DAC, of which the DEO is a member, co-ordinates the implementation of all district HIV/AIDS-related activities.

District HIV/AIDS partnership forums have been established to bring together all HIV/AIDS stakeholders in the district, with the purpose of broadening participation and sharing information, knowledge and experience on HIV/AIDS. The forums provide additional channels for linking to the national-level response. At the same time, much emphasis is placed on creating a decentralized response, through focusing on locally generated knowledge, in relation to experiences from other areas. The partnership forum convenes once a year and is used to identify DAT and DAC members. It brings together government ministries, United Nations agencies and bilateral agencies, PLWHA, the private sector, national and international NGOs, Faith-Based Organizations and researchers.

5.3 In-school advocacy

As already discussed, advocacy responses filter out from the centre where they were developed, to the districts and eventually into schools.

At the school level, the headteachers' HIV/AIDS forum brings all of the headteachers in the respective district together and is central for developing strategy and following up on HIV/AIDS-related issues arising from school management. Parent-Teacher Associations also provide an advocacy forum for teachers and parents in government schools. Private secondary and primary schools are excluded from the Parent-Teacher Association arrangement.

As outlined in the preceding chapter, school clubs are engaged in HIV/AIDS activities, with the guidance and support of the districts and the ministry. Club activities include regular HIV/AIDS and health education programmes, drama and songs with HIV/AIDS themes, shows and exhibitions on HIV/AIDS activities, educational visits to allow pupils see the effects of HIV/AIDS, talk shows and debates, the production of posters and IEC materials, child-to-child information sharing, club visits and the in-school promotion of basic messages on HIV/AIDS. The following quotes give a flavour of the importance of in-school clubs, their underlying strengths and the challenges that they face:

> *"The drama club in the school has a great role to play in AIDS awareness since plays have been acted on HIV/AIDS prevention and care. Because of such plays we no longer discriminate [against] infected persons. The health club also plays a big role in the school because some of its activities emphasize protective ways to live and there is a focus on AIDS. Many of us have greatly benefited from such preventive activities."*
>
> Student, Mukono District

The districts, through regularly organized competitions that emphasize HIV/AIDS themes, support some club activities. These include drama, music, debating, etc. Sometimes competitions are planned up to national level.

> *"There is a small vote for control of HIV/AIDS of about 3-4 million [shillings]. The department also receives a little funding from the UAC. This money is to support sensitization seminars for pupils and teachers and support for music, dance and drama competitions in schools."*
>
> Education Official, Mukono District

In Mukono District, headteachers highlighted the importance of the HIV/AIDS clubs in disseminating information to learners, but some also cited the inclusion and exclusion criteria of the clubs as a limiting factor. Membership is voluntary and attendees are self-selecting, which means that a relatively small number of learners attend the clubs and have the possibility of deriving benefit from them.

> *"The school has an anti-AIDS club through which a lot of messages are passed on to other students. However, it is just a small section of students who benefit from these clubs, [in other words, only] those who are members."*
>
> Headteacher, Mukono District

5.4 Challenges of advocacy

Study findings indicate that advocacy forms an integral part of HIV/AIDS activities in the MoES. Several advocacy tools have been developed within the frameworks of the ministry, the districts and the UAC. Although these tools have been effective, the MoES has made relatively few attempts to formulate a comprehensive advocacy strategy for the sector – a necessary instrument for effective policy and leadership for HIV/AIDS interventions. In fact, advocacy is used like a general catchword, associated with any form of awareness creation. It therefore lacks depth and focus and has a limited utility beyond merely creating awareness of some of the issues.

Because there is no comprehensive advocacy strategy, commitment and follow through are lacking. The often scattered and un-coordinated efforts to promote awareness and behaviour change have caused 'AIDS fatigue' among target audiences. Some actors have developed a 'hear and go', 'talk and vanish' attitude, which presents a challenge in terms of developing long-term, sustainable strategies for the education sector. In many ways so much has already been done, but at the same time very little has been done to follow up and maximise those advances.

Although some school libraries were stocked with reading materials on HIV/AIDS, a few respondents asked researchers for HIV/AIDS books – to our minds a clear indication that not enough relevant reading material is reaching the target group. IEC materials that have been produced by the ministry, such as the PIASCY handbooks and the Youth Survival Kit, have been inadequate in quantity, thus limiting the potential that they have for influencing behaviour.

The MoES and other partners have been keen to exploit a wide range of advocacy channels in the fight against HIV/AIDS. However, learners cannot easily access them all. In many schools visited, regulations do not permit the use of televisions or radios; to be found in possession of one would lead to serious punishment. As a result, the messages that are disseminated on HIV/AIDS through electronic media frequently do not reach the intended target group.

The existing mechanisms (i.e. workshops and seminars) for the sharing of information with other beneficiaries in the sector are weak. Workshop and seminar outputs would seem to reach a limited number of beneficiaries and it is the lower level support staff that are most usually excluded. An effective mechanism needs to be found to ensure dissemination and follow-up of workshop and seminar outcomes to and with all of the key actors in the sector.

6. OTHER RESPONSES TO HIV/AIDS IN THE EDUCATION SECTOR

This chapter will examine other responses to the HIV/AIDS epidemic in the education sector besides policy, leadership and advocacy. It will be demonstrated that the former assume a far greater significance in the absence of a comprehensive sector policy. The chapter will consider curriculum interventions, co-curricula activities, condoms, personnel issues and how sector staff have been trying to cope with the effects of the epidemic in the workplace. Attention will also be given to orphans, stigma and discrimination, guidance and counselling and the contribution of the teachers' unions.

6.1 Curriculum interventions

Study participants praised that fact that HIV/AIDS has been integrated into the primary school curriculum and highlighted the importance of doing the same for the secondary school curriculum. A secondary school curriculum that addresses HIV/AIDS is currently being developed. Although participants were generally positive, many did express concerns that HIV/AIDS should not overshadow important subjects and lead to overcrowding of the school timetable.

> *"The new curriculum has integrated aspects of HIV/AIDS. You can teach social studies but in it you integrate aspects of HIV/AIDS. The curriculum is a good tool to fight the problem."*
>
> Education official, Mukono District

> *"We don't have a clear curriculum on HIV/AIDS and because of that we miss a lot of information which may be of great importance to us. In this school HIV/AIDS is taught from Senior 1 to Senior 3 as part of their lessons. [Pupils in] candidate classes[4] are regarded as being too busy to attend these lessons."*
>
> Student, Mukono District

Study respondents were also concerned about the complexities involved in handling the subject, such as the level at which to introduce the subject.

> *"AIDS has many complex components. People must change their way of reasoning and ways of looking at things. Bringing about behaviour change has to be done step-by-step. AIDS education must be in the syllabus right from primary up to tertiary institutions because at secondary level, we receive students who are already infected. So even if you start AIDS education in Senior 1, we still have problems coming from primary schools."*
>
> Teacher, Kasese District

A study participant made the following suggestion, which suggests that some teachers tend to regard PLHWAs as separate and different from 'normal' people:

[4] Candidate classes are Senior 4 and Senior 6, i.e. those that are preparing for Ordinary Level and Advanced Level examinations.

"I would propose that [the] government declare people with HIV/AIDS as people with special needs. [The] special needs education curriculum should incorporate components on people living with HIV/AIDS."

Teacher, Kasese District

There is no general consensus on how best to approach HIV/AIDS in the curriculum. Furthermore, interviews with primary school headteachers indicated that curriculum messages on HIV/AIDS lack breadth and are focused too much on the scientific or medical aspects of the epidemic. One of them had this to say:

"I want HIV/AIDS addressed separately other than being part of science. If you put it under science, it covers little on each topic. The curriculum is not yet broad enough to cover all the important things. It does not provide for the messages to be delivered down to the people for practical purposes. I wish the curriculum could even involve the community."

Headteacher, Kumi District

In order to address some of these gaps, a Life Skills Planning Education (LSPE) curriculum was designed and is being piloted in selected schools. The new curriculum stipulates that HIV/AIDS should be taught as a separate topic – i.e. LSPE.

In view of all of these curriculum changes and the concerns raised by staff, the findings suggest that there is a need to re-train teachers, so that they are better informed, more comfortable talking about sensitive issues and can deliver the new curriculum components more effectively.

6.2 Co-curricular activities

Peer education was found to be an effective strategy for the dissemination of HIV/AIDS information at central, district and school levels. However, the concept of a peer educator was understood differently at the different levels. In addition, findings revealed that some peer educators do not have adequate knowledge on matters relating to HIV/AIDS and the psychosocial needs of their peers because of limited access to information. In order to achieve a higher level of uniformity, the concept of peer education needs to be clearly defined and the capacity of peer educators needs to be developed so that they can carry out their role more effectively.

It was established that club members who play the role of peer educators are not adequately facilitated and guided by the school administration, leaving them feeling unsupported. Furthermore, a rigid and packed timetable means that HIV/AIDS education runs the risk of being squeezed out and sends the message that HIV/AIDS is not prioritized over other key subjects:

"HIV/AIDS is being dealt with by different clubs. However, the problem has been how to make the activities of these clubs fit into the school timetable."

Headteacher, Mukono District

6.3 Condoms in schools

The issue of condoms in schools is very sensitive and emotive. In the absence of an unequivocal ministry position, teachers deal it with in many different ways, although most education managers prefer a moralistic to a pragmatic approach to the issue. Schools frown upon sexual activity among learners and have in some cases expelled students found in possession of condoms, which are widely thought to promote promiscuity.

> *"When a student is found with a condom, he [or] she is just expelled. Being in possession of a condom is a sign that one [has the] intention of having sex."*
>
> Teacher, Mukono District

However, although the ministry emphasizes the importance of abstinence, it does not support punishing students who posses condoms.

> *"In the 1980s, if you found a child with a condom obviously he would be expelled from school. Now it is not the case. It can be bearable if you found a person with a condom in a [school bag]. I will not, however, provide them in … school. If a child is found with a condom in a [school bag], obviously I [would] be interested to find out what this condom is for."*
>
> Headteacher, Iganga District

> *"I do not allow condoms in schools because the message to young people is that they should abstain from sex."*
>
> Senior management official, MoES

> "*We do not encourage condoms because the temptation of sex is higher at any time. As a school we encourage students to abstain. If we get students with condoms, we talk about it in the school assembles and we counsel them.*"
>
> Headteacher, Gulu District

Faith-Based Organizations are very influential in Ugandan education, particularly at the secondary level, where many BoGs represent religious denominations. Some schools do not support condom distribution to learners on religious grounds, although some staff do realize the importance of using condoms, as the following quote illustrates:

> "*This being a Moslem institution, condoms are not allowed. I am of the opinion that pupils should be given condoms for their safety. There was a case for instance when a girl and a boy indulged in sex. They did not have a condom and admitted that they had used a polythene bag.*"
>
> Teacher, Mukono District

> *"All government schools are positive about condoms, but faith-based schools are indifferent."*
>
> Senior official, MoES

Although the majority of headteachers questioned were strongly against, or at best, ambivalent towards condom distribution in school, a few did admit that they believe that it is unrealistic not to allow sexually active learners to use condoms.

"I think the use of condoms [by] students … is essential. Controlling nature is a bit difficult and therefore somebody who wants to engage in sex in these deadly moments should be encouraged to use condoms."

Headteacher, Gulu District

The distribution of condoms can also lead to dissention between schools and other stakeholders, for example, NGOs. Many NGOs are in favour of the promoting the use of condoms amongst young people and many actively distribute them in schools.

"[The] MoES has no systematic programme on condom distribution. Many of the condoms find their way into schools through NGOs."

Participant, Validation Workshop

Condoms are distributed to staff at ministry headquarters. However, the supply is inconsistent and the adequacy of the distribution mechanism needs to be reviewed.

6.4 Personnel issues

The MoES currently follows the generic public service personnel policy. This policy was developed many years ago, however, and does not make any provision for HIV/AIDS-related personnel issues. The MoPS is aware of this and is undertaking a policy review, in collaboration with stakeholders, specifically to integrate HIV/AIDS concerns in the civil service reform. The revised human resource management policy, which is still in draft form, highlights key guiding principles, drawing upon the International Labour Organization (ILO) code of practice on HIV/AIDS and the world of work (ILO, 2001), which aims to safeguard decent working conditions and protect staff rights.

Until this reform exercise has been completed, education managers have no clear mechanisms for catering for teachers who are infected or affected by HIV/AIDS. However, study findings show that each school has developed its own unwritten modalities and practices. These informal arrangements take the form of ensuring job security, granting transfers, workload sharing, hiring relief staff on extra-budgetary resources, special leave arrangements, etc.:

"There is no specific policy for teachers living with HIV/AIDS. We are working based on sympathy and consideration. It is relative [to the] capacity and creativity of the heads of the institutions. There is no formal arrangement."

Senior official, MoES

"Welfare issues are left to heads of departments. Due to resource constraints, ad hoc but informal arrangements are made through the heads of department. For example, a staff member may be given one or two nights' allowance to buy drugs, fruit, etc. Besides [these school-led activities], individual staff members, or even groups, contribute on their own initiative to assist a colleague."

Senior official, MoES

"If a staff member gets sick, we give him [an] advance to get treatment. If it exceeds the staff member's income the school can meet some of the medical expenses. This may not be much because we are operating on a limited budget. The problem with HIV/AIDS is that it is a chronic illness and it is on and off. It is only when [it reaches an] advanced stage that one leaves work."

Headteacher, Mubende District

"The school has been supportive [of] staff members with long illnesses. Their salaries are not interrupted. Sometimes, a teacher is called in to assist [to] reduce the workload of a sick colleague."

Teacher, Mukono District

"Support is offered on [an] individual basis. There is a private scheme arrangement that can support a member in [the] form of provision of medical care, burial costs in case of death and other needs. Some money – about 1 United States dollar (US$) – is deducted from each staff member per month as a contribution to the teachers' welfare account to cater for such problems or emergencies. The school, through the BoG, may come in to provide a coffin and the school truck can be used to provide transport to the ancestral home of the deceased staff member or pupil."

Teacher, Mubende District

"The school took the responsibility of meeting the cost of all burial expenses. The school management decided to pay the bereaved family [the dead staff member's] salary for three months. She had two brothers who were students in this school. The school management decided to take the responsibility of supporting the two boys. This came as our personal arrangement, having looked at what she did and the long service she had given to the school."

Headteacher, Gulu District

"HIV/AIDS is a big problem. We lost nine teachers since 1990 from the disease, including three secretaries and two librarians. They were very good teachers. As I speak now, some teachers are suffering from HIV/AIDS. One of them is unable to teach now because he is ailing. AIDS has affected this college on both the teaching and non-teaching side."

Headteacher, Gulu District

The staff recruitment policy set by the ministry does not allow the recruitment of a new teacher until there is a vacancy. This has increased the workload of the teachers, because those suffering from long illnesses are still officially in post, so cannot be easily replaced.

"Due to [a] staff ceiling, we no longer have stand-by teachers in Uganda. In most cases if a teacher is sick or absent, other colleagues will assist in teaching that class."

Education official, Kyenjojo District

"There is [a] need for the government to lift the ban on staff recruitment. When need arises we advertise, but recruitment takes some time and the teachers are already overloaded. There is always a gap. We have a personnel officer in charge of teachers only. We have decentralized the inspectorate up to county level. They report back to us."

Administrative officer, Mubende District

There is no formal arrangement concerning access to medical care for staff and learners living with HIV/AIDS. Some school administrators suggested that schools should assist staff living with HIV/AIDS to meet the cost of antiretroviral (ARV) drugs:

"As a board we have not thought about the provisions of ARVs to our teachers, but it would be a good idea if the school could at least come in to assist, since teachers get peanut salaries."

School BoG member, Mukono District

Some schools do offer support with medical care for infected teachers. They also grant them sick leave and reduce their workload. All of this has a huge financial impact on the affected school and on the education sector in general.

> *"In most schools it is the responsibility of the school to look after the sick teachers. The school gets into financial constraints because of the disease."*
>
> Headteacher, Mubende District

In addition to providing financial support to infected staff and their families and paying the salaries of absent teachers (see quote below), money has to be found to pay for the training of replacement personnel. It is not known how much is spent in this way, a fact that further complicates planning and management of teachers and staff affected by HIV/AIDS.

> *"There are about 28 sick teachers (out of 1,519 in the district) during any one month who do not work but who receive full salaries. Each is paid a salary of US$55 per month. For 28 teachers, this costs the district about US$1,600 per month or US$19,200 per annum."*
>
> Education official, Kyenjojo District

6.5 Stigma and discrimination

Stigma and discrimination are major challenges to achieving fair treatment for education sector staff living with HIV/AIDS. In the past, teachers who were suspected of being HIV-positive were discriminated against in many different ways (see case studies for examples). It was also observed that teachers living with HIV/AIDS are often depressed and suffer psychologically due to the negative social perceptions directed at those infected:

> *"The other problem the HIV/AIDS positive teachers have is psychological. Besides that, the people, the society, pupils and the community in which he lives looks at him as a sick person."*
>
> Official, Uganda National Teachers' Union

Non-discrimination has been highlighted as a central feature of Uganda's official response to the epidemic. However, study findings reveal that rejection of teachers living with HIV/AIDS *does* happen. The following three case studies highlight the contexts in which HIV/AIDS-related discrimination among teachers takes place, including the causes and forms of rejection and sources of stigma.

Rejection takes many forms and arises for many reasons. In Mary's case (Case Study 2), she faced rejection and was forced to leave her job because she openly admitted that she was HIV-positive. According to her headteacher, by staying in school Mary was exposing the children to possible infection. John (Case Study 3) also makes the point that it is only people with 'nothing to loose' that can admit to being HIV-positive. Those with jobs cannot risk being discriminated against in this way. The fear of this form of rejection has other repercussions; some teachers living with HIV prefer to leave of their own accord, rather than opening themselves to the possibility of being fired. Jane (Case Study 1) resigned from her job, because she feared possible stigmatization and rejection once people started to notice her symptoms.

Case Study 1 Jane

I am a Grade 5 teacher by profession, teaching 'O' ['Ordinary'] level. I am 35 years old. I was diagnosed [as] HIV-positive in November 1998 at the AIDS Information Centre . I am a widow with one child. I started teaching in 1991 and ceased teaching in 1999 when I joined counselling [at the AIDS Information Centre]. At that time I started developing [a] skin rash. So I decided to quit before the students could start noticing the rash. I was not sacked. The excuse I gave was that the school was not paying me well, but my hidden motive was [that] I had already started showing signs of AIDS. So I had to quit.

For me I was not affected much. The experience I want to [share] is about my friend. He was also teaching 'O' level in a private mixed school. I used to visit him and he would tell me about the problems he was facing. It reached a time when he felt that the administration was allying with the students to stigmatize him. Whenever he entered class for a lesson he would find pictures of him on the blackboard. When he tried to punish the students, it became worse. The students could mock him and laugh at him whenever he was passing by. He took the matter to the administration, which did not do anything. So he felt that the administration was colluding with the students. The school ceased paying for his house rent. Whenever he asked for 'off duty' [time] in order to go for treatment, the administration would either refuse to grant him permission or it would deduct that day from his pay. The administration imposed harsh conditions on him after realizing [that] he is HIV-positive. For example, they would put him on heavy duties such as guarding the students at night, yet the watchman was also there. They put him on duty throughout – day and night. There was one time when he was very sick and he spent five days without going to … school. The students collected condolence money and kept it in a chalk box. So when he later reported and entered the class, he found it placed on his table with a note saying, "Condolence money. We thought you had died".

In the most extreme cases of dismissal, teachers may not simply loose their jobs; as Mary discovered, they can even be denied the salary and benefits that they had already earned. In Mary's case, her superiors also ensured that she was forced to leave in as humiliating and public a manner as possible, thus ensuring that rejection spread to her family as well. Mary's children, for example, lost friends because of the perception that they too were probably infected.

Teachers that are permitted to stay at school may still suffer rejection and stigmatization. Thus, Jane's friend was harassed by pupils, who even organized condolence money, suggesting that he was as good as dead, and was shunned by the school administration, who denied him leave to seek treatment, cut his salary and assigned him demanding tasks.

Case Study 2 Mary

I was a nursery school teacher in Kampala. I joined the school after I lost my husband. But I did not know [that] I was HIV-positive. I started falling sick frequently and I was on and off from school. After being advised by a friend, I took [an] HIV-test and the result was positive. I decided to join the post-test club. This is a club for people who are HIV-positive and [who] give their experiences on HIV/AIDS. I started going out and giving testimonies about myself. The staff at school did not know about my status. So one day we had a meeting at the Constitution Square about HIV/AIDS and one of the teachers at school was there. When he went back, he reported to the headmaster. So when I returned the following day, I found different faces. The headmaster was so rude. He called me to his office and asked me, "Where were you yesterday?" I wondered why he was asking me. So he told me, "You are HIV-positive. Don't you know you can infect these children? Why didn't you tell us that you are HIV-positive? We would not have even employed you. Why are you here?" He quarrelled until I left his

office and went away. Other teachers were telling the children, "Auntie Mary is positive. She has AIDS, she is going to die and she can even infect us". It was really terrible for me. I went home early that day and I did not teach. After three days, I went to school. The headteacher called an assembly. All children were called. He said, "From today … Auntie Mary is no longer your teacher. She is sick. She can even infect you. Do not share anything with her". He said all that while I was … standing [there]. I felt like collapsing because I did not expect it. I was friendly to the children. They loved me so much. Then he told me, "Can you please leave the compound now? I don't want you". I told him, "Now you are sending me away, what about my salary?" He said, "I am not even going to pay you. Why should I pay you? You will come back next week". I went out crying. The young kids, when they went back home, told their parents, "Our teacher [has] AIDS". It was a concern for everyone. I was still staying in the same place. It even reached my parents. Well, they knew [about] my status but it was confidential. It was between my family and me. When people came to know about it, I lost friends. My children also lost friends. They used to tell them things like, "Your mum is HIV-positive. She has AIDS. You might even be having AIDS also. We cannot eat anything from your place". It was really terrible. I thank God that I coped with it.

After a week I went back. He [the headmaster] said, "Mary, you have come back here? Do you want to spread AIDS to us?" He told me, "Leave this place. I will bring your money to your place". I was thinking, I had lost a job, I am a mother of two children and no partner to assist, how would I manage? So everything was hard for me. Fortunately, the post-test club wanted reproductive health service providers. Since I was a member of the post-test club, the club organised training for me and I started giving the service. I even forgot everything he [the headmaster] did to me. Unfortunately last year, the same headmaster came when he was sick. He had come for an HIV-test. When I saw him I wondered. I asked him, "Mr Mukasa, how are you?" He answered, "Things are not good. I have problems". He even wanted to hide from me, but because I saw him first he [could do] nothing [about it]. He took the test and he was found to be HIV positive. He is now bed ridden and not at school. The headteacher is also positive. I think he remembers how he treated me and what he did to me.

The case studies also show that stigma and discrimination arise from many sources. For teachers the most immediate sources are learners and fellow teachers. Jane's friend, for example, was mocked and laughed at by students. The administration and fellow teachers apparently did nothing to avert the situation. Mary too suffered discrimination from fellow teachers, and most especially, the headteacher.

Often another source of stigma is the HIV/AIDS victim him- or herself. This is sometimes called 'self stigma' and it can be just as destructive and hard to root out. An example where self-stigma is evident is that of Jane, who felt that she must leave her job before the signs of AIDS became too obvious.

The wider community offers yet another far-reaching source of stigma and discrimination. In Mary's case, learners living in her neighbourhood told their parents about her condition, with the result that both she and her children lost friends.

Case Study 3 highlights the fact that knowledge does not automatically lead to behaviour change. Commenting on the HIV/AIDS warning messages on Radio Uganda, John admitted that he and his friends would often turn off the radio so that they would not have to hear them. The design of the radio message was apparently not appealing or informative to John or to many others. Part of this particular message stated: "Beware of AIDS. AIDS kills." In addition, John possibly felt that he already knew the information in the message and that it did not apply to him, although he did admit later on that even at the time that his wife died, he had little concrete information about HIV/AIDS.

The case study also demonstrates that cultural beliefs and practices are still strong amongst people in Uganda. John was convinced that his wife had died of something other than AIDS. He preferred to believe the pronouncement of a witchdoctor, who said that his wife had been bewitched, than to admit to the alternative possibility. This indicates that teachers, and indeed many other members of the population, are reluctant to seek help because they are in denial. In a further illustration of this, John says his friend told him that herpes was associated with HIV/AIDS. However, John 'rubbished him' saying that he was an upright man, despite his earlier admission of his reckless lifestyle.

Case Study 3 John

I was brought up in a staunch born again family with restrictions. My childhood was characterised by fear and total submission. I was caged until … I joined a boarding secondary school in 1972. This marked the time of liberation and exploration of what I had previously missed. I lacked sense of direction and failed to control my social life. Drinking, smoking and sex were habits I lived to regret. That was the time when HIV/AIDS was spreading like a bush fire. We didn't know much beyond the morning, midday and evening drum on Radio Uganda sounding a warning about AIDS. That sound used to irritate us and many times we [w]ould switch off the radio soon after the news to avoid that drum sound. Out of 10 to 15 members of our drinking club, only three are still alive. The rest died in [the] early 1990s of AIDS.

In 1979, I graduated as a teacher. I married in 1986 and my life changed completely. However this could not change what I had already done. In January 1988 our baby boy was born amidst poor health of the mother. We thought that being her first child that was the reason she experienced adverse health conditions. However, once in a while she [w]ould mention to me her fear of AIDS, a fact I used to ignore since I never had sex outside marriage. She was expecting our second child in December 1989 when she developed herpes zoster. We didn't suspect anything related to AIDS. As I was discussing with a friend about the health condition of my wife, he wondered whether I was safe since herpes zoster was associated with HIV/AIDS. I rubbished him, saying that I was an upright man and did not cheat on my wife, so there was no way we could be infected. Our second child died of pneumonia after four months. In March 1993 my wife gave birth to our third child. After that her health steadily declined and she died nine months later, in 1994, with full-blown signs and symptoms of AIDS. None of us was a virgin by the time we met so one of us or both of us were already infected at the time we married.

After my wife's death I went to see a witchdoctor, who told me that my wife didn't die of AIDS but that a certain woman bewitched her. I believed that revelation from the witchdoctor when I linked it with what my wife used to tell me concerning that same woman. I must confess that by that time I still had little information about HIV/AIDS, not until March 1998 when I developed severe herpes zoster. This experience confirmed to me what a friend had previously told me. I had to go for a confirmatory test. Indeed I was found [to be] HIV-positive. I shared my results with close friends and they were supportive. I was initiated to the [Kampala branch of the] post-test club … which started preparing me for positive living. I was later trained to offer on-going supportive counselling in the post-test club as a volunteer. That was a big challenge to shoulder alone, especially without employment.

In the same year [that] my wife died, [the] government [established] a staff ceiling … in primary schools at a ratio of 1 teacher to 40 pupils in all government-aided schools. The implementation of this policy was to be carried out by headteachers and management committees at school level. Most headteachers ignored the guidelines and instead looked for those who had lost their spouses, those with political, religious and cultural differences. Many of us were affected by this policy and our names were scrapped off the payroll in June 1995. The intention of the exercise was to relocate the surplus teachers to other districts that lacked manpower but not to terminate their services. But here in Kampala the opposite was done. By 1997 we were not yet relocated and not even paid, so we took [the] government to court for breach of contract. The case was ruled on 6 August 2003 in our favour. So [the] government has to pay salary arrears from 1 June 1995, damages and costs of the suit to each of the 108 teachers and to re-deploy us or terminate our services legally.

It is my positive attitude that has enabled me to live up to this day. Many of our people have stayed in denial for a long time after having seen signs and symptoms, but that has not helped them to live longer. Most people fear going for VCT [Voluntary Counselling and Testing] so that they don't deteriorate quickly and lose their jobs. Currently, people spearheading testimonies and campaigns against HIV/AIDS are those working with HIV/AIDS organizations … By virtue of their employment they may be bound to give open testimonies. Others are those who have already lost jobs or [who are] not employed at all, so they have nothing to lose since they have nothing to protect. The rest who test positive and are employed fear to give open testimonies for fear of losing their jobs.

Despite these problems, study findings reveal that there appear to be signs that stigma and discrimination are decreasing. This may be principally due to the fact that since prevalence is so high, almost everyone has now lost a close relative or friend to HIV/AIDS. Most school administrators, teachers and other study participants concurred that stigma or discrimination of PLWHA, though still present, is not encouraged by schools. In some schools, empathy and sympathy, rather than stigma and discrimination, would seem to be the more usual responses encountered. During an FGD with teachers in Mukono, participants observed that one can live with HIV/AIDS and look very healthy for a long time. Those infected are encouraged to live positively with the disease.

> *"There have not been any cases [of] stigmatization reported. Pupils are aware that infected people are members of the school. In discussions pupils are encouraged not to isolate those people who have the disease."*
>
> Headteacher, Mubende District

> *"I remember at one time we had a case of a pupil who was infected with HIV but he could interact freely with others. We sympathise [with, rather] than condemn those infected."*
>
> Education official, Mubende District

> *"The Acholi culture does not allow a sick person to suffer alone. Cases of people suffering from HIV/AIDS being abandoned are rare."*
>
> Education official, Gulu District

The draft national workplace policy on HIV/AIDS, discussed in Section 6.4, provides a framework to prevent the further spread of HIV and seeks to mitigate the socio-economic impact on the world of work. As part of the latter, it provides guidelines for the elimination of stigma and discrimination on the basis of perceived or real HIV status, the promotion of care and support, and the creation of a conducive working environment for PLWHA. The policy provides an opportunity for the MoES to re-model its own personnel policies to take into account the concerns of staff living with HIV/AIDS.

6.6 Orphans

The onslaught of AIDS has led to an increasing number of orphans, which in turn has had a negative impact on social and family structures in Uganda. Orphans present a serious challenge to the education sector, and policies and interventions must be formulated to accommodate their concerns.

"There are too many orphans. It is difficult to deal with them. In primary schools, there was a programme dealing with orphans. When UPE came in, it was assumed that orphans [were] supported equally in primary schools. In secondary schools, bursaries are sent back to sub-counties to identify needy children to be supported at this level. It is one of the ironies of ... UPE. It came to serve all children, but ... orphans, ... [who] need more attention[, are disadvantaged by it]. The CHAI [Community HIV/AIDS Initiative] group would be useful if it succeeds because it targets orphans. There is no policy at the district [level] about how to support orphans"

Education official, Mukono District

A baseline survey on staff mortality conducted by the MoPS in 2000 and involving all central line ministries, revealed that male officers thought to have died of AIDS-related causes tended to have more children than female officers who died in similar circumstances. The average number of biological orphans of female officers suspected to have died of HIV/AIDS was 3.1, while that of males was 5.2. In addition to their own children, these deceased staff members left behind other people's orphaned children, whom they had been caring for, and whose biological parents were suspected to have died of AIDS. On average, there was one AIDS orphan under the care of each deceased female officer and 2.2 under each deceased male officer. The study concluded that the orphan problem is on the increase and that if the educational rights and requirements of these children are to be met, a systematic planning solution must be adopted (MoPS, 2000).

Some NGOs have developed interventions in response to the growing number of AIDS orphans in the education sector. For example, in the year 2000 TASO launched the child survival initiative, to provide tuition and boarding fees for orphans at primary, secondary and tertiary institutions. This programme supports only one child per family. Under the same initiative, TASO runs an apprenticeship programme, through which children are placed in private and informal institutions where 'learning is by doing'. On completing the training, children are given start up tool-kits. Although this is a good intervention, it does not match the growing number of orphans. Highlighting the roles currently played by NGOs and the ministry, a study participant made the following observation:

"About one third of the NGOs operating in Uganda deal with orphans. We deal with UPDF [Uganda People's Defence Force] orphans and in some districts, war related orphans – but this is not a strategy with [the] MoES. We just network. We have a plan of first identifying the needs of the orphans and then bas[ing] our action on that."

Senior official, MoES

In most FGDs, teachers observed that when parents fall sick, the future of their children, if not planned for, might be jeopardised. Orphans may fail to cope with the demands placed on them when their parents' die and their succession rights to property left by their parents may be abused, even by close relatives. In addition to this, orphans suffer terrible psychological trauma following the death of their parents. This always affects their performance in school and may lead to their dropping out altogether. In some foster homes, these children may be given a lot of work and those who drop out of school often become susceptible to abuse.

In Gulu district, the problem of insecurity, coupled with the high prevalence rate of HIV/AIDS, has led to an increasing number of orphans in school enrolments. According to one district education official, about 20 per cent of enrolments within the municipality are of

orphans. Only a very limited number of them are supported by NGOs, such as Australian Foundation, World Vision, Good Samaritan, and the Italian Association of Volunteers in International Service. The support offered by these NGOs is focused on meeting extra charges levied by the schools and providing scholastic materials (e.g. books, pens, etc) and uniforms. However, the approaches used to meet the needs of orphans are not harmonized across the NGO community, making it more difficult for foster parents and schools to ensure that they are well informed of the procedures for accessing aid. Thus, for one scheme the foster parents have to approach the NGO for support, while in another the NGO approaches the school and the school identifies the orphans. The criteria for selection of orphans are determined by the NGOs and frequently depend on the religious affiliation and school performance of the child in question[5].

6.7 Counselling and guidance

In almost all of the schools visited there is a senior teacher who performs counselling and guidance duties for learners on many issues, including HIV/AIDS. However, in some cases it was found that the senior teacher did not possess adequate counselling and guidance skills, especially in relation to HIV/AID and other SRH issues.

> *"At the moment there is [a] need to train teachers about how to counsel learners and fellow teachers. Though we counsel and guide learners, we are not really qualified to do so. [The] government should arrange seminars to facilitate [the acquisition of]e counselling and guidance skills."*
>
> Teacher, Mukono District

Some teachers argued for the intensification of the coverage of counselling and guidance services so that all teachers become competent to carry out these duties. They also felt that training was needed right from the beginning of a teacher's career – i.e. that it should be provided as part of pre-service training at teacher training institutions.

> *"A programme or course on AIDS should be set up to train all teachers, which should be supervised so that every teacher is sensitized. Every teacher is a potential counsellor as far as AIDS is concerned."*
>
> Teachers, Kasese District

> *"The ministry should integrate HIV/AIDS counselling and guidance within the teacher training institutions' curriculum, so that at least whoever comes out of them is a very good counsellor for HIV/AIDS."*
>
> Teacher, Mubende District

The role of the senior teachers is not adequately facilitated or remunerated. While little, if any, financial support is allocated for their activities, further motivation, in the form of financial incentives, would strengthen their roles in reproductive health education and, most importantly, HIV/AIDS.

There is also a need to enhance capacity for counselling and guidance at the district and institutional levels, to respond to the psychosocial needs of learners and staff. However, there are ongoing individual initiatives by certain districts to mobilize resources towards

[5] The definition of who is an orphan varies from one institution to another. Some organizations use 15 as the cut-off age for orphans while others use 18. In addition, 'orphans' may be children who have lost a mother, a father or both parents.

improving the counselling and guidance skills of teachers. For example, in Kyenjonjo district participants observed that:

> *"We are soliciting a training package of about 15 million shillings (US$7,500). We have 14 sub-counties and one Town Council. If each sub-county could get a trained counsellor, trained by TASO at a cost of about 1 million [shillings] (US$520), in a period of about a month we would be in position to have counselling as a strategy in the department."*
>
> Education official, Kyenjojo District

6.8 The role of the teachers' unions

Uganda has two teachers' unions: the Uganda National Teachers' Union, and the National Teachers' Association. With regard to participation in HIV/AIDS prevention and care activities, study findings revealed that the activities of both bodies are still very restricted. Organizational development and resources are at present too limited to enable them to actively participate in decision-making and advocacy for education sector staff. As a result they have had little impact on staff, especially at the grassroots level: quite a number of primary and secondary school teachers interviewed expressed ignorance about the operations of the National Teachers' Union and Teachers' Association.

Interviews with union officials revealed that they have adopted certain positions on issues relating to HIV/AIDS, as reflected in the following remarks:

> *"HIV/AIDS is really a catastrophe of humankind. Teachers are affected both individually and collectively. While we as the Teachers' Union representatives appreciate that the condom is a useful tool in fighting the disease, it is also a problem especially for the young boys and girls. Love and sex are so powerful that these young people may throw away the condoms. Without emphasizing morals…you don't solve problems by providing condoms… We need to emphasize the moral values relating to sex. AIDS is a strange disease. Generally people do not choose to become infected. We advocate for teaching of morals and health education in the schools."*
>
> Official, Uganda National Teachers' Union

The union, however, does not have an official HIV/AIDS strategy. It follows that statements made by officials may be more indicative of personal opinions, than the official position of the union. At the district and school levels, there was no evidence that teachers' unions had made any public statements on HIV/AIDS issues in the education sector.

Overall study findings suggest that the unions could have a significant role to play in championing the cause of teachers affected and infected by HIV/AIDS. However, they have yet to develop the capacity to deal with the problems affecting their members. A framework of activity and viable linkages with partner organizations must be created, if the unions are to meet the demands placed on their members by the HIV/AIDS pandemic.

6.9 Poverty and insecurity

HIV/AIDS prevention and mitigation interventions have been hampered in some districts by the perception that HIV/AIDS is a lesser problem than the more immediate and

acute issues of insecurity and poverty. In Gulu District, for example, these issues have overshadowed HIV/AIDS, even though the current statistics show that Gulu has an adult prevalence rate of 14.7 per cent (MoH, 2003), which is the highest in the country. According to district leaders and education managers, insecurity and poverty continue to claim many lives, pushing HIV/AIDS into the background in the minds of education managers, teachers, learners and support staff. In Gulu District, rebel attacks on civilians are frequent and many children have been abducted to become boy soldiers or 'comfort girls' for the adult soldiers. Thus, day-to-day survival of violence becomes a more pressing concern than an illness whose effects are not felt for years.

> *"Insecurity is the biggest problem. About 80 per cent of ... [Internally Displaced Persons] are in camps. They are not producing and cannot pay taxes. All other problems, for example street children, traumatized groups and delinquents, are emanating from the problem of insecurity. You can only deal with HIV/AIDS if you solve the problem of security."*
>
> District official Gulu

> *"Insecurity is the first problem in this school. It has made it very difficult to operate in many ways. Brilliant and capable students are lost. When we are here there are fears and threats all the time."*
>
> Headteacher, Gulu District

6.10 Conclusions

This chapter has highlighted some of the significant themes that emerged, mainly from the field research. Perhaps the most significant challenge to meeting EFA goals in Uganda is the growing number of orphans. These children have special emotional needs, which schools are ill equipped to meet. Left destitute by relatives who may confiscate their inheritance, orphans are vulnerable to exploitation by foster families who may use them as free labour or worse.

While the overall decline of HIV prevalence in Uganda suggests that silence, stigma and discrimination are being overcome, the research documented persistent stigma and discrimination related to HIV/AIDS in schools. Even though FGD participants and interviewees in a number of schools claimed that seropositive teachers and pupils were respected and supported by their peers, it is telling that all seropositive teachers interviewed for this study were found with some difficulty and interviewed *outside* of schools. In all cases, they only consented to be interviewed on condition of anonymity.

School-based responses to HIV/AIDS are limited mainly to curricular interventions and co-curricular activities organised by anti-AIDS clubs. There is a lack of adequate teaching and learning materials, as well as supervision and support of club activities. A further obstacle to enabling schools to respond to HIV/AIDS is the lack of trained guidance counsellors. While there are senior teachers who have been trained as counsellors in some schools, very few have adequate training or support to deal with HIV/AIDS-related issues. The need is particularly acute in the case of orphaned pupils.

Condoms are the focus of great controversy in Ugandan schools. Although NGOs promote them, school authorities generally frown upon them, as they are thought to incite pupils to engage in sex. By default, it seems, the sector policy on AIDS prevention for pupils is abstinence from sex.

The needs of teachers infected with or affected by HIV/AIDS have been overlooked by most partners. In the absence of a sector policy on HIV/AIDS, ad hoc policies are devised at the school level. In most cases, teachers who are out sick continue to be paid full salaries and some schools will subsidise the costs of medicines and treatment.

The research team was directed to study the role of the teachers' unions in responding to the HIV/AIDS epidemic, in the hope of finding leadership or advocacy initiatives for protecting teachers from discrimination or giving them access to VCT. However, it was found that neither union has mobilized to address the epidemic's impact on its members.

Finally, the researchers discovered that poverty and insecurity are serious obstacles to AIDS prevention and mitigation. Because so many citizens in northern Uganda are living in refugee camps or in areas frequently raided by armed groups, people's preoccupations tend to be focused on meeting immediate needs for personal safety, food, clothing and shelter. Despite very high HIV prevalence in the areas of the country affected by armed conflict, mobilization against HIV/AIDS in these locations is weak. Special initiatives and methods will be required to develop HIV/AIDS prevention and mitigation among war- and poverty-stricken communities.

7. CONCLUSIONS AND RECOMMENDATIONS

The HIV prevalence rates in Uganda have declined from over 30 per cent in some urban areas in 1992, to 6.5 per cent at the end of 2001. Although this is an encouraging sign, prevalence is still high. Thus the impact of the disease will continue to be felt for a while to come among learners, teachers, education mangers and planners. There is no room for complacency.

There is no comprehensive education sector policy on HIV/AIDS. This has created problems in focusing, co-ordinating, advocating for and implementing HIV/AIDS activities in the sector. The sector policy formulation process has been delayed by the absence of a national HIV/AIDS policy, since in Uganda sector policies are usually derived from national policies. In addition, individuals, rather than entire systems, drive the policy-making process, which limits the capacity to complete and sustain initiatives when individuals leave. This is compounded by insufficient technical, human and institutional capacity to drive policy formulation. The ministry unit in charge of policy formulation is under-staffed, ill equipped and under-funded.

In the absence of a comprehensive sectoral policy, the education sector draws upon a mix of national and sector HIV-related policy instruments and strategies. In addition, several micro or informal policies have been developed to fill the policy vacuum. Although the micro-policies are fragmented, they do contain good elements that could be reviewed and strengthened to constitute a comprehensive HIV/AIDS sector policy.

HIV/AIDS control structures and mechanisms have been put in place at the national, sector, district and school levels to respond to the impact of the epidemic. However, the effectiveness of these structures and mechanisms is constrained by structural and conceptual problems. The co-ordination office for HIV/AIDS is located in the office of the Commissioner of Secondary Education. This raises issues of power and authority relations in the sector bureaucracy that are yet to be clearly resolved. HIV/AIDS roles are ‘add-ons’ to routine responsibilities, which further weakens the leadership and success of initiatives.

The vision of the leadership in the education sector focuses more on learners than teachers, school managers and support staff. It has been particularly silent on teachers’ needs, even though teachers form a central pillar of the system and are essential to its long-term sustainability. HIV/AIDS is not viewed as a systemic issue, despite the fact that it affects all areas of the sector, including the institutional capacity of the MoES and its affiliated bodies at central and district levels.

Although efforts have been made to communicate initiatives both within and without the MoES, there is no comprehensive advocacy strategy for articulating HIV/AIDS sector issues. Advocacy is used as a catch-all term for any form of awareness creation and mobilization for action. As such, advocacy in the education sector lacks depth and focus, and has only a limited utility beyond creating initial awareness. With no comprehensive advocacy strategy, commitment of resources and follow-through of activities has been constrained, leading to ‘AIDS fatigue’ among target groups. Without a sustained advocacy strategy, the

silence, stigma and discrimination that haunt staff and learners infected or affected by the epidemic cannot be overcome.

Workshops and seminars in the MoES are used as tools for consultation, sensitization, training and dissemination of information. However, workshops are organized on an ad hoc basis and are generally directed at the same audience – usually sector managers. Little attention has been paid to support staff, teachers and learners.

IEC materials are also used as advocacy tools, although they suffer from reduced impact, due to limited production and inadequate distribution. Distribution mechanisms are not clearly demarcated. For example, only 30 PIASCY handbooks have been distributed to each primary school; a very small quantity compared to the number of teachers and learners they are supposed to reach. A more fundamental problem, however, is that some IEC materials can be misleading on the basic facts of HIV/AIDS prevention. Although in some cases DEOs and headteachers have intervened to verify the content of materials before they are disseminated, there are co-ordination challenges inherent in ensuring the quality of content, production, distribution and dissemination of IEC materials on a countrywide scale.

The MoES and its partners have used other advocacy channels, such as electronic media, in the fight against HIV/AIDS. However, television sets and radios are not allowed in the majority of schools. This means that learners cannot access and discuss important messages about HIV/AIDS, which invalidates the choice of electronic media as an effective advocacy tool.

HIV/AIDS activities in the education sector are not accorded their own budget line despite the fact that HIV/AIDS has been declared to be an integral part of the day-to-day business of the ministry, rather than a discrete issue. This means that resources have not been able to expand sufficiently to accommodate HIV/AIDS activities at all levels. For example, key documents that determine resource allocations, such as the Education Strategic Investment Plan (MoES, 1998), do not commit sufficient financial resources for HIV/AIDS.

The MoES operates an EMIS for monitoring and evaluation purposes. However, the sector does not generate comprehensive information on HIV/AIDS at the school and district levels to feed into the EMIS. This weakness has affected planning and advocacy for HIV/AIDS activities. Designing a strategy to incorporate HIV/AIDS information into the system has proved to be a slow process, as key departments have shown only limited commitment, enthusiasm and support for the project.

Counselling and guidance services for learners and teachers are inadequate. The choice of senior teachers to carry out these duties is based on the perceived competence of the teacher to help learners with their psychosocial needs. However, many of these teachers do not possess adequate skills and motivation, especially in relation to HIV/AIDS and other SRH issues. Moreover, counselling and guidance tasks are 'add-on' responsibilities, for which teachers receive no extra remuneration.

Anti-HIV/AIDS clubs exist in a relatively large number of schools. However, these clubs do not receive direct financial support from the MoES or the schools. It was found that in the schools visited some clubs were not functional due to lack of resources, effective leadership and guidance. In addition to this, the patrons are frequently not well trained or motivated to run the clubs. Club members, who play the role of peer educators, are not

adequately facilitated and guided by the school administration. The environment in which they operate does not seem to be a supportive one, due to a rigid timetable and a heavily compacted curriculum.

Continuing with the subject of the curriculum, HIV/AIDS has already been integrated into the primary school curriculum. In some pilot schools, HIV/AIDS is also being taught using the new LSPE curriculum. HIV/AIDS must now be integrated into the secondary curriculum, a fact that many of the teachers interviewed recognized and appreciated. There are, however, fears that this could lead to marginalization of important academic subjects and overcrowding of the school timetable. With these new developments, the re-training the teachers in order to increase their capacity to deliver the curriculum more effectively will prove a further challenge.

There are no formal arrangements in place to ensure that staff and learners living with HIV/AIDS have access to counselling and medical care. Some school administrators extend minimal support for sick teachers and learners. This does not, however, extend to critical services such as VCT and the provision of ARV drugs, which are both essential for positive living.

The in-school promotion of condoms as an effective means of preventing HIV transmission has proved to be a contentious and sensitive issue. In general, teachers and education managers would seem to prefer a moralist rather than a pragmatic approach to dealing with the issue.

Table 7.1 Recommendations

Recommendation	Details	Responsibility within MoES	Other stakeholders	Remarks
▪ *Develop a comprehensive HIV/AIDS policy for the education sector.*	▪ Initiate policy dialogue with significant stakeholders. ▪ Design policy to cover teachers, managers and support staff in terms of prevention, care and support, and mitigation.	HIV/AIDS Sector Co-ordinator; FPOs; ESC; HIV/AIDS TA; Dept. of Finance and Administration; Policy Analysis Unit.	UAC; Public Service Commission; MoH; NGOs; Teachers' Union and Association.	The process must be put in place immediately as the absence of a policy is hampering the implementation and effectiveness of HIV/AIDS activities in the sector.
▪ *Develop a well-organized system of policy formulation, implementation and monitoring for the education sector that does not depend on individuals but is self-driven.*	▪ Increase the number of technical staff in the policy unit and the HIV/AIDS unit. ▪ Train technical staff on policy issues.	ESC; HIV/AIDS Sector Co-ordinator; HIV/AIDS TA; Commissioner, Finance and Planning; Commissioner, Secondary Education; Personnel.	UNAIDS; World Bank; the United Nations Educational, Scientific and Cultural Organization (UNESCO); the United Nations Development Programme (UNDP); the United States Agency for International Development (USAID); Ireland Aid; the World Health Organization (WHO); the World Food Programme (WFP); NGOs.	The small number of technical staff means that the thrust of policy formulation falls to individuals, who are overwhelmed.
▪ *Establish a clear budget line for MoES HIV/AIDS activities.*	▪ Mainstream HIV/AIDS in the ESIP through the review process. ▪ Mainstream HIV/AIDS in district development plans.	Finance and planning department; HIV/AIDS Sector Co-ordinator; HIV/AIDS TA; commissioners.	UNAIDS; World Bank; UNESCO; UNDP; USAID; Ireland Aid; WHO; WFP; UAC; NGOs.	Lack of a budget line for HIV/AIDS activities has limited interventions.

Recommendation	Details	Responsibility within MoES	Other stakeholders	Remarks
▪ *Review the HIV/AIDS co-ordination structure to make it work better given the overall MoES structure.*	▪ Establish a fully fledged HIV/AIDS co-ordination function within the MoES. ▪ Consider the position of the HIV/AIDS sector co-ordinator in the existing chain of command and bureaucratic thresholds.	Permanent Secretary; commissioners; HIV/AIDS Sector Co-ordinator; HIV/AIDS FPOs; HIV/AIDS TA; planning, finance and administration; headteachers; ESC.	UAC.	Empowering the HIV/AIDS sector co-ordination unit would increase efficacy.
▪ *Broaden the vision of the education sector leadership on HIV/AIDS to take in teachers, managers and support staff in addition to learners.*	▪ Design HIV/AIDS interventions specifically for teachers, managers and support staff in the sector.	Permanent Secretary; commissioners; ESC; Sector Co-ordinator; HIV/AIDS TA; planning; headteachers; support staff.	UNAIDS; World Bank; UNESCO; UNDP; USAID; Ireland Aid; WHO; WFP; NGOs.	Managers, teachers and support staff are key actors in the education sector, so interventions should be tailored to their needs.
▪ *Improve the quality, production and distribution of IEC materials and link them to an advocacy strategy.*	▪ Produce more IEC materials for distribution in schools. ▪ Vet the quality of messages in the IEC materials before dissemination.	Commissioners; HIV/AIDS Sector Co-ordinator; FPOs; HIV/AIDS TA; DEOs; headteachers.	UAC; USAID; UNESCO; NGOs.	IEC materials will have a greater impact if more materials are produced and distributed.
▪ *Strengthen leadership and guidance in school HIV/AIDS and other health clubs.*	▪ Allocate a staff member to provide guidance and leadership for each club. ▪ Allocate financial and logistical support to club activities. ▪ Assist the clubs to develop proposals and work plans.	Commissioners; HIV/AIDS Sector Co-ordinator; HIV/AIDS TA; headteachers; senior teachers and teachers; DEOs; school BoGs; Parent-Teacher Associations.	NGOs.	Strong and effective clubs can only be realized through adequate financial, technical and managerial assistance.

Recommendation	Details	Responsibility within MoES	Other stakeholders	Remarks
▪ *Develop operational guidelines for clubs and ensure that they are reviewed on a regular basis.*	▪ Issue a circular to headteachers containing operational guidelines for the clubs.	Commissioners; HIV/AIDS Sector Co-ordinator; HIV/AIDS TA; FPOs; Curriculum Development Centre.	NGOs.	Operational guidelines will facilitate the smooth running of clubs.
▪ *Develop a comprehensive advocacy strategy.*	▪ Initiate the process of developing an HIV/AIDS advocacy strategy.	HIV/AIDS Sector Co-ordinator; TA; FPOs.	UAC; UNAIDS; World Bank; UNESCO; UNDP; USAID; Ireland Aid; WHO; WFP; NGOs.	A comprehensive advocacy strategy will enhance the dissemination of HIV/AIDS information to target groups.
▪ *Review the regulations that govern the use of radios and televisions in schools.*	▪ Introduce 'radio time' in schools. ▪ Introduce 'TV time' in schools.	Sector HIV/AIDS Co-ordinator; TA; headteachers; DEOs.	Radio Stations; TV Stations; Ministry of Information.	Increased access to radios and TVs for learners will improve dissemination of HIV/AIDS information to the target groups.
▪ *Introduce LSPE into the secondary school curriculum.*	▪ Finalize the LSPE curriculum for secondary schools and teacher training institutions.	National Curriculum Development Centre; ESC; Uganda National Examinations Board; commissioner, Teacher Education; Commissioners, Secondary Education and Primary education.	UAC; MoH; UNESCO; UNDP; USAID; World Bank; NGOs.	Secondary level learners are very vulnerable to the HIV/AIDS epidemic, so introduction of curriculum interventions must be a priority.
▪ *Build the capacity of teachers to deliver the LSPE curriculum more effectively.*	▪ Provide in-service teacher training on techniques for teaching LSPE.	Commissioners, Teacher Education, Primary Education and Secondary Education; HIV/AIDS Sector Co-ordinator; TA.	UAC; MoH; UNESCO; UNDP; USAID; World Bank; NGOs.	Effective delivery of LSPE requires skill and specialist training.

Recommendation	Details	Responsibility within MoES	Other stakeholders	Remarks
▪ *Build the capacity of teachers to deliver counselling and guidance more effectively.*	▪ Provide pre-service training for teacher trainees, so that every teacher is sensitized and may be a potential counsellor.	National Curriculum Development Centre; Uganda National Examination Board; ESC; Teacher Education Commissioner; HIV/AIDS Co-ordinator.	MoH; UAC; UNESCO; USAID; UNDP; Ireland Aid.	Teachers can carry out Counselling and guidance as part of their day-to-day work.
▪ *Review the condom distribution mechanism in the MoES and ensure a consistent supply for staff.*	▪ Ensure the consistent supply of condoms. ▪ Strengthen the distribution system.	HIV/AIDS Sector Co-ordinator; HIV/AIDS FPOs.	UAC; MoH; USAID; NGOs.	A good condom distribution system and a consistent supply would entrench the culture of condoms for adults in the sector.
▪ *Formulate a policy on condoms for learners, teachers and district staff.*	▪ Initiate the policy formulation process.	HIV/AIDS Sector Co-ordinator; HIV/AIDS FPOs; headteachers; DEOs.	MoH; NGOs.	Condoms could save the lives of teachers, managers and learners.
▪ *Assist staff and learners living with HIV/AIDS to obtain access to counselling, testing and medical care.*	▪ Adjust the medical benefits scheme to take care of staff living with HIV/AIDS. ▪ Introduce a scheme to provide ARVs to teacher living with HIV/AIDS. ▪ Introduce a scheme to meet the cost of HIV/AIDS monitoring for teachers with HIV.	Under Secretary, Finance and Administration; Personnel Office; Sector Co-ordinator; HIV/AIDS TA; FPOs.	MoH; USAID; UAC, Joint Clinical Research Centre; Mild May; hospitals; African Air Rescue; Insurance companies.	A system of supply of ARVs could be worked out for teachers living with HIV through a public-private partnership arrangement.

Recommendation	Details	Responsibility within MoES	Other stakeholders	Remarks
▪ *Mainstream HIV/AIDS in the EMIS.*	▪ Review the current EMIS. ▪ Re-design the EMIS to include HIV/AIDS indicators. ▪ Network the EMIS at the central and district levels.	ESC; HIV/AIDS Sector Co-ordinator; data analysts and statisticians; HIV/AIDS TA; planning; personnel; headteachers.	MoH; UAC; UNAIDS; UNESCO; NGOs; USAID; UNDP; World Bank; the Danish International Development Agency; Ireland AID; UNICEF.	The EMIS should be a centralized, computerised and networked database system to enhance data storage, retrieval and use.
▪ *Ensure that there are proper support mechanisms for orphans and infected or affected learners.*	▪ Review existing MoES and other stakeholders' arrangements for the support of orphans. ▪ Review the Orphans and Vulnerable Children policy to reflect the responses to learners who are orphaned. ▪ Develop guidelines for support to orphans in school.	Planning department; Commissioner, Pre-primary and Primary Education; Commissioner, Secondary Education; HIV/AIDS Sector Co-ordinator; HIV/AIDS TA; DEOs, headteachers.	Ministry of Gender, Labour and Social Development; UNESCO; NGOs; WFP; UNICEF.	Selection criteria for orphan support are not clear and few orphans are being supported.
▪ *When planning interventions, give special attention to the unique features and dynamics of districts affected by civil conflict.*	▪ Poverty and wars may overshadow the prevalence of HIV/AIDS in many areas of conflict. ▪ Sensitization should be carried out to alert leaders and organizations involved in providing humanitarians services in the area.	Planning department; ESC; HIV/AIDS Co-ordinator; TA; DEOs; headteachers.	USAID; UNDP; Ministry of Gender, Labour and Social Development; UNICEF; WFP; NGOs.	HIV/AIDS activities must be integrated into the work plans of these organizations. This will then filter down to the schools and communities.

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APPENDIX 1

HIV INFECTION PREVALENCE RATES (PERCENTAGES) AT SELECTED ANTENATAL SENTINEL SITES, 1989-2001

Sentinel site	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Nsambya	24.5	25.0	27.8	29.5	26.6	21.8	16.8	15.4	14.6	13.4	12.3	11.8	9.5
Rubaga	-	-	27.4	29.4	24.4	16.5	20.2	15.1	14.8	14.2	10.5	10.7	10.4
Mbarara	21.8	23.8	24.3	30.2	18.1	17.3	16.6	15.0	14.5	10.9	11.3	10.0	10.6
Jinja	24.9	15.8	22.0	19.8	16.7	16.3	13.2	14.8	11.0	10.5	10.8	8.3	7.4
Tororo	-	4.1	12.8	13.2	11.3	10.2	12.5	8.2	9.5	10.5	4.5	4.7	7.0
Mbale	3.8	11.0	12.1	14.8	8.7	10.2	7.8	8.4	6.9	6.3	5.7	5.5	5.6
Kilembe	-	-	-	-	7.0	16.7	11.1	10.4	8.5	-	7.5	4.2	2.1
Soroti	-	-	-	-	9.1	-	8.7	7.7	5.3	7.7	5.0	5.0	5.0
Hoima	-	-	-	-	-	-	-	12.7	9.0	5.4	3.5	-	5.3
Arua	-	-	-	-	4.4	-	-	-	-	-	5.2	5.2	4.8
Pallisa	-	-	-	7.6	5.0	1.2	-	-	3.2	2.6	3.2	3.8	3.7
Matany	-	-	-	-	2.8	7.6	-	2.0	1.6	1.3	0.9	1.9	1.7
Kagadi	-	-	-	-	-	-	-	-	10.3	11.5	11.0	10.5	7.4
Mutolere	-	4.1	5.8	-	4.2	-	3.6	2.6	-	2.5	2.3	2.1	4.1
Moyo	-	-	-	-	5.0	-	3.1	-	-	3.2	5.2	2.7	2.7
Lacor	-	-	-	-	27.1	21.9	14.7	14.3	16.3	12.8	12.3	13.1	11.3

Source: MoH, 2002.

APPENDIX 2

SUMMARY OF STUDY POPULATION AND METHODS OF DATA COLLECTION USED

Category of respondent	Method of data collection	No. of times method employed	Average no. of participants	Composition of respondents	Theme of interviews or discussions
▪ *Students*	FGDs	17	6-10	Male and female primary school pupils and secondary school students	Knowledge and experience of HIV/AIDS.
▪ *Teachers*	FGDs	15	5-7	Male and female teachers	Unique demands resulting from HIV/AIDS attrition and deaths.
▪ *Patrons of school clubs*	In-depth interviews	4	3	Male and female patrons	Management of health and HIV/AIDS clubs; counselling and guidance.
▪ *School support staff*	FGDS	2	4-5	Bursar; lab technicians; secretaries.	Unique demands resulting from HIV/AIDS attrition and deaths.
▪ *School administrators*	Personal interviews	More than 10	19	Headteachers; deputy headteachers; members of the BoG or School Management Committee.	Micro-policies and response mechanisms in the absence of clear guidance from MoES headquarters.
▪ *District officials*	Key informant interviews	More than 10	14	DEOs; District Inspector of Schools; CAOs; HIV/AIDS FPOs.	Policy; personnel issues; budgeting for HIV/AIDS activities; EMIS; HIV/AIDS programmes and services.

▪	*MoES officials*	Personal interviews; key informant interviews; case study.	More than 10	9	Commissioners; Assistant commissioners; HIV/AIDS FPOs; TA on HIV/AIDS.	Policy; personnel issues; budgeting for HIV/AIDS activities; EMIS; HIV/AIDS programmes and services.
▪	*MoES support staff*	FGDs	1	6	Secretaries; messengers; drivers.	Unique demands resulting from HIV/AIDS attrition and deaths.
▪	*Members of Parliament*	Informal interviews and discussions	More than 5	7	Members of the Parliamentary Social Service Committee and HIV/AIDS Standing Committee.	Policy; resource allocation.
▪	*NGOs officials and staff*	Key informant interviews; FGDs.	More than 10	-	Officials and staff from TASO, the AIDS Information Centre, Uganda Youth and AIDS Association, Straight Talk Foundation.	Collaborative roles with the education sector as regards HIV/AIDS activities.
▪	*PLWHAs*	Case study; FGDs; In-depth interviews.	More than 5	5	Teachers living with HIV/AIDS	Experiences of discrimination and stigma by education administrators, fellow teachers and learners.
▪	*Teachers' Union or Association officials*	Key informant interviews	More than 5	-	Representatives of teachers; union officials.	Union/Association policy and advocacy for teachers in view of HIV/AIDS.

APPENDIX 3

RESEARCH TEAM AND VALIDATION WORKSHOP PARTICIPANTS

Research team	
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