

## Chapter 12

# Mitigating the Impact of HIV/AIDS on Education Supply, Demand and Quality \*

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**Summary.** This chapter focuses on the relationship between HIV/AIDS and education in countries with different levels of HIV/AIDS prevalence. It concentrates on the sector's response to schools' issues, with some attention to teacher training colleges. For purposes of this analysis, technical and vocational education, special education, adult basic education and training, universities and out-of-school programmes have been excluded. The survey of experience in Section 1 has concentrated on Sub-Saharan Africa, and on Asia and the Pacific, and the lessons that have been learned from high prevalence and low prevalence countries in those regions.

Section 2 analyses current and anticipated impact of HIV/AIDS on education in order to clarify probable changes in demand for and supply of education services. Section 3 discusses education's responses to HIV/AIDS principally in high prevalence countries. Section 4 makes suggestions about 'best practices' at local, national and international levels that recommend themselves in terms of cost, coverage and efficiency. Section 5 offers summary conclusions.

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**\* This study presents the views of its author and not the official UNICEF position in this field.**

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**AIDS, PUBLIC POLICY AND CHILD WELL-BEING \***

edited by Giovanni Andrea Cornia

**Table of contents**

Introduction - *Giovanni Andrea Cornia*

Part I: Overview of the HIV/AIDS Impact and Policy-Programme Responses

1. Overview of the Impact and Best Practice Responses in Favour of Children in a World Affected by HIV/AIDS - *Giovanni Andrea Cornia*

Part II. The Social and Economic Impact of HIV-AIDS on Children:  
Evidence from Eight Country Case Studies

2. The Impact of HIV/AIDS on Children: Lights and Shadows in the “Successful Case” of Uganda – *Robert Basaza and Darlison Kaija*

3. The Impact of a Growing HIV/AIDS Epidemic on the Kenyan Children – *Boniface O.K’Oyugi and Jane Muita*

4. The Socio-economic Impact of HIV/AIDS on Children in a Low Prevalence Context: the Case of Senegal - *Cheikh Ibrahima Niang and Paul Quarles van Ufford*

5. HIV/AIDS, Lagging Policy Response and Impact on Children: the Case of Côte d’Ivoire - *Jacques Pégatiénan and Didier Blibolo*

6. The Current and Future Impact of the HIV/AIDS Epidemic on South Africa’s Children - *Chris Desmond and Jeff Gow*

7. Perinatal AIDS Mortality and Orphanhood in the Aftermath of the Successful Control of the HIV Epidemics: The Case of Thailand - *Wattana S. Janjaroen and Suwanee Khamman*

8. HIV/AIDS and Children in the Sangli District of Maharashtra (India) - *Ravi K. Verma, S.K. Singh, R. Prasad and R.B. Upadhyaya*

9. Limiting the Future Impact of HIV/AIDS on Children in Yunnan (China)  
*China HIV/AIDS Socio-Economic Impact Study Team*

Part III: The Sectoral Impact of HIV-AIDS on Child Wellbeing and Policy Responses

10. The HIV/AIDS Impact on the Rural and Urban Economy - *Giovanni Andrea Cornia and Fabio Zagonari*

11. Poverty and HIV/AIDS : Impact, Coping and Mitigation Policy - *Tony Barnett and Alan Whiteside*

**12. Mitigating the Impact of HIV/AIDS on Education Supply, Demand and Quality - *Carol Coombe***

13. The Impact of HIV/AIDS on the Health System and Child Health - *Giovanni Andrea Cornia, Mahesh Patel and Fabio Zagonari*

14. Increasing the Access to Antiretroviral Drugs to Moderate the Impact of AIDS: an Exploration of Alternative Options - *Pierre Chirac*

15. The Impact of HIV/AIDS on Orphans and Program and Policy Responses - *Stanley Phiri and Douglas Webb*

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## 1. Introduction

This chapter focuses on the relationship between HIV/AIDS and education in countries with different levels of HIV/AIDS prevalence. It concentrates on the sector's response to schools' issues, with some attention to teacher training colleges. For purposes of this analysis, technical and vocational education, special education, adult basic education and training, universities and out-of-school programmes have been excluded.<sup>1</sup> The survey of experience has concentrated on Sub-Saharan Africa, and on Asia and the Pacific, and the lessons that have been learned from high prevalence and low prevalence countries in those regions.

Section 2 analyses current and anticipated impact of HIV/AIDS on education in order to clarify probable changes in demand for and supply of education services. Section 3 discusses education's responses to HIV/AIDS principally in high prevalence countries. Section 4 makes suggestions about 'best practices' at local, national and international levels that recommend themselves in terms of cost, coverage and efficiency. Section 5 offers summary conclusions.

### 1.1 Definitions and assumptions

The paper is based on several assumptions. The first is that increasing numbers of countries, especially in Sub-Saharan Africa and the Caribbean, are facing one of the great crises of human history. The second is that other countries in Eastern Europe<sup>2</sup> and the Asia and Pacific regions will confront similar challenges as the pandemic spreads (MAP, 2001). Third, despite the difference in the nature of HIV and AIDS pandemics in the Americas and Europe, Africa, and Asia and the Pacific, it should be possible to extrapolate common ideas about what works and what doesn't in the fight against AIDS.

As the pandemic snowballs, health-driven national strategies are being replaced by multi-sectoral strategies in which ministries of education are now taking responsibility for identifying and driving education's response to HIV, as in Botswana, Namibia, Rwanda

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<sup>1</sup> HIV and AIDS are assaulting *all* education sub-sectors, from early childhood development to colleges and universities. This understanding makes it clear that HIV and AIDS is not just a schools issue: the pandemics must be tackled at all levels of the education sector. The education sector's response must also include concern for out-of-school youth, and the creation of adult basic education, nonformal and distance education opportunities for children and young people disadvantaged by AIDS. There is little evidence of critical analysis of HIV's implications for these education sub-sectors, even in high prevalence countries. The lack of strategic thinking in the areas of technical education, early childhood development, and out-of-school programmes has been highlighted regularly with little effect

<sup>2</sup> In advance of AIDS Day 2001, the United Nations reported that 'the AIDS epidemic is sweeping across Eastern Europe, with HIV infection rates rising faster within the former Soviet Union than anywhere else in the world. The combination of economic insecurity, high unemployment and deteriorating health services in this region are behind the steep rise, which shows no signs of abating'. So far, infections are confined mainly to young people experimenting with drugs. Report from Associated Press, 28 November 2001. The International Coalition on AIDS and Development likewise reports that HIV shows no signs of curbing its exponential growth in the Russian Federation, and that it is now spreading into the general population.

and South Africa, ministries of education alone do not have the capacity to respond to the challenges HIV/AIDS poses for education. It is clear they can only achieve their strategic goals in partnership with others as in South Africa. The capacities of all partners within the education sector as a whole need to be strengthened, and policy and regulatory frameworks established for effective collaboration.

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

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

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

1. *Prevention*: helping prevent the spread of AIDS
2. *Social Support*: working with others to provide a modicum of care and support for learners and educators affected by HIV/AIDS, and
3. *Protection*: protecting the education sector's capacity to provide adequate levels of quality education – by stabilising the sector, and responding to new learning needs (Coombe and Kelly, 2001; Inter-Agency working Group, 2001).

In addition, an effective response will require *capacity in the sector to manage* this crisis (Coombe and Kelly, 2001).

## **2. The impact of HIV and AIDS on education**

In highest prevalence countries HIV/AIDS is affecting the supply of education, the demand for education, the quality of education, the way education is managed, and its capacity to respond to new and complex demands (Inter-Agency Working Group, 2000). The relationship between the HIV/AIDS pandemic and education provision can only properly be understood within the context of the lives of people – children and adolescents and their families, teachers and principals, education officials and college lecturers – who are coping in the first instance with the impossible demands the pandemic makes on them as individuals. The pandemic's impact on households directly influences the choices that learners and educators make (LoveLife, 2000; Desmond in University of Natal, Health Economics and AIDS Research Division, 2001).

## 2.1 Contextual factors affecting supply and demand

*“The Sinisizo home-based care programme helps children aged nine to 14 who are the primary caregivers for parents dying of AIDS and for smaller brothers and sisters. The majority live in households with no incomes, many with parents who have been sent home from hospital - sometimes comatose - a day or two before they are expected to die. In the many homes where there are no beds, the children, often malnourished, struggle to lift and turn their parents and to help them to the toilet. Children from some of the 900 families with whom Sinisizo is working told ... the [13<sup>th</sup> International AIDS Conference, Durban, July 2000] about their difficulties. “They say waste disposal is the most difficult thing - getting rid of soiled dressings and incontinence pads. They also have to find food for their families, cook for and feed their parents and younger siblings. They have to ask for food from the neighbours and it takes hours to get enough for one day. They have to cook on paraffin stoves and open fires while they are carrying smaller children on their backs or hips. They have to fetch water for drinking, cooking, bathing and washing clothes, and a small child can't carry enough.” If there is any medication available, the children also dispense that, “but most of the time they can't even get aspirin”. So, the children help their parents die; there is no time to mourn, because they must go and seek assistance to arrange a funeral” (The Natal Witness, 11 July 2000).*

**Socioeconomic Conditions.** In Southern Africa, the financial burden of HIV/AIDS-related illness or death on households is at least 30% greater than for deaths from other causes. Many of those who are ill, or caring for those who are, are poor and live in cramped housing with limited access to water or sanitation. Costs for treatment place a strain on savings, but most affected families cannot opt for drug therapy or even the most basic panaceas. By striking more than one family member HIV imposes major stress on the household, forcing single parents, older children or the elderly to take over responsibility. Affected households suffer from loss of medical and insurance benefits, treatment costs including transport, and reduced capacity for income-generating work. Such households may depend solely on old-age income or sale of assets. Resources for education, food, housing, basic utilities and home maintenance decline substantially. Burial costs consume remaining resources, and children may be forced into low paid work, crime or sex work, thus increasing their own risk of infection.

Many at-risk learners come from the context of socioeconomic deprivation complicated by and further complicating HIV infection whether they live in North America, Europe, Africa, Latin America, the Caribbean or Asia-Pacific. HIV/AIDS is not a disease of the poor, but the poor are at higher risk of HIV infection, the poor are more vulnerable to HIV infection, and the disease makes the poor poorer (Kelly, 2001a; Stillwaggon, 2001).

**Stigma and Isolation.** Affected people are stigmatised and may be prevented from gaining access to social support mechanisms. HIV/AIDS-related stigmatisation is responsible for social rejection, alienation, and can compromise employment, housing, schooling and child-care. It means that HIV/AIDS-related loss of family and friends is not likely to be

acknowledged. Fear of isolation is particularly strong among teachers who live and work in small communities, where confidentiality is problematic.

***Psychosocial Stress.*** The disease brings with it psychosocial stresses. Illness and the prospect of death in the family, often not discussed with children, are as traumatic for the child as for the adult. When illness becomes evident, family members are likely to experience rejection, ‘fear of contagion’, and anticipatory grief. When death occurs, high levels of grief enter households and communities, with implications for mental and physical health, as well as social and work relationships. Loss of a child particularly causes acute grief. Children are highly traumatised by watching parents die and not being able to talk about it. Stress and depression can compromise function and well-being in all areas of family life including school and work performance, family relationships, and capacity for child care. Responses to stress may include alcohol and drug abuse, and unsafe sexual behaviour. The difficulty here is that little is known yet about how children and young people process the stresses that engulf them (Solomon, 2001; Ebersohn and Eloff, 2001; Devine and Graham (n.d.).)

***The Condition of Women.*** Women are strongly affected by HIV/AIDS. They are at greater risk of infection, and more vulnerable to the socioeconomic effects of the pandemic. Women-headed households tend to be poorer than those headed by men, and have less reserves. Unemployment is generally higher among women than men, and even those who are married may be consistently subject to maltreatment without being able to resist for economic reasons. Violence against women often complements high prevalence rates. Women face risk of abandonment and abuse, and traditionally provide care for the terminally ill: girls may be withdrawn from school to do so.

This is the backdrop against which the challenge of HIV to education services is being played out in the high prevalence countries of Sub-Saharan Africa. It is these factors that will ultimately determine the profile of learner and educator populations, the supply of and demand for education (Collins and Rau, 2000).

## **2.2 Education demand and supply in high prevalence countries**

***Evaluating the Evidence.*** Isolating and assessing the consequences of HIV/AIDS for education services in high prevalence developing countries is difficult for a number of reasons. Put very simply, children drop out of school but there is no way of knowing why they leave. It is only possible to guess at reasons for changes in enrolment, progression, completion and dropout rates by using, with caution, what data is available. Use is also being made of anecdotal evidence and the observations of educators and social workers, and proxy measures like social welfare orphan registrations, rising incidence of child abuse presenting in paediatric units, and prevalence rates among school-age rather than school-going populations.

Teachers are known to be ill, absent from work and dying out of the teaching service, but HIV/AIDS is rarely named as the reason. There is no official procedure for terminating

the services of African teachers who are HIV/AIDS positive and who should be pensioned off for medical reasons. Nor is there any way of determining whether teachers dying out of the service do so because of AIDS, except that – as in South Africa and Botswana – certain graphic data ring alarm bells for demographers.

Accurate information is hard to come by. Figures on which impact calculations are made for the education sector are meagre. They are collected with difficulty, and provide a poor base from which to generalise. Various models are used to predict national infection and prevalence rates with varying degrees of success depending on surveillance methods, quality of data analysis and the interference of other factors.<sup>3</sup> National statistics can mask local variations in prevalence, and therefore in levels of impact on individual districts and schools. In most affected countries there are clearly risk ‘hot-spots’ that differ from the national average (Badcock-Walters, 2001). For education, additional information that must be factored into the demand and supply equation relates to the composition of the teaching force in terms of age, gender and marital status, relative salary levels, teacher perceptions of marketability, teacher education and qualification levels, levels of unionisation, and even ethnicity. This information is often difficult to obtain (Crouch, 2001a).

Added to this are puzzles related to what the statistics really mean. For example, is a downward curve the result of active intervention by government, or of intervention by others, or of personal choices to change behaviour, or the natural course of the pandemic (which is not well understood, and varies from place to place), or of the intersection of factors like incidence and morbidity which might suggest lower prevalence rates? It is often not possible to know whether shifts one way or the other are due to HIV/AIDS or to fiscal adjustments (up or down), adverse educational policies, the influences of increasing or decreasing socioeconomic deprivation, increasing or decreasing levels of international development support, or some other factor.

For example, and very crudely, observable changes in enrolment at primary and secondary level in Uganda, and to some extent in Malawi, are due to EFA-driven progress in improving levels of primary provision (see chapter 2 of this compilation). As more school places become available, more children attend primary school. With places at secondary level increasing more slowly and still falling short of demand, any place vacated by a student affected or infected by HIV/AIDS will be taken up by another candidate with the result that secondary enrolment figures will appear to remain stable, or even rise as levels of secondary provision improve (World Bank, 2000a, p 59).

In the South African province of Kwa-Zulu Natal where HIV infection rates are probably the highest in the world, changing regulations on age of entry have skewed grade 1 en-

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<sup>3</sup> Projections for South Africa for example are based on the most recent statistics using the Metropolitan-Doyle model. ‘The Metropolitan-Doyle model was first published in October 1990, with a view to producing reliable estimates of the progress of HIV/AIDS in South Africa. The model has been extensively used in Southern Africa by many sectors... and has performed well when used in practical applications at the sub-group and general population level. The model is continually reviewed in the light of new demographic and population statistics, as well as interventions that may influence the course of the epidemic and result in changing incidence of infection, morbidity and mortality. The model is able to consider various interventions including behavioural changes (increased condom usage, reduced numbers of partners, etc) and medical interventions (improved treatment of STDs, vaccinations, treatment of HIV positive and AIDS sick individuals)’ Moore and Kramer (1999) p 14.

rolment data. So the alarming drop of 24% in grade 1 enrolment in the province in 2000 was possibly a combination of new age of entry regulations, increasing poverty (much of it related to AIDS), and HIV-related reduction in school-age population. The relative proportions in the mix are impossible as yet to determine (University of Natal, Health Economics and AIDS Research Division, 2001, Chapter 5).

Virtually every prediction of the pandemic's impact on education is surrounded with caveats. There is tension between those who prefer to rely on so-called hard data, and those who rely on qualitative evidence derived from the experience of educators, social and health workers, police and churches, homebased care volunteers, researchers and parents (Crouch 2001a). Either way, impact can remain invisible for long periods of time. For example, in a country or state of say fifty million people, with a service of 400,000 educators, a 10% prevalence rate would mean that 40,000 were HIV positive, at some point along the continuum from initial infection to morbidity and mortality, with or without access to drugs. With 30,000 schools, each school might have only one or two infected teachers. More probably, some schools would have no infections, while others might have many. The most severe critical-mass impact can be expected in future because of the long lag between infection and development of full-blown AIDS and death. That means infections in the 1990s, particularly heavy in South Africa and Botswana for example, will not be felt until the first decade of the millennium. Uganda, where the epidemic is thought to have peaked in the early 1990s at between 9-12%, may already have passed through the worst of the full-blown AIDS phase. And so reports and perceptions of the size and quality of the pandemic differ radically.

What is truly 'known' about HIV's impact on education services is questionable. Crouch, in a seminal interim analysis of HIV and teacher supply issues in South Africa opens his study by confessing that

*there seems to be little doubt in the minds of most well-informed opinion-makers that the teacher work force in South Africa has been undergoing turbulent change in the last few years. Furthermore, with the onset of the HIV/AIDS epidemic, further turbulence is predicted. Sharing this commonly held view, and wanting to put some parameters around this presumed past and future turbulence, we started out to undertake a systematic analysis of the main data sources available [including national household surveys, labour force data, educators' salary databases, demographic forward modelling, and administrative records]. We expected to be able to document great turbulence and dire trends. We expected to be able to make simple and portentous macro-level statements. What we found is worrying, but far too nuanced to drive statements that are both portentous and simple.<sup>4</sup>*

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<sup>4</sup> Crouch (2001a) p 4. Crouch notes (p 2) that 'the in-depth sociological and economic analyses of teacher identity, occupational choice, and the dynamics of the teacher labour market in South Africa, which would be needed to underpin a serious policy and planning position on these matters simply have not been done. We are offering a first approximation to extremely complex issues...perhaps 1/20<sup>th</sup> of the work that needs to be done before really firm conclusions about teacher identity and dynamics can be established. We challenge our colleagues and the education establishment in South Africa to undertake the necessary studies. In particular we call for an in-depth socio-economic random sample survey of teachers and case-controls in the labour market and society at large, combined with a qualitative analysis; a study that takes the individual and collective voice of teachers seriously enough to honour it with the best research possible. We feel that the choices young people make, in terms of choosing or not choosing the teaching occupation, are

It is only possible to estimate, to use the best data, information and models available, and to test predictions again and again. It is nevertheless necessary to indicate the most probable trends for education in future with the onset of AIDS.

The following supply and demand analysis is based on a number of sources: the preliminary but systematic teacher supply analysis by Luis Crouch and colleagues in South Africa, the World Bank's study of turbulence in four high-impact countries (Kenya, Uganda, Zambia and Zimbabwe), a review of Ugandan data by Parkhurst, assessments by Abt Associates of the impact of HIV/AIDS on education sectors in Botswana and South Africa, preliminary analysis of data for Kwa-Zulu Natal Province in South Africa by the Health Economics and AIDS Research Division of the University of Natal (HEARD), and the summary of case studies in eight Sub-Saharan African countries by Michael Kelly for the Economic Commission for Africa/Africa Development Forum (Crouch, 2001a; World Bank, 2000a; Parkhurst, 2001; Abt Associates, 2001; LoveLife, 2000; Badcock-Walters, 2001; Kelly, 2000a.)

### 2.3 Demand for education services

*Size of Learner Populations.* HIV/AIDS will affect the size of learner populations. Where prevalence is high, rising deaths among adults of reproductive age and declining fertility rates result in fewer children being born. Combined with increased mortality among children infected around the time of birth, most of whom die before they are five years old, this means there are fewer potential learners than there would have been without AIDS. It is anticipated that Zimbabwe will experience a 24.1% reduction in primary school age population by 2010; Zambia 20.4%, Kenya 13.8%, and Uganda 12.2% (Abt Associates, 2001, p 4; World Bank, 2000a, p 3).

In Botswana, there are likely to be 860,000 young people under 25 by 2015, rather than 1,200,000 if HIV/AIDS had not intervened. There is already evidence that the 0-4 year age group is declining in absolute numbers while the 5-9 year age group showed signs of starting to decline in 2001. Grade 1 intake, which appears to have been slowing for some time, declined by 3% in 1998. Declines in numbers of children in older age groups are likely to become apparent by the end of the decade (Abt Associates, 2001, p 4).

In South Africa, the number of potential learners is expected to decline if orphans and other vulnerable children do not enroll, delay enrolling, or leave school in large numbers. In general, orphans, at-risk children, and those in HIV/AIDS-affected homes are likely to be withdrawn from schooling and higher education. Introducing drugs to reduce MTCT, assuming governments are able and willing to provide this option, will ultimately make a difference, but only over a long period of time (Abt Associates, 2001; LoveLife, 2000, pp 26-27; see also Unicef and USAID, 2000).

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simply not sufficiently understood, and that unless this understanding is improved many-fold, policy and planning mistakes are very likely.'

It is essential that the accuracy of demographic projections be monitored, their assumptions interrogated, and changed circumstances, like the provision of anti-retrovirals, be factored into these equations. In the short-term, planning will need to take account of reductions in enrolments as fewer children are born and many HIV-infected children fail to thrive or survive to school-going age.

***Demand for Education.*** HIV/AIDS will influence demand for education throughout the region. Declining primary enrolment over the next decade will translate into subsequent reductions of qualified candidates for high school and tertiary training. In South Africa, younger people are most severely affected by the disease with around 60% of all adults who acquire HIV becoming infected before they turn 25.

Orphans are more likely to be denied education. In Mozambique for example, only 24% of orphans attend school, compared with 60% of those with living parents. Children affected by AIDS often perform poorly at school and their dropout rates in parts of in Botswana are reported to be unacceptably high (Kelly, 2000a; Abt Associates, 2001). These results are confirmed by the survey data reported in the country studies in this compilation (see chapters 2 through 9)

Botswana, South Africa, Swaziland, Zimbabwe and Zambia already have evidence of stagnating or declining enrolments, much of it very likely attributable directly or indirectly to HIV/AIDS (Kelly, 2000a; Abt Associates, 2001). Observable factors likely related to changes in demand include fewer resources for education in HIV/AIDS-affected households because of high death rates resulting from HIV/AIDS. Learners will be withdrawn from school as orphaning and poverty rise, or will not enroll because of fees and opportunity costs, and the need to care for those who are ill. Communities will be unable to provide support for schools as they did in the past although some communities are already reacting positively by building community schools for their own children.

***More Complex Learner Cohorts.*** HIV/AIDS is affecting the potential clientele for education services by creating large cohorts of orphans and other vulnerable learners (see chapter 15 of the study). In most parts of the industrialised world usually no more than 1% of the child population is orphaned. In developing countries, the proportion would normally be 2% of the child population, and orphans (under 15s who have lost mother or both parents) could be absorbed into the extended family.

By 2010, it is estimated that maternal and double orphans will rise to more than 25% of children in Zimbabwe, to nearly 19% in Zambia and about 17% in Kenya. The addition of paternal orphans and orphans from causes other than AIDS would raise the proportions for these countries even further (UNICEF, 1999; World Bank, 2000a, p 7). By 2005 there will be 800,000 orphans under fifteen in South Africa, rising to almost two million by 2010. The number of orphans in Botswana is projected to rise rapidly from 38,000 in 2000 to 161,000 by 2010 (current population 1.8 million) with one in two children aged 10-14 orphaned. Rates of orphanhood will be higher in some districts, schools and classrooms than in others. Some secondary schools in Botswana already report that 20-30% of students in some classes are orphans (Abt Associates, 2001).

In Malawi, during 1999, the percentage of children in school who had lost one or both parents increased from 12% to 17%. One-third of children in one study reported they missed school in order to care for the sick. This percentage doubled for children who had lost both parents. Six per cent of children reported missing school for funerals. Children with both parents dead were twice as likely to drop out (17.1%) during the 2000 school year as children with one parent dead (9.1%), or both parents living (9.5%). Repetition rates for children whose parents were dead were 5-15% higher (depending on cohort and grade) than for children with living parents. The average age for pupils with both parents dead was about six months older than the average age in their grade cohort (Harris and Schubert, 2000).

The consequences for education of large numbers of HIV/AIDS-affected learners are likely to be profound. Such learners are often at physical disadvantage for nutritional and economic reasons. Their attendance and performance declines and they are likely to suffer HIV-related discrimination. Their attendance at school becomes increasingly random, and they must learn under a cloud of trauma and loss. When teachers suffer for the same reasons, and are unable to respond to the needs of children in distress, decline in motivation, morale and performance on both sides is inevitable.

## 2.4 Supply of education services

Predicting basic supply and demand for teachers is virtually impossible.

*It must be understood that forecasting something so susceptible to social trends and policy shifts as teacher supply and demand is extremely hazardous. Furthermore, these sorts of forecasts have absolutely no rigorous confidence intervals: that is we cannot state our confidence in the results with any degree of precision.... The demand side is relatively easy to forecast, but the supply side (and therefore the gap between supply and demand) is really quite chancy. All we can say therefore is that...projections [are] conditional on a whole host of assumptions, some of which have to do with the likely course of say, normal demography or the AIDS epidemic, and some of which have to do with possible policy choices in the future.(Crouch 2001a, p. 28)<sup>5</sup>*

Nevertheless, it is remarkable that, at a time when the business community in high prevalence countries is being forced to assess the potential impact of HIV/AIDS on workforces, and attendant cost and inefficiency problems, governments have given little or no attention to protecting the education service, the largest, most expensive and highly trained cohort of workers in any developing country (Moore and Kramer, 1999, p 4).

***Increased Educator Morbidity and Mortality.*** HIV/AIDS will affect the supply of education services through increased mortality of educators. The World Bank assumes very generally that losses of educators will parallel those in adult populations. Zimbabwe

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<sup>5</sup> Crouch's list of the assumptions that need to be factored into a relatively accurate teacher demand and supply projection are set out in Table 7 of his paper.

would therefore lose about 2.1% of educators to AIDS between 2000 and 2010, Zambia and Kenya 1.7% and 1.4%, and Uganda (where AIDS mortality appears to be lower) an estimated 0.5% (World Bank, 2000a, p 5). The Zambian Ministry of Education reported that 2.2% of all teachers died in 1996. This was already more than the number of teachers produced by colleges that year, but it has been estimated that teacher death rates might triple by 2005 (LoveLife, 2000). The World Bank reported a study that projected 14,460 Tanzanian teachers would die by 2010, costing US\$21 million in replacement training (Save the Children UK, 2001a). Crouch's stylised projections for South Africa suggest that whereas teacher education production capacity is now 5,000 annually, at least 30,000 new teachers will be required to be trained each year by the end of the decade (Crouch 2001b).

Kelly (2000a) and others<sup>6</sup> suggest that the educator cohort is at high risk of infection because of relative affluence, mobility and status in the community, their expectations of sexual 'bonuses' in lieu of better conditions of service, and circumstances that separate them from their families<sup>7</sup>. Recent analysis suggests that for teachers, as for other professionals, early high incidence rates are reducing gradually to below-average rates (Botswana Ministry of Education, December 2000; Abt Associates, 2001).

Death rates in excess of 3% of educators per year have been reported in at least two countries (Abt Associates, 2001). There are indications that primary school teachers are at greater risk than secondary educators. Teachers are also being lost to other sectors of government and to the private sector to replace personnel lost to AIDS (Swaziland Ministry of Education, 1999). Educator productivity is reported to be down and absenteeism up because of AIDS-related sickness, care for family members, and attendance at funerals. There are increasing problems finding replacements for specialist teaching and other staff, especially as teacher mortality outstrips teacher provision in countries like Zambia.

***Increased Costs of Provision.*** HIV/AIDS will affect the supply of education services because of the costs it imposes on the system. In Botswana, direct costs of HIV/AIDS to education include employee benefits, hiring of temporary staff, and costs of recruitment and training. Indirect costs include loss of productivity due to absenteeism, loss of skills, declining morale and low performance among ill employees. Most studies of HIV/AIDS impacts on employees and organisations indicate that the impact on organisation function and costs is seldom disastrous in any one year, unless a key official is lost at a critical time. The greatest concern is for the relentless loss of skills that build up to a significant human resource deficit, and gradual decline in quality.

For Botswana, possibly the only country where these calculations have been done for the education service, Abt Associates suggest that if the total education workforce were provided with ARV treatment, medical costs might well exceed 0.9% of the basic salary bill by 2005, and 1.8% in 2010. Pension funds are structured in a way that means the cost implications of illness and deaths to the sector will be neutral. There is concern however

<sup>6</sup> LoveLife (2000) p 27; Badcock-Walters (2001); Desmond in University of Natal Health Economics and AIDS Research Division (2001).

<sup>7</sup> Whether teachers have higher infection rates for these reasons, or because teachers are predominantly young women at high-risk, is not clear.

that levels of benefits provided to employees who are ill or die could be considered inadequate. Benefits currently give sick employees a financial incentive to stay in post until they die, even though this is clearly undesirable for them and their families, as well as for learners and colleagues (Abt Associates, 2001).

## 2.5 The quality of education provision

*Challenges to Education Quality.* The HIV/AIDS pandemic will affect the quality of education services. Teachers are being lost through illness and mortality (Kwa-Zulu Natal Province and Botswana), and transfers to other sectors (Swaziland). AIDS-related illness means educators become increasingly unproductive. Death or absence of even a single educator is particularly serious because this affects the education of fifty or more children. Because teaching service management has made no provision for medically boarding educators who are ill (and may refuse to be tested), teachers continue to teach even during terminal illness (Botswana and South Africa). With high teacher and pupil absenteeism, instructional time is disrupted. Textbooks and teachers' manuals are designed for a full school year of full-class instruction. There is no evidence that provision is being made for individual learning or for adjusting lessons to learner needs. Repetition is not the answer, for this merely increases class size, reduces efficiency, and puts girls at risk when older boys join the class (LoveLife, 2000; Harris and Schubert, 2000; Caillods, 2000).

Current shortages of educators in critical fields such as science, mathematics and technical skills will become more acute. Loss of key individuals in management or senior leadership – planners, principals, inspectors, teacher educators – may compromise quality and efficiency. Concentration of deaths among staff in the 30-39 year age group, just when they have accumulated important experience, means not only loss of their skills but may jeopardise less formal processes of mentoring and skills transfer within the sector.

As the average age and experience of teachers falls, systems will rely increasingly on less qualified teachers, young teachers with less experience and poorly qualified new recruits whose secondary and teacher education may have been disrupted by the loss of qualified teachers and lecturers. These effects are likely to be compounded by the reduction of numbers of qualified entrants to teacher education from secondary schools (LoveLife, 2000).

HIV/AIDS is impacting on the emotional status of educators and young people (Kelly, 2000a). Teacher morale is low where impact is high, combined with considerable student and teacher trauma. Teachers who, at least in Africa, have generally resisted voluntary testing and counselling may be uncertain about their own HIV/AIDS status (Abt Associates, 2001). Both educators and learners have difficulty concentrating in the face of illness, death, mourning, and dislocation (Kelly, 2000a). Many learners affected by the presence of HIV/AIDS have a widespread sense of anxiety, confusion and insecurity (Devine and Graham, (n.d.); Ebersohn and Eloff, 2001). The psychosocial needs of affected children are not as well understood as their material needs (UNICEF, 2001; Save

the Children UK, 2001a; Coombe, 2001b). Adult caregivers may fail to identify psychological difficulties as the cause of more visible problems like truancy or anti-social behaviour. And where emotional problems do manifest themselves, few people responsible for children are equipped to handle them. Further, where abuse and violence along with teacher misconduct characterise the learners' community, young girls and boys fear they will be sexually abused or maltreated.<sup>8</sup> There may be uncertainty and distrust between learners and educators if the latter are seen to be those responsible for introducing or spreading HIV/AIDS (Leach et al, 2001; Kelly, 2000a).

All this adds up to a school environment characterised by constant change and distress. Even children from intact, healthy families are surrounded death and loss. Stress is unrelenting, and contributes to what one educator described as the 'inchoate unease' which textures the learning environment in heavily infected countries (Harris and Schubert, 2000). Not all schools will suffer to the same extent. But there is enough personal and systemic trauma to undermine education quality generally.

Finally, and ironically, policies intended to support children affected by HIV/AIDS such as Malawi and Uganda's introduction of free primary education for all children, have dramatically overstretched the education system and reduced quality of provision.

***Getting the Balance Right Between Demand and Supply.*** HIV/AIDS will likely affect the demand for educational services somewhat more than the supply through 2010. It is probable, on the basis of statistical analysis for Kenya, Uganda, Zambia and Zimbabwe (1) that fewer teachers will be needed because the school age population will be smaller and (2) that fewer teachers will be available because of increased teacher mortality. This is a very tentative conclusion because the calculation on which it is based does not take into account teacher absenteeism and early mortality caused by opportunistic infections, or many others of the complex panoply of factors that influence educator supply and learner demand (World Bank, 2000a; Crouch, 2001a).

### **3. Current education responses to HIV/AIDS**

Responses to the pandemic vary worldwide relative to infection rates, geographical, cultural and religious variables, the leadership and management capacity of governments, and the level of commitment in nongovernment sectors. Where prevalence is low, or confined to high-risk groups, there is little evidence of concern in the sector about the potential implications of the pandemic for education. Learning institutions may fairly routinely deliver safe sex messages as in Thailand and the United Kingdom. But education systems in low prevalence areas are not yet confronting large numbers of AIDS-affected learners or high teacher attrition, and the pandemic for the moment remains largely invisible.

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<sup>8</sup> The South African Medical Research Council reported late in 2000 that one half of all schoolgirls had been forced to have sex against their will, one third of them by teachers. 'We were shocked by the finding that teachers are the major perpetrators of child rape, but no one experienced in education seems to be surprised.' The Minister of Education reported subsequently to parliament that there were perhaps 6-8 cases involving sexual abuse pending with the South African Council for Educators, and that in most cases the accused were still in the classroom (Coombe, 2001b).

This analysis of current policy responses concentrates on experience in high prevalence countries, mainly but not exclusively in Sub-Saharan Africa and the Asia-Pacific Region, in (1) helping to contain the spread of HIV/AIDS, (2) providing social support for affected learners and educators, and (3) protecting the system of education. The review focuses principally on the response of the official or formal system. It emphasises the increasing role being played by nongovernment agencies, and the importance of strengthening their contribution to the fight against AIDS.

### **3.1 Prevention: containing the spread of HIV/AIDS among children and adolescent**

Governments in high prevalence countries have accepted responsibility for delivering mass prevention campaigns through learning institutions and nongovernment partners. While the intended responses of such campaigns can be categorised, their actual achievements are poorly described in the literature and are very rarely evaluated. Much supplementary prevention work is carried out by communities, NGOs and Faith Based Organizations (FBOs), with support from the international community. What follows is a description of what is known from observation, experience, case studies, information from conference reports, a survey of Southern African Development Community (SADC) ministries of education, and so-called gray literature.

*Developing Lifeskills Curriculum and Learning and Teaching Materials.* The teaching response to HIV/AIDS (known as HIV/AIDS education, reproductive health and sex education, lifeskills or life orientation)<sup>9</sup> is generally supposed to communicate relevant knowledge, engender appropriate values and attitudes, and build personal capacity among learners to maintain or adopt behaviour that will minimise or eliminate the risk of becoming infected by HIV. An indirect benefit of such programmes is that teachers too, lacking educator-focused prevention programmes of their own, learn about HIV. Curricula generally aim at equipping learners with skills such as decision-making, problem-solving, effective communication, assertiveness, and conflict resolution (Kelly, 2000a).

Most countries in Eastern and Southern Africa have either elaborated HIV/AIDS-related curricula or are 'planning to do so'. Problems persist about how to include life skills and reproductive health in the school curriculum – a separate subject, or integrated in other subjects? (Neither is believed to be particularly effective.) There is ubiquitous evidence that few teaching and learning materials are getting into classrooms, and that teachers have virtually no guidelines for coping with the pandemic (Berkhof, 2001). South Africa's emergency guidelines for educators and similar guidelines drafted by Zambia's ministry of education are intended to provide basic guidance for educators, but are not known to be available in other countries (Zambia Ministry of Education 2001; South Africa Department of Education 2001b).

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<sup>9</sup> Generally defined as including the ability to distinguish between healthy lifestyles and risky behaviors (such as unsafe sex, substance abuse, and violence); the development of a strong self-concept and skills to resist peer pressure; and an examination of the situation of women, gender equity, and healthy family relationships.

(Although one in nine of those who are HIV positive globally live in India, school-based education programmes do not yet seem to be a principal element of India's IEC strategies. Government of India has gone only as far as distributing a training module (*Learning for Life*) to all states to assist with training teachers and peer educators among students. A number of states are reported to have initiated school-based programmes (India Ministry of Health and Family Welfare, 2001).)

**Disseminating Information.** Youth-focused media campaigns like *Love Life* and *Soul City* (see [www.comminit.com](http://www.comminit.com)) in Botswana, Namibia and South Africa, the media campaign of the Johns Hopkins University unit in Rwanda, the *Sara* programme in Tanzania, and the Recross AIDS Network for Youth (West Africa) (Adu-Aryee, 2001) effectively supplement school- and college-based HIV/AIDS programmes. But media campaigns focused at youth in Africa have for the most part tended to be limited in coverage, poorly designed and disseminated, and sometimes thematically inappropriate where they fail to take account of adolescent and contextual realities. They are best when youth are up-front.

**Providing Guidance on the Distribution and Use of Condoms.** The idea of condoms for youth is a persistent cause of conflict between ministers and their constituencies, between parents and teachers, and between teachers and students. There is no evidence that guidance on condom availability, accessibility and use has been issued to teachers or school heads in any country surveyed. Resistance by church leaders, older teachers, and traditional leaders has created an aura of ambivalence. One girls' hostel matron in Botswana obtained condoms from the local clinic but, without guidance, feared to make them available and hid them under her bed.

To get around ambivalence and confrontation, Uganda is reported to have waged a 'silent campaign' during which, without public debate, condoms were made available to those who needed and wanted them. The Thai 100% condom programme succeeded because it concentrated on a limited goal and excluded questions of morality or the elimination of prostitution. 'Other countries would do well to consider this aspect when drawing up their own programmes' (Larson and Narain, 2001, p 35). This is true even where many schools are concerned. Difficult decisions will need to be made by young people and their parents, locally by communities and school governing bodies, rather than by central authorities, about condoms.

Problems of accessibility to VTC, the confidentiality of test results, and treatment of STDs has undermined the transparency necessary for successful prevention programmes. Fear, denial and silence still characterise the Sub-Saharan pandemic particularly for university students and all educators. There is evidence from Botswana that teachers who are eligible to receive ARV treatment under their medical aid scheme coverage refuse to do so for fear of being identified as HIV positive (Botswana Ministry of Education, December 2000).

**Inservice and Preservice Preparation of Educators.** Sub-Saharan Africa education sector strategic plans commonly ignore or fail to address the need to adjust INSET (In serv-

ice teacher education) and PRESET (pre service teacher education) programmes, their curricula, their delivery and their purpose, and the urgent importance of adjusting guidance manuals and teaching/learning materials appropriately. A review of university- and college-based teacher education programmes in South Africa demonstrated recently that while some institutions were 'thinking about' preparing to teach HIV/AIDS curricula, most had done little or nothing to move in that direction.<sup>10</sup> Neither are there any known programmes for upgrading the skills and knowledge of teacher educators.

Thirteen of the fourteen countries in the SADC region were surveyed in February-March 2001 about their response to the pandemic, including introduction of lifeskills curriculum and preparation of teachers (SADC 2001).<sup>11</sup> Although HIV/AIDS has been present in the region for twenty years, ministries of education reported as follows:

**Table 1:** Responses to HIV/AIDS in SADC

<b>HELPING TO LIMIT THE SPREAD OF AIDS: THE SADC REGION</b>	Y	P	N
<i>Appropriate curriculum in all learning institutions:</i> Are learners being guided through the curriculum on safe sex and appropriate behaviours and attitudes?	2	5	6
<i>Materials developed and distributed:</i> Have materials suitable for learners in schools and post-school institutions been developed and distributed to institutions? Are they up to date?	1	7	5
<i>Serving educators prepared:</i> Are school teachers adequately prepared through pre-service and inservice to teach life skills curricula? Have they accepted this responsibility?	2	5	6
<i>Teacher educators prepared:</i> Have university, teacher training college and local teacher support staff been trained in HIV/AIDS issues and curriculum implementation?	0	3	10
<i>Evaluation of curriculum and materials:</i> Have materials and courses been evaluated in terms of content, implementation and outcomes?	1	1	11
<i>Partnerships:</i> Are other partners helping with prevention programmes?	0	9	4

Y Yes, action in being taken

P Some action is planned

N No action is being taken

An analysis of case studies from Ethiopia, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda and Zimbabwe for the United Nations Economic Commission for Africa highlights the shortcomings of current prevention programmes in the sub-region (Kelly, 2000a). Most programmes start too late, for children age nine and up. They are developed from the top with little consultation with parents, teachers and young people, and are more concerned with the biology of human reproduction and barrier methods of prevention than about understanding relationships, showing respect for others, and protecting the rights of all. Delivery is almost exclusively in the hands of teachers although they are for the greatest part poorly prepared, and generally lack knowledge and understanding. The discredited cascade model used to train them (if they receive training at all) often dilutes or even misrepresents content. Many teachers are poor role models and feel uncomfortable talking about sexuality. Cultural beliefs, expectations, traditions and taboos related to behaviour receive little attention, and materials generally portray sexuality as

<sup>10</sup> Survey undertaken by staff of the University of Pretoria Faculty of Education (2001).

<sup>11</sup> The thirteen countries that reported are Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, South Africa, Tanzania, Zambia and Zimbabwe.

heterosexual and consensual, ignoring problematic issues of rape and harassment and rising levels of incest, homosexuality and child abuse. Programmes are driven by ministries of education, with little except ad hoc unofficial support from stakeholders in the sector or other social sectors. Finally, there has been no effective evaluation of lifeskills programme content, implementation and outcomes. The extent to which such programmes reduce HIV transmission, STDs, rape or coerced sex is not known.

Evidence was produced at the 6<sup>th</sup> International Congress on AIDS in Asia and the Pacific (Melbourne, October 2001), that there is serious potential for extensive spread of HIV in that region, in part at least because prevention programmes still have not reached most people. Coverage is too limited. There is only 40% awareness among Indian women, and vast areas of rural China remain unreached (Brown 2001, see also chapters 8 and 9 of this compilation).

### **3.1.a Challenges**

AIDS prevention delivered through schools is agreed to have potential for helping to keep children and young people safe, and allow them to help others. Effective skills-based health education for learners, from the time they enter school, must be a key education sector strategy. But its potential is not being realised for a number of reasons (Inter-Agency Working Group, 2000; Kelly, 2000a; Coombe 2001a).

In many communities, belief persists that any kind of sexual education leads to increased sexual activity. Adult conservatism, cultural taboos and the ‘sensitivity’ of the content area create tension around implementing effective lifeskills programmes. African case studies confirm what has been found elsewhere: that young people who participate in reproductive health programmes do not become promiscuous. They do not engage in sex earlier or seek more frequent sexual intercourse, and in some cases delay initiation of sexual activity (Kelly, 2000a).

There have been very high expectations that prevention education will result in desired behaviour change. When changes fail to appear quickly, the assumption is made that the programme has failed. Clearly HIV/AIDS prevention education, to be successful, must be complemented by a range of consistent, long-term, supportive strategies. (Nevertheless, it is discouraging to note that in Botswana, ‘antenatal survey data and various surveys of knowledge, attitudes and practices indicate that despite high levels of awareness of AIDS and basic HIV/AIDS knowledge, there has been no change in behaviour that seriously begins to turn back the pandemic’ (Abt Associates, 2001).)

Lifeskills programmes are just not getting out to those who need them. Prevention programmes are often under-funded, with inadequate attention to training teachers, sensitising managers, providing supportive health services, and linking programmes with other community services. There is serious concern about the capacity or willingness of many teachers to engage with lifeskills programmes, or to provide complementary care and counselling support to affected learners or colleagues (Coombe, 2001b). Many so-called national strategies remain at pilot project level, although countries like Kenya are now

making efforts to scale up to national level, especially in the areas of materials development and distribution, and teacher training. The current challenge is to continue to expand and strengthen education-driven programmes aimed at AIDS-related behaviours (World Bank, 2000a, p 38).

Education ministries and their nongovernment partners are struggling to deliver. HIV/AIDS is only one of many problems faced by education services. Failure to deliver prevention messages effectively is compounded by the dire physical environment of many schools (lack of water, latrines, adequate classrooms and teachers' housing, decent hostels, furniture and books), by the teacher- and child-unfriendly ambience in many learning institutions (where physical and sexual abuse are present along with corporal punishment and poverty- or HIV/AIDS-related trauma), and by inadequate management support for teachers (overcrowded classes, low and irregular salaries, an inappropriate policy framework which may discriminate against HIV/AIDS-affected learners and educators, and comprehensive failure to make provision for educators affected by HIV/AIDS) (Coombe, 2001c).

In many countries, sexuality education cannot, for religious reasons, be part of the educational curriculum. Talking about sex publicly continues to be taboo in much of Pakistan and China (see chapter 9 of this study) for example, where illiteracy and school exclusion rates continue to be high<sup>12</sup>.

### **3.2 Social support: care and counselling for learners and educators affected by HIV/AIDS**

UNICEF's strategic paper, *Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS* (2001) stresses that although they are 'less tangible than the violations of other rights that children suffer, (HIV/AIDS-related) psychosocial problems are rarely addressed in HIV/AIDS programmes, and yet can have long term impact on development. A child's progression through basic developmental stages is jeopardised if HIV-related illness reduces and then ends a parent's capacity to provide consistent love and care' (Unicef 2001, p 8). Adequate socialisation might have been added to the list.

While there have been regional conferences and much informal discussion on issues relating to HIV, gender and sexuality for example, and there is significant literature on orphan care,<sup>13</sup> little is known in practice about how children and their families are coping with HIV/AIDS-related trauma, and the impact it has in the classroom (Ebersohn and Eloff, 2001). The South African Department of Health, HIV/AIDS and STD Directorate (2001) has produced a guidebook, *HIV and AIDS: Care and Support of Affected and Infected Learners: A Guide for Educators* to supplement the 'emergency guidelines for educators' (South Africa Department of Education, 2001b). There is talk about lay coun-

<sup>12</sup> Contribution to IIEP internet dialogue, October 2001

<sup>13</sup> Subbarao et al (2001); Hunter and Williamson (2000); Williamson (2000a and 2000b) for example. See also chapter 15 of this compilation.

selling INSET and PRESET courses for educators, and Botswana has provided counsellor training a few educators through its Institute of Development Management.

But most countries are at an early stage in their orphan epidemics, and it appears difficult for them to anticipate or plan how educators will cope with very large numbers of distressed children. Re-orphaning of children is expected to be common, and the group psychological effects of the epidemic may change current norms around schooling in unpredictable ways. Many non-orphans will be affected indirectly by AIDS impacts on friends, teachers and families especially in households that assume extra orphan-care burdens (Abt Associates, 2001).

The SADC review graphically demonstrated the failure of countries to provide even a modicum of social support in schools or to engage with the likely consequences of having increasing numbers of intellectually, socially and psychologically dysfunctional learners:

**Table 2:** Social support in SADC

<b>PROVIDING SOCIAL SUPPORT: THE SADC REGION</b>	Y	P	N
<i>Counselling for learners:</i> Can pupils and students who are affected by AIDS find help from their teachers? Or from someone else?	0	2	11
<i>Counselling for educators:</i> Are teachers affected by AIDS, and those who are dealing with the trauma of children affected by AIDS getting help to cope?	0	1	12
<i>Social support:</i> Are children affected and infected by the pandemic receiving counselling and care? Is there a culture of care in schools and institutions?	1	1	11
<i>Orphan needs:</i> Is planning underway to understand and respond to the special needs of increasing numbers of orphaned and other vulnerable children?	1	5	7

Y Yes, action is being taken

P Some action is planned

N No action is being taken

There is substantial evidence from principals and teachers that nongovernment agencies are providing support to schools through peer group programmes, teacher advice and counselling, and training. Such programmes are generally ad hoc, often grossly underfunded relative to the role they play (or could play), and are not generally recognised, resourced, or formally contracted by the official system to undertake tasks that the system itself is apparently not capable of doing (see chapter 15 of this compilation).

### 3.2.a Challenges

Education sector's responsibilities here need defining. What do teachers need to be able to do, and when should they hand over to other social service staff? Should some or all teachers be prepared to identify children in difficulty? ...to provide a modicum of compassionate care? ...to help institute a culture of care in each school? Should not all educators be held accountable for creating safe and secure environments for girls in schools and hostels? Potential problems can be predicted because of limited systematic leadership on social support issues in learning institutions. With concentration focussed on preven-

tion programmes, there has been no clear definition of the sector's role in social support, or of schools' role in local strategic planning. Teachers clearly feel daunted by the challenge of responding to increasing orphan numbers. Although many teachers, especially women, are responding generously as individuals, the education service generally does not promote social support. And guidance and counselling programmes are not a suitable alternative. There is potential for forming a circle of care network involving education, social and health systems but for the most part there is poor coordination among social sector staff at all levels, and between them and local volunteers.

### **3.3 Protecting quality: sustaining education provision**

Here is the core of the education demand and supply equation: the need to stabilise provision and maintain education quality. Education is big business. In any country, the education budget commands one of the largest slices of the national fiscus. Nevertheless government managers have been, perhaps inexplicably, slow to take action to maintain efficiency, sustain output, and reduce cost in the face of this pandemic.

Education sector 'strategic plans' are widely variable in the extent to which they recognise and incorporate (if at all) the turbulence caused by HIV/AIDS in planning for the sector, although the situation is fluid.<sup>14</sup> Botswana, Namibia and Zimbabwe are currently assessing the impact of HIV/AIDS on the sector, and Zambia has prepared an HIV/AIDS strategy within the context of its Sector-wide approach (SWAp) programme. In Kenya, projections used for education planning take account of likely HIV/AIDS impact scenarios but are not factored into planning. In Uganda, though official projections incorporate assumptions about HIV/AIDS, planning projections in the ministry are based more on assumed intake and repetition rates than on projections of the size of the school age population and assumed enrolment ratios during a period when Uganda is moving strongly toward UPE goals (Abt Associates, 2001; World Bank, 2000a).

Evidence from both SADC and Economic Community of West African States (ECOWAS) (Baku, 2001; Casley-Hayford, 2001) regions shows that current HIV and education strategic plans are characterised by concentration on curriculum interventions aimed at behaviour change. They focus principally on primary and secondary schools to the exclusion of early childhood development, the post-secondary training, university and college sector, and out-of-school children. They generally fail to address issues related to the management of the teaching service affected by HIV/AIDS (Ghana and South Africa may be exceptions) and the needs of learners affected by HIV/AIDS. Perhaps the implications are too large and too complex. There is no evidence in the region of workplace policies in schools and offices,<sup>15</sup> codes of conduct, HIV monitoring protocols for the service, guidance on the rights and responsibilities of teachers, or management guidelines for senior managers. Current teaching service regulations need major review, as well as human resource management policies.

<sup>14</sup> The Cambodian Strategic Plan 2001-2005 for the education sector is limited to prevention measures (Cambodia Ministry of Education, 2001).

<sup>15</sup> The South African Department of Education has included workplace policy as one of the eight pillars of its HIV plan 2001-2002 (South Africa Department of Education, 2001c).

Finally and fatally, there is no observable attention being given to the managerial capacity, funding, human resources and infrastructural requirements that need to be in place to support practical strategic action in the sector (Association for the Development of Education in Africa, 2001). African ministries are failing consistently, in their planning and in their practice, to seek to sustain education quality and levels of provision, or to create new learning opportunities for the disadvantaged.<sup>16</sup> Neither are they attempting to ensure that demand and supply are in qualitative and quantitative balance so that the level and quality of education provision is sustained through the future period of extreme dislocation. There is little research or expert analysis of complex cost factors, and no evidence of teacher training colleges or universities adjusting preservice and inservice models and curricula appropriately.

SADC evidence demonstrates the extent to which most ministries have failed to address the planning and management complexities that HIV/AIDS imposes (Coombe, 2001d; Southern African Development Community, 2001).

**Table 3:** Mitigating the impact of HIV and AIDS on education sector

	Y	P	N
<b>Assessment:</b> Has an assessment been done of the likely impact of HIV/AIDS on the education sector in future?	4	2	7
<b>Risk profile:</b> Is there some understanding of the factors that make educators and learners vulnerable to infection?	0	5	8
<b>Stabilising:</b> Are steps being taken to sustain the quality of education provision and to replace teachers and managers lost to the system?	0	3	10
<b>Projecting:</b> Have relatively accurate projections been made of likely enrolments and teacher requirements at various levels of the system over the next five to ten years?	2	3	8
<b>Responding creatively:</b> Is the system trying to provide meaningful, relevant educational services to learners affected by HIV/AIDS, finding new times, places and techniques for learning and teaching?	0	0	13
<b>All subsectors:</b> Is attention being paid to the planning requirements of all education subsectors – from early childhood development through to university?	0	8	5

Y Yes, action in being taken

P Some action is planned

N No action is being taken

### 3.3.a Challenges

Strategic action to protect the education service may be anticipated following completion of the impact assessments currently under way. But while impact assessments are being undertaken, there is no concurrent effort to establish strong, viable, executive HIV/AIDS divisions in ministries that can drive strategic plans, and have the technical capacity to develop them.

### 3.4 Protecting quality: responding creatively to more complex learning needs

<sup>16</sup> Evidence from fieldwork in SADC and ECOWAS regions, in Asia and Pacific region.

Perhaps the greatest provocation to education quality will come from the ‘randomisation’ of learning and the complexity of learner cohorts which include large numbers of vulnerable, orphaned and otherwise traumatised children. At the same time as educational systems and institutions become more fragile appropriate learning opportunities will need to be created for multitudes of AIDS orphans and other vulnerable children. That means, for example, making special learning provision for orphans suffering disorientation or isolation, for children caring for younger children, and girls caring for the sick. Young people and selected teachers will need to learn basic caring and counselling skills so they can help those in physical or emotional difficulty. Alternative learning opportunities are required for those forced out of school early, or who need to move in and out of learning. This probably means moving in the direction of a lifelong learning paradigm, and a broader and fresher definition of ‘nonformal education’.<sup>17</sup>

Schools have a critical role to play as centres of support for communities in the grip of HIV/AIDS, the principal CBOs in the fight against the pandemic and attendant poverty, sexual violence, female disempowerment, and abuse of human rights (Kelly, 2000a). There is growing recognition among policy-makers and educators that each school can be a fulcrum for community welfare. That means working more closely with health and social services, and providing a physical focus for community effort (including providing fax, phones and electricity in some instances).

### **3.4.a Challenges**

The problems faced by governments, districts and schools in creating new opportunities for challenged learners are generalised. There is a profound lack of creativity in bureaucracies at all levels, especially where conditions of service for teachers are poor. Schools often lack resources to share with communities. Educators are already under pressure from HIV/AIDS, and are having enough difficulties delivering basic HIV-related knowledge. Being creative may be a step too far. To expect them to make a swift transition to providing care and counselling is unreasonable. Most schools are very basic places, with far too many problems already. The need to make measurable, creative responses to the HIV crisis shines a bright torch on the difficult circumstances of most schools and their staff.

### **3.5 Evaluating current responses**

Many countries around the world have established national AIDS councils and secretariats, and HIV units in their ministries of education though they are typically understaffed and lack executive power. There is extensive political commitment at the highest level in countries like Uganda and Botswana, although others like South Africa for example, have fallen short in this regard. Many countries are now emphasising a multisectoral approach that deals with HIV/AIDS as a development issue that transcends health, and the importance of working together both multisectorally and with other stakeholders.<sup>18</sup> It is diffi-

<sup>17</sup> Communication from Aster Haregot, Unicef New York.

<sup>18</sup> Information from Family Health International, Kigali, 2001.

cult to ascertain whether governments are keen to hand to communities because they know local strategies can work, or because they recognise the problem is too big, too costly and too complex for central government to handle.

Several countries have commissioned education sector impact assessments (Botswana, Mozambique, Namibia, South Africa, Swaziland, Zimbabwe) and have created HIV/AIDS and education policy and strategic plans. But implementing such plans reveals persistent management weakness. Most managers have not received professional preparation for their responsibilities and many hold posts by virtue of their seniority or experience gained as they rose through the ranks. HIV/AIDS is wreaking havoc with fragile management systems (Kelly, 2000a). Financial resources are reducing because of the pandemic's impact on availability of private and public funds for the sector, reducing total disposable assets, diverting resources away from education to other areas like health and social welfare, increasing costs, and reducing taxable income from the private sector. Ministries have been deficient in planning how to make best use of international resources.

The SADC survey summarises the consequences of inadequate management capacity:

**Table 4:** Creating a foundation for action

	Y	P	N
<b>Combined approach:</b> Is equal consideration given to (1) preventing spread of the disease and to (2) reducing the anticipated impact of the pandemic on education?	3	6	4
<b>Leadership:</b> Are political leaders, senior officials, unions, the teaching service, and school governing bodies knowledgeable and committed to action?	4	8	1
<b>Collective dedication:</b> Are partners outside government involved in the fight against HIV/AIDS? Do mechanisms exist for partnerships?	4	7	2
<b>Research agenda:</b> Is information about HIV/AIDS being collected, analysed, stored and spread? Is there an HIV/AIDS and education research agenda for the education sector?	2	3	8
<b>Effective management:</b> Has a full-time senior manager been appointed? Does a standing structure exist which includes partners in and out of government?	5	1	7
<b>Policy and regulations:</b> Are HIV/AIDS sector policies and regulations in place? Are there appropriate codes of conduct for teachers and learners, and are they applied rigorously?	1	4	8
<b>Strategic plan:</b> Is there an education sector HIV/AIDS strategic plan which covers all levels of the whole education sector, and is it funded?	2	5	6
<b>Resource allocation:</b> Are plans being funded adequately? Are funds being channelled to various levels of the system, and to partners outside government who can use them?	2	5	6

Y Yes, action in being taken

P Some action is planned

N No action is being taken

There is much to be done. What are the priorities for action, and how can they be achieved?

#### 4. 'Best practice' responses

Evaluation of current responses to HIV/AIDS suggests that 'education is not living up to the demands that the HIV/AIDS crisis imposes' (Kelly, 2000a). Is it possible to deter-

mine what can be done better, to define elements of ‘best practice’? On what basis can recommendations be made about what education should be doing?

#### **4.1 Identifying ‘Best Practice’**

This section examines what seem to be effective strategic principles, significant interventions, and successes of education services worldwide. To do so is daunting, because there is still little hard evidence, especially from governments, about what works and what does not. There is too little monitoring of practice, and virtually no hard evaluations. It is not possible to know what interventions create what outcomes. Behaviour change is a complex process, and so even when declining prevalence or incidence can be traced to such changes, it is difficult to identify the direct causes of those changes. Such studies as there are usually test the impact of health or medical interventions on HIV spread, such as STD treatment, rather than the impact of any government information and AIDS prevention campaigns (Parkhurst, 2001).

There are many distinct and complex circumstances in which HIV/AIDS is spreading. There is danger in generalising from one country’s set of data because data collection and analysis may be flawed, and because what works for place may not work for another (Webb, 2001). The Thai and Cambodian epidemics for example have not followed natural epidemiological history: behaviour change was widespread and prevalence peaks of 2-3% did not represent the pre-existing potential of the epidemic given the favourable climate for its spread. It is therefore not possible to assume that other countries can limit the pandemic in the same way (Brown, 2001). In addition, interventions that work in a country with low incidence rates, and succeed in keeping them low (UNAIDS/FHI, 2001) may not be appropriate in a community or country with high prevalence rates, where the pandemic is out of control.

##### **4.1.a The case of Uganda**

Concern has recently been raised about what can be learned from the anomalous success of Uganda, where ‘proving any causal link [between intervention and behaviour change] is particularly challenging because there exist no studies to scientifically prove such hypotheses one way or another’. In his analysis of Ugandan data, Parkhurst stresses that to learn from the evidence of Uganda, it must first be understood that a decline in prevalence or incidence does not necessarily reflect changes in behaviour or intervention effects (Parkhurst, 2001). The HIV-response community has regularly cited the success of the Government of Uganda in controlling its HIV/AIDS pandemic, and its declining HIV (infection? prevalence? incidence?) rates. ‘Unfortunately, there is often a lack of detailed explanation of what these HIV rates actually indicate, and what the Ugandan government might have done to achieve any apparent declines’ (Parkhurst, 2001).

Statistical analysis of the Ugandan pandemic and its impact is extremely complex, and assumptions that it is possible to learn from Uganda’s purported success in coping with AIDS, and to apply evidence of ‘best practice’ there to other countries, may fatally

flawed. Parkhurst argues that researchers and the press alike may have misinterpreted or misused Ugandan data and evidence in ways that led to the construction of a notion of success in Uganda. Repetition of commonplace errors has created a ‘myth’ which supports the current international belief of a Ugandan success story. Calls to emulate Uganda rarely examine possible biases involved in the Ugandan epidemiological data. Other nations facing HIV prevalence rates of 30% cannot simply copy the Ugandan policy response and achieve a 2/3 reduction in their national prevalence rate. Yet, Parkhurst argues, authors imply emulation is possible when they claim Uganda’s infection rates decreased from 30% to 10%, attribute this drop to the actions of government, and call upon African nations to adopt a similar response to bring their own HIV epidemics under control’ (Parkhurst, 2001).

No one can quite determine why Uganda’s prevalence has dropped so quickly (World Bank 2000a). Ugandans invariably identify the strong leadership of President Museveni early in the epidemic as a key factor. Some observers think that the wide diffusion of information about HIV/AIDS has been a significant factor for the decline in prevalence. However, the recent UNAIDS survey of ‘best practice’ in Uganda, Senegal and Thailand notably fails to identify interventions that have made a difference in incidence and prevalence rates in Uganda (UNAIDS, 2001). And if information diffusion has been key to Uganda’s success, the education sector has evidently not been a major player. HIV/AIDS programmes in schools began as early as 1992. A few activities – AIDS drama, for example – have been used extensively in schools. But Uganda education officials say that school- and teacher-oriented programmes have not been particularly strong. The ministry is now ‘looking to strengthen programmes so the sector can play a more active role in addressing the epidemic’ (World Bank, 2000a).

Agreement does seem to exist on the reality of the observed decline in HIV prevalence in Uganda. But why has HIV prevalence dropped so sharply in Uganda? Why did prevalence in rural areas never really explode the way it did in Zimbabwe or Zambia? HIV/AIDS in Sub-Saharan Africa spread overwhelmingly by heterosexual contact, and it is only when large numbers of people change their sexual behaviour or consistently take preventive measures that prevalence declines. To some extent this seems to be what has happened in Uganda. But no one has been able to link behavioural change to any particular programmatic intervention. The World Bank notes that Uganda had one of the earliest HIV outbreaks in the region (World Bank, 2000a). The arrival of heterosexually-transmitted ‘slim’ in Uganda in the early 1980s attracted the attention of the international community led by Peter Piot, and changes in incidence and prevalence may have as much to do with early and rapid response, the Hawthorne effect, and an earlier epidemiological peak in Uganda, as with subsequent interventions.

#### **4.1.b Elements of good practice**

Despite these caveats, is it possible to identify a suite of principles and models that constitute ‘best practice’? A study of presumed HIV prevention success in Senegal, Thailand and Uganda (UNAIDS, 2001) suggests that successful national AIDS programmes share common features:

- strong political commitment
- early intervention/prevention
- intensive multisectoral approaches at national, provincial and community levels
- implementation on a large scale
- effective monitoring and dissemination of findings to sustain awareness, and
- combined prevention and care.

Unfortunately, the three-country review extrapolates little of practical use in terms of best practice. It modestly suggests that prevention can work if properly implemented, monitoring and research are needed, and policy-makers and international and local communities need to see that investment is paying off.

UNAIDS' analysis of HIV prevention measures in Asia (UNAIDS/FHI, 2001) stresses that there is no magic bullet, that providing information alone is likely to prove ineffective, and that effective prevention programmes address people's behaviour in context. Community responsibility is highlighted in supplementing large-scale intensive and extensive interventions that require substantial technical and managerial capacity that may take time to build. The most important message for low prevalence countries is that prevention must *begin before HIV prevalence grows* to measurable levels.

By reflecting on such understandings, it should be possible to identify fundamental strategic planning principles, and from there to highlight, in largely generic terms, some interventions that seem promising.

#### **4.2 Reality checks and strategic principles**

HIV and education strategic plans based on sound policy and a realistic assessment of available capacity are essential for counterattacking AIDS (Hunter and Williamson, 2000). Principles to guide strategic planning and action in the sector can be summarised as follows.

1. Governments cannot by themselves protect education services, but must work with all other stakeholders in the education community – NGOs, parents and traditional leaders, CBOs and faith-based organisations, international agencies and volunteers – as well as with social sector departments at national, provincial and community levels.
2. Effective responses are usually those that are locally devised to meet local conditions, and this principle seems to underlie success. Knowledge, behaviours, attitudes and understanding exist within a complex set of cultural values, economic circumstances, and gender understandings which must inform planning and action.
3. Local responses must be complemented by vigorous, extensive and intensive blanket programmes relating to condom use and STD prevention, lifeskills curriculum in schools, orphan feeding and subsidy schemes for example, in order to reach as many

people as possible. Rigorous coordination of local programmes within a national policy framework might achieve similar results.

4. Many governments are managerially challenged. It is essential to choose interventions that are within the competence of the system to deliver. Ensuring good STD care for example is simpler than organising peer education or doing outreach with marginalised groups, and points to the kinds of prevention tasks that are within the capacity of the system to implement. If simple tasks are successfully managed, they will contribute to building an environment which will make more challenging interventions possible at a later stage (Marais, 2000).
5. Educators are often not the best people to deliver vital messages about death and sex, behaviour change and risk. Young people on the other hand have often been at the forefront of successful change. Peer group work by young people, and their capacity to interrogate values and behaviours, their energy and their perceptions of reality are everywhere making vital contributions to saving lives (Devanney, 2001).

### 4.3 Adjusting the legal and regulatory framework

The battle against AIDS in the sector requires that all education legislation, policy, regulations, codes and statutes be reviewed for at least two reasons. First, it is necessary to identify the rights and responsibilities of individuals and agencies in the time of AIDS. Second, it is essential to adjust laws and regulations antithetical to the promotion of rights, of women and children particularly. The South African Law Commission undertook a complete review of existing legislation for the Department of Education before its policy on HIV and AIDS was promulgated. The Law Commission considered international conventions and national legislation and regulations as well as Constitutional implications<sup>19</sup>.

The South African Law Commission's *Consultative Paper on Children Infected and Affected by HIV/AIDS* (1998)<sup>20</sup> for example specified that learners with HIV/AIDS should not be unfairly discriminated against, that no learner should be denied access to school on the basis of his or her HIV status, that testing of learners for HIV for admission to or attendance at school is prohibited, that needs of learners with HIV should be accommodated within the school environment, that a learner's HIV status is confidential and may not be disclosed without consent, that all schools should implement universal precautions to eliminate the risk of transmission of blood-borne pathogens including HIV in the learning environment, and that HIV/AIDS education programmes should be implemented at all institutions for learners, educators and other staff.

It is also necessary to check teaching service regulations, codes of conduct and government general orders relating to the service to keep them in line with changing conditions

<sup>19</sup> South Africa Law Commission (1998). Personal communication from the author to UNICEF with regard to *Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS*, 2001; see also Smart (1999).

<sup>20</sup> Smart (1999) p 42. The SA Law Commission project on HIV/AIDS was driven not by Department of Health, but by the Commission itself, under the Department of Justice. Its recommendations were incorporated in the Minister of Education's policy on HIV/AIDS, learners and educators.

(regulations on illness and bereavement, misconduct, grants and pensions, for example) (Ndubani, 2001). Although teaching service management in Botswana and Zambia is stretched to the limits by high levels of infection, little has been done to address these issues.

#### 4.4 Counterattacking HIV/AIDS within the education sector

*The first thing to do is to 'recognize that for twenty long, hard years we have lived with this epidemic which is causing unspeakable human suffering, entrenching poverty, subjugating women, and unravelling development efforts. Recognize that we know what to do. Recognize that we know how to protect our education systems. Recognize that with these systems protected, education has the potential to stem the further spread of the disease and to assist individuals in coping with its impacts. Recognize that what is needed is action'* (Coombe and Kelly, 2001).

##### 4.4.a Helping to contain the spread of HIV/AIDS

Global prevention targets have been spelled out in the *Declaration of Commitment on HIV/AIDS (2001)*. It is clear that prevention can work if the response is quick, intensive and extensive, and if it mobilises all stakeholders in the public, private and community sectors. Education's first responsibility is to educate learners on sexuality, reproductive health and prevention of STDs and HIV *before* they become sexually active (Larson and Narain, 2001, p 32).

*Teaching Safe Sex: The Lifeskills Approach.* Mainstreaming, strengthening and extending lifeskills programmes is everywhere essential (Carr-Hill et al, 2001). Current lifeskills programmes may not be working well (in the SADC region for example, see above), but they can be made to work.

Intensive commitment to creating effective materials and establishing sound practice in schools, supported by community action, *can* make a difference in behaviour among both educators and young people. The Government of India has distributed resource materials for schools nationwide; in China Save the Children is working with the Yunnan Provincial Education Commission to deliver prevention programmes in more than 2000 schools (see chapter 9); Thailand's success in reducing incidence rates is often attributed to school-based IEC programmes. Such programmes will not change behaviour where they are ineffectively implemented. Teaching and learning materials must be relevant and available in all learning institutions. Teachers and other educators must be prepared through INSET and PRESET for the task of talking about issues that may customarily be taboo. Communities must be mobilised to understand and support the work of educators (Life Skills Development Foundation Thailand, 2001).

Where it is difficult or taboo to teach life orientation programmes including sexuality education because of cultural, religious or customary perceptions, alternatives to conventional lifeskills curricula are being sought. Value-based approaches to AIDS awareness are being used effectively in Botswana among very young primary school children, and

in Pakistan where the *Aware for Life* curriculum focusses on human, and children's, rights and responsibilities as a way of sustaining behaviour change. In both countries, involvement of young people, parents, teachers and community elders in the value-based approach is deemed to be essential (Save the Children UK, 2001b).

Ultimately however, the life orientation approach can only take root where there is a climate in learning institutions that affirms the principles of respect, responsibility, rights and transparency, and which, more fundamentally, projects an image of good sanitation, safe water, and good general health.

***Educator Awareness: Educating the Teachers.*** It is assumed that teachers will be at the HIV/AIDS battlefield, but they are generally unarmed. Providing guidance to all educators and learning institutions on the basic facts about HIV/AIDS, universal safety precautions, condom availability and HIV/AIDS-related human rights issues has not been a priority in many countries with high infection rates. In South Africa, the Department of Education's *HIV and AIDS Emergency Guidelines for Educators* sets out HIV/AIDS facts and eight key messages about preventing HIV and related discrimination, deals with questions educators ask about sexuality education, advises on universal precautions and how to build a school culture of nondiscrimination. It offers help-line numbers and channels to other support services (South Africa Department of Education, 2001b).

Preservice and inservice programmes offered by universities and colleges are not being transformed to meet the demands of HIV/AIDS. INSET and PRESET curricula need to be adjusted to take account of new classroom realities including increasing numbers of disadvantaged and traumatised children, and illness and absenteeism among learners and educators. INSET structures are very rarely robust anywhere in the developing world, and they are able to do little, despite reported successes in a few places like Karnataka State in India, and the Western Cape Province in South Africa for example,<sup>21</sup> to prepare large numbers of serving teachers to cope with AIDS at school. Preservice programmes have three problems: how to adjust the curriculum, how to upgrade the knowledge and competence of professors and lecturers, and how to reform programmes to increase output in anticipation of increased teacher requirements within the near future.<sup>22</sup>

Teaching and learning materials are needed to guide teachers, heads of institutions, and parents on dealing with HIV/AIDS issues with children in their care. *Securing a Future: Mekong Children and HIV/AIDS* is a good example of material prepared for those working with younger children. *HIV and AIDS: Care and Support of Affected and Infected Learners: A Guide for Educators* is a useful resource for South Africa's teachers and others working with children in trauma (Unicef East Asia, 2001; South Africa Department of Health, 2001; see also Rwanda Christian Counselling and Training Centre, 2001). Every educator should have a personal copy, however cheaply produced, of a booklet setting out the aetiology of the disease (Visagie, 1999, for example), for educator ignorance about the nature of the virus, transmission modes, precautions and basic therapy for af-

<sup>21</sup> Personal communication from Karnataka State Minister of Health; South Africa Western Cape Department of Education, 2001.

<sup>22</sup> Crouch (2001a) estimates that South Africa will have to train at least 30,000 new teachers per year by 2010 compared to its current output of around 2,000.

fectured children is universally and abysmally high. UNESCO Harare has created a collection of teaching and learning materials, but there are too few calls on its resources by ministries.<sup>23</sup> Trainers report that in Kwa-Zulu Natal Province of South Africa, some district officials have failed to deliver lifeskills materials to schools, or that heads, having received materials, have locked them away for safekeeping. Botswana teachers collect simple media pamphlets from local health clinics. Appropriate educational materials are needed, they need to be distributed, they need to be in place and accessible, and teachers need to know how to use them.

Finally, educator training and sensitisation needs to be done in conjunction with development of workplace policy, workplace prevention programmes (every learning institution is a workplace), and impact management programmes. The ILO *Code of Practice on HIV/AIDS and the World of Work* (2001) has been tabled and is suitable for adaptation to local circumstances (International Labour Organisation, 2001).

***Youth Awareness: Using the Energy of Young People.*** Children and adolescents are part of the solution to HIV/AIDS. They need to be involved in the design and delivery of prevention programmes through peer school health teams, local and international NGO programmes, and anti-AIDS clubs. UNAIDS reports that where HIV prevention has been successful, young people have been at the forefront of change. In Rwanda, a recent evaluation of anti-AIDS clubs demonstrated their potential, and the advantages of youth working with youth, a strategy also being promoted in Rwanda by PSI. Without external advice and support, adequate training, planning support and focus, and up-to-date information on the aetiology of HIV/AIDS, 'les clubs existent, cependant leur dynamisme laisse a desirer...Toutefois, la plupart des participants ...considerent que les clubs sont d'une grande importance et qu'il faudrait les soutenir car ils peuvent bien contribuer a la reduction des comportements a risque d'infection du VIH/SIDA a travers leurs enseignements'<sup>24</sup>. The AIDS Task Force of Fiji works with peer educators throughout the Pacific Region through community organisations. Among other things, it provides fourth-year medical students from the Fiji School of Medicine with training in interpersonal communication skills. Peer educators from Samoa, Tonga, Kiribati, Marshall Islands, Solomon Islands and Nauru have been trained in outreach work, interpersonal skills, and AIDS issues and help to train other peer educators. They are known for their commitment and dedication.<sup>25</sup>

***Women and Girls: Putting Them First.*** Girls who are learners and women who are educators are at greater risk of infection than their male counterparts, both inside and outside the classroom or lecture theatre. The United Nations General Assembly Special Session on HIV/AIDS made special reference to their vulnerability, and responses to the UNGASS Declaration have highlighted their inferior economic, political and social status

<sup>23</sup> Personal communication from UNESCO Harare.

<sup>24</sup> Information from IMPACT Kigali.

<sup>25</sup> The initiative is perhaps too limited to be visible generally in the Pacific. The Pacific response to UNGASS (2001) expressed concern that 'in our region very little prevention programs which lead to sustained behaviour change is happening. The few educators in each country only have the skills and knowledge to give information about the virus. It was only recently that we learned that this alone would not change behaviour. But we do not have access to training to help understand this better and thus develop programmes' (AIDS Task Force of Fiji, 2001, p 14).

and insisted on their right to sexual and reproductive health as a core prevention issue. Women must be empowered to make decisions and take control over their lives and sexuality and measures put in place to protect them from and eliminate further sexual violence and abuse (United Nations, 2001).

***Retaining Learners: Education as Vaccine.*** School is like a vaccine for children at risk: children who drop out of school are more vulnerable to HIV infection, are more likely to engage in early sexual activity with larger numbers of partners, and to use alcohol earlier than children in school.<sup>26</sup> ‘Education is a crucial, and currently essential, element in society’s armoury against HIV transmission. It is a necessary, though not sufficient, component in all prevention activities’ (Kelly, 2000a). Simply put, the more education, the less HIV. This is the single most certain step that any government can take to counteract HIV/AIDS among the young: to increase the provision of education and to ensure young people remain in education programmes. Ensuring that every child gets into school, stays in school for a minimum number of years, and has some worthwhile learning and skills at the end is critical, especially for girls (Coombe and Kelly, 2001; Vandemoortele, 2001). ‘Education ministries should bend every effort to implement [EFA] strategy. Finance ministries should ensure that the resources are made available. The outcome will be a society with less AIDS, less poverty, greater female empowerment, and a human resource base from which the skills lost to HIV/AIDS can be replenished’ (Kelly, 2001a, p 13).

***Learning What Works: Monitoring and Evaluation.*** None of the high prevalence countries encompassed by this study has carried out an objective evaluation of lifeskills content, implementation and outcomes.<sup>27</sup> Evidence from many sources makes it clear that unless life orientation curricula are being taught in all schools, to all learners, *before* children become sexually active, by teachers who have been adequately prepared, with suitable resource materials, and within the context of the local culture and community, a great deal of money will be wasted on half-baked prevention interventions.

If governments are not in a position to monitor the work of schools in this regard, the work must be contracted out to partner institutions or policy units, and the results fed back into the system as a matter of priority.

#### **4.4.b Providing basic social support**

##### ***Children in Trauma: Meeting their Needs***

*The AIDS-orphaned child is not just another orphan, but a child who suffers from unique pressures and influences which may lead to depression, hopelessness and psychological trauma later in life. Because the concept of ‘orphanhood’ is relatively new in African communities where children who have lost parents have customarily been incorporated into extended families, we need to know much more about ‘orphanhood’ and the material, psychological and social deprivation that accompanies it. We need*

<sup>26</sup> Information from Uganda, Delhi and Rajasthan in Save the Children UK, 2001a, p 25; Coombe and Kelly, 2001.

<sup>27</sup> South Africa has done a partial review in Kwa-Zulu Natal Province (Macintyre et al, 2000), and another partial review that has not been released by the Department of Education (Khulisa, 2000).

*to know more about AIDS orphans in particular, and how educators can work with social and health workers, sociologists and psychologists, and behavioural scientists and managers to comprehend and address their needs* (Coombe, 2001b).

In their update of *Children on the Brink*, Hunter and Williamson (2000) suggest that ‘when HIV/AIDS strikes, the first line of response comes from the children, families and communities themselves. The extent to which the work of other agencies – governments, learning and religious institutions, NGOs and donors – is effective is a function of how well they support the efforts of children, families and communities’.

Schools cannot meet all the material, intellectual, emotional and social needs of children who are distressed. Clearly HIV/AIDS-affected children are not the only ones in dire circumstances. But governments can concentrate on keeping disadvantaged and challenged children in school or other suitable learning programmes, and creating acceptably healthy, secure and compassionate learning environments for them (Morrell et al, 2001; Hepburn, 2001; Williamson, 2000a). Schools are already overloaded but there are things that should be fundamental to every learning environment.

1. They must provide a healthy environment for learners and educators. There must be adequate latrines separately for boys and for girls, and an adequate supply of potable water. Where many learners are hungry – in both urban and rural areas – schools must pay attention to the nutritional welfare of students, which may mean providing school feeding schemes (Coombe, 2001c).
2. They must be safe places, where there is zero tolerance for sexual abuse, harassment or abrogation of civil rights of any kind. Teaching service management in the SADC region has been talking for over fifteen years about disciplining educators responsible for widespread misconduct, without effect. Girls and women teachers must be empowered to protect and assert themselves, and they must not be exposed to high-risk situations in or on the way to and from school.
3. They must be places where the human rights of all are guaranteed.
4. They must be able to move beyond conventional teaching programmes and provide life and survival skills to children at relatively early ages. Educators must be able to identify children in trauma, handle them sensitively, provide basic counselling, and then know when to hand over to health, social services, homebased care or the police.
5. They must all have a youth peer health team, trained by social and health workers, whose members are professionally trained by local health and social workers and therefore knowledgeable about the virus and its transmission, communication techniques and lay counselling, care for the sick, and universal precautions, at a minimum.

6. They must have ways of referring learners in confidence to accessible voluntary testing and counselling sites, and must make informed decisions about condom provision, accessibility and guidance on use.
7. To do these things, they must work vigorously with community authorities, parents, NGOs and FBOs. Until governments develop care and counselling skills of educators through preservice and inservice programmes, much social support work for learners in difficulty will be done by NGOs, CBOs and FBOs (South Africa Department of Health, 2001).
8. In high-risk areas, those with large numbers of HIV-affected learners should consider appointing specialist counsellors or social workers.
9. Every learning institution must have a rolling AIDS-response plan, with resources to implement it. Staff, in consultation with students and parents, must decide how to respond to the problems posed by HIV, how to integrate the institution's resources into the community response, and to link it also with the plans and procedures of health and community workers, and the homebased care system.

A common reason that HIV/AIDS-affected children drop out of school, or perform poorly, is lack of material resources to meet basic needs. If short-term crises can be avoided or managed, many orphans and other vulnerable children would be able to continue successfully with their schooling (South Africa Department of Health, 2001). In Botswana, teachers and schools have developed a range of responses to vulnerable children's needs, including recognition and referral of such children for grants and other support, providing supplies, monitoring orphan well-being, interacting with households and homebased care teams to reduce stress on children, helping with psychological needs and behaviour disturbance, and developing school HIV/AIDS plans. Botswana already has an established culture of schooling and high female enrolments. There is less reliance on child labour for subsistence tasks, and relatively good prospects of work after completion of school. Government may have reduced the potential adverse affects of orphaning on learners by creating three complementary support programmes which together seem to keep many children in school, and help them perform adequately. The package is not a technically difficult one and includes school feeding, home based care, and orphan registration and subsidy (Abt Associates, 2001).

Subbarao et al (2001) make a strong argument for education subsidies for orphans not in school on a number of grounds, principally that they could easily be monitored, would keep children in school and reduce some of the financial burden on carers, and in the long term provide them with marketable skills. Subsidies have not been tried in Africa, except in Botswana, where they are reported to help keep children in families and in school, when complemented by homebased care and school feeding schemes. Some countries like Malawai, Tanzania and Uganda waive fees at primary level. In countries that have 'implemented fee waivers, primary gross enrolment ratios have dramatically increased'.

***Teachers Without Support: Meeting Their Needs.*** Many teachers perceive that the system does not care about them. Their morale is low, not only because they are poorly paid, but because too often the system is unresponsive to their needs and concerns. They work in dire conditions, with little or no professional or administrative support at school, district or higher levels. If no one cares for teachers, why should they care about each other or about the children and their parents?

Teachers in high prevalence settings are caught between a rock and a hard place. They may be HIV positive themselves, and they may be relatively or completely ignorant about HIV/AIDS. Yet they are required to reach out to children and adolescents and provide them with advice and counselling. For most of this decade teachers throughout the SADC region have been mandated to teach lifeskills without the necessary tools, workplace policy, information programmes aimed at them as adults, or access to lay and professional counselling. There are fundamentals of support to which every teacher is entitled:

1. Every teacher must have access to adequate knowledge of the aetiology of HIV/AIDS, starting with a book in accessible language which is graphically illustrated.
2. Every teacher must have adequate training and guidance in lifeskills curricula, and have syllabi and manuals, as well as enough suitable learning materials.
3. Selected teachers must be trained additionally in care and counselling techniques, and should perhaps be chosen on the basis of trust by children in consultation with the school head and governing body or parent-teacher association for special upgrading. All preservice teacher education programmes must make provision for basic tutoring in HIV/AIDS issues and lay counselling techniques.
4. Every teacher must have access to counselling if they are worried about their own health, and to help them cope with the trauma of working with learners and families in difficulty. Access to confidential VTC is essential for educators.
5. Heads of schools and teaching service managers must have adequate preparation appropriate to managing HIV/AIDS-related crisis, especially in high prevalence areas.
6. Wherever possible, educators in high prevalence countries should have access to anti-retroviral therapy. This is already being considered in at least one Sub-Saharan country, as a cost-effective and humane response, and is perhaps the only way to sustain the teaching service.

#### **4.4.c Sustaining provision of educational services**

In order to stabilise education systems, it is essential now to ensure at the very least that the potential consequences of HIV and AIDS are factored into every education plan by

national ministries and their partners as accurately and with as much integrity and attention to detail as possible.

Ultimately, by combining analysis with action it should be possible to provide for

- enough teachers to replace those leaving the service, especially those with scarce skills in university departments, teacher education, maths, science and technology,
- supply teachers to cover for those regularly ill and absent
- enough new teachers to keep expansion and quality up
- INSET support for those coping with trauma in the classroom
- replacement management skills lost to the system.

Impact assessments are necessary to identify the ramifications of HIV/AIDS for the service. Botswana, Namibia, South Africa, and Zimbabwe are assessing the impact of HIV/AIDS on education in order to understand the impact of HIV/AIDS on society and human resource development, as well as its internal impact on employees (education supply), and external impacts, focusing on learners and demographic shifts (education demand). Impact assessments provide the basis for understanding the social, economic, labour and planning implications of the pandemic for the sector, and to plan appropriate responses (South Africa Department of Education, 2000a).

Projections of levels of HIV/AIDS infections, illness and death of learners and educators are based on various prediction models, observations, interviews with key informants in the education sector as well as data and information collected from development, finance, planning and medical aid schemes, group discussions with education managers, customised projections of learners and educators, field visits to education districts, and reviews of relevant documents, policies and regulations (Abt Associates, 2001; World Bank, 2000a; South Africa Department of Education 2001b; impact assessments ongoing in Zimbabwe, Namibia).

It is no use undertaking impact assessments however, if there is no planning and management capacity to respond to and implement their recommendations. There must be a system for monitoring and reacting to skills shortages within the education service – from early childhood development programmes, through schools, up to universities and college, and through to the nonformal and private sectors. Policies and systems for reducing costs, improving efficiency and planning staff deployment and replacement must be in place. HIV/AIDS prevention training initiatives for professional and other staff are urgently required, as well as procedures to monitor HIV/AIDS rates and impacts on educators, in conjunction with government planning and manpower units (Coombe, 2001e).

#### **4.4.d Protecting quality: Responding to complex learning needs**

The International Convention on the Rights of the Child stipulates that every child has the right to education (article 28) (Unicef and USAID, 2000; Smart, 1999). Providing appropriate education of quality for orphans and other children at risk requires education systems to be increasingly flexible. For many systems, it will mean pressure to shift from the

current generic focus on formal provision, to alternative learning modes including life-long learning strategies, adult education and literacy, a new 'nonformal education' paradigm (Unicef and USAID, 2000).

***Curriculum Adjustment: Greater Practicality.*** School curricula do not generally respond to the needs of learners affected by loss, or of those for whom immediate employment and income-generation possibilities are urgent necessities. Clearly it would be difficult for any system to equip them with vocational training but it should be possible to integrate an orientation towards the practical within the curriculum.

***Delivery System Adjustment: Greater Flexibility.*** It should be possible to meet more random learning needs by establishing broad principles for the timetable, daily schedules, and even the education and training calendar, while allowing schools, colleges and communities to regulate these in ways that respond to local requirements. To some extent this has been achieved in southern Africa where schools have been established by communities, with their own teachers, curriculum, and management structures. Such schools commonly charge no fees, require no uniforms, provide almost all educational materials, and use teachers from within or close to the community, often on a voluntary basis and with little training (Unicef and USAID, 2000). Similarly, the Rajasthan Shiksha Karmi Project in India harnesses the energies of 'barefoot teachers' for children in remote rural areas where primary schools are either non-existent or dysfunctional (Swedish International Development Cooperation Agency, 2001).

Positive aspects of this development are the ability of a community school to respond instantly to felt community and learner needs, and build on a deep sense of community ownership and involvement. The danger is that such schools might become second-rate institutions catering for the poorest, or that the state might feel itself absolved of responsibility for such schools and in consequence for some of the most disadvantaged in society (Coombe and Kelly, 2001).

Other responses to the problem of reaching out to orphans and other vulnerable children who are not able to attend school include the use of interactive radio (Ghana Community Broadcasting Services, 2001; USAID, 2000), and the appointment of itinerant teachers who go out from a central school to animate and supervise tutors engaged by community groups. There is a growing sense in some communities that schools must be seen as a comprehensive, community-based organisation where teachers are joined by those with a traditional role in society (leaders, healers, birth-attendants, crafts-persons) in collectively educating children (Unicef and USAID, 2000).

***Adjusting for Teacher Loss: Alternative Learning.*** The simple solution of expanding teacher training capacity will not solve the problem of teacher attrition, and institutions may well be left short of teachers, lecturers and trainers. Alternative measures include a more systematic and extensive use of multigrade teaching (provided this is backed up by the resources, training and supervision it requires); greater reliance on educational broadcasting; more use of community members for supervisory responsibilities and for actual teaching in areas where they have some expertise; greater use of untrained (or 'para'-)

teachers with a system in place for their ongoing training on the job; transferring certain curriculum topics or areas to co-curricular activities that would be managed by senior students; and more extensive provision for peer education (with some teacher supervision and monitoring). Children would have greater continuity of instructional and emotional support if younger children were to be linked with same sex older children for tutoring, support and protection. They might be provided with instructional materials for out-of-school learning when necessary, or given help with individualised learning through sequenced learning materials for individual or group use, in or out of school (Harris and Schubert, 2000).

***Community Backup: Harnessing and Supporting Local Resources.*** Community participation must be central to the response to HIV/AIDS. For education to combat HIV/AIDS and manage its impacts, it must also be proactive in establishing linkages with the communities being served. Education authorities and institutions must constantly explore with communities how best they can be of service to one another. In Zambia, one objective of the education sector HIV strategic plan is for all schools and colleges to participate in homebased care and other responses to AIDS-related community needs (Coombe and Kelly, 2001; Zambia Ministry of Education, 2001). Likewise in Botswana close links are emerging between learning institutions, local NGOs and faith-based organizations, and social and health workers (Abt Associates, 2001). In Thailand, the Sanga Metta project, with support from local and international agencies, supports a shift in the focus of work of some Buddhist monks and temples in the direction of social responsibility for those suffering from HIV and AIDS, including orphans who become novices, or are given education support. The programme is being extended in the region through Unicef's Buddhist Leadership Initiative (*Buddhist Approach*, 2001). The 2001-2002 plan of action of the South African Department of Education (South Africa Department of Education, 2001c) includes provision for the establishment of 27 multi-purpose education and training centres linked to community development. They are particularly designed to assist with victim empowerment, cooperate with local programmes supporting victims of sexual violence and rehabilitation of school offenders, and 'make schools centres of community life through innovations in infrastructure provisioning' (South Africa Department of Education, 2001c).

***Women Power: Creating a Safe Environment.*** Possibilities for harnessing the energy of women in school, around the school, and on behalf of the school need to be elaborated, preferably within the context of existing government and agency gender programmes. Mothers in Uganda are known to have mobilised in informal ways to save their daughters from death by AIDS, and there is evidence that this is happening in South Africa. Mothers in Bangladesh teach their children in community schools; mothers in Ghana make sure their children have access to potable water and food at school; mothers in Dominica become community teachers for five years before they undertake 'initial' teacher training; mothers in the United Kingdom assist classroom teachers with special subjects or children with special learning needs. Mothers everywhere are the principal and most reliable guardians of their daughters' well-being.

Anecdotal evidence suggests that female teachers and principals are already carrying much of the burden of AIDS care and counselling in learning institutions. They are the ones who commonly deal with learners traumatised by conflict, poverty, loss and insecurity, for helping children who have complex emotional and learning needs. More needs to be done to identify ways of mobilising mothers on behalf of their community schools, getting them into classrooms and around the school, getting them involved in decision-making about their schools, and setting targets for their schools. There need to be more female teachers trained (using the initial teacher training route for example) and more female officials in positions of authority at school, district, and higher levels. The idea of greater numbers of female principals, district officials, inspectors and senior executives is not new. Like much else about HIV and AIDS, what must be done is known. It is now a question of putting it into effect.

#### **4.5 The challenges for low HIV prevalence countries**

Low infection rates in the early stages of an epidemic mean there are few motives for assigning resources to education sector action on AIDS. The denial and silence which still characterise the HIV pandemic in high prevalence countries is often compounded in low prevalence countries by cultural and religious barriers that restrict open dialogue on sexual and drug-related issues, and inhibit analysis of later-stage epidemics in the Caribbean and Sub-Saharan Africa. Low prevalence often means there is a substantial lack of data, making it more difficult to assess where a prevention response might make a significant difference.

The pandemic's impact on education in low prevalence countries will take years to determine because of the invisibility of relatively low proportions of learners and educators affected by AIDS. So although one in nine of all those currently HIV-infected lives in India, together they constitute less than 5% of the total population, and a very small proportion indeed of the education community itself.

Prevention efforts need to focus on braking the advance of the disease in Asia. This is particularly critical where patterns of transmission indicate stark similarities with the outbreak of the African pandemic: high infection rates among truck drivers, and increasing rates among pregnant women and transmission to their children (Unicef, 1999). Behaviour change through prevention interventions for targetted at-risk populations is currently thought to be the cheapest and most cost-effective way to maintain low HIV prevalence (UNAIDS/FHI, 2001).

Youth are deemed to be a critical target population in low prevalence settings if a society resistant to HIV is to be built in future. Most adolescents do not have settled sexual habits and patterns and their behaviours are easier to change if prevention efforts reach them before they enter risk zones. They are accessible in large numbers in existing institutions at relatively low cost – in schools and youth organisations – and they have proved to be a powerful force in their own right as active resources for prevention. Mobilising and strengthening existing youth organisations and institutions, and harnessing the energies of youth themselves to provide HIV prevention skills and messages.

## 4.6 Making things happen

The success of education as a force for the long-term conquest of HIV/AIDS depends on its ability to do what it is supposed to be doing. National responses to AIDS have been constrained by many things including the hidden nature of HIV/AIDS itself, and its long incubation period. Research and resources have focussed on the nature and control of the virus. Failure to understand the transformation from virus to pandemic in high prevalence countries has contributed to the absence of a sense of urgency especially where numerous pressing social and economic needs compete for scarce resources and management time. Governments are coping with AIDS at the same time as they try to balance major economic problems related to structural adjustment and debt servicing, social transformation, political transition and military conflict and globalisation. Too many African governments have been battered by corruption, ineptitude, or financial, moral or intellectual bankruptcy, and natural disasters like droughts and floods. AIDS is just one problem among many (Kelly, 2000a; Coombe, 2000b).

Analysis of the best-known evaluation of a national HIV strategy and its implementation during the 90s (Marais, 2000), emphasises the leadership and managerial shortcomings responsible for South Africa's prevalence rate soaring from less than 1% in 1990 to over 25% in 2000. The Marais analysis suggests by implication the principal elements of a sound capacity to challenge AIDS, the managerial building blocks that must be in place if local, regional, national and international strategies are to work.

***Committed and Informed Leadership.*** Strong leadership is indispensable (Botswana United Nations Development Programme, 2000, p 49). There is general consensus, based on evidence from Uganda, Thailand, Botswana and elsewhere (Unicef and USAID, 2000), that effective action takes place when politicians, senior education department officials, and senior international agency staff are 'committed', are convinced that disaster is around the corner, and that their very systems are being steadily undermined. Politicians and officials need to be not just dedicated, but knowledgeable (Larson and Narain, 2001, pp 32-33).

***Collective Dedication: Working Together Regionally, Nationally and Locally.*** Education ministries can only overcome this pandemic by working with partners inside and outside government in a holistic sector-wide approach which harnesses available resource in cooperative arrangements characterised by trust. (Inter-Agency Working Group, 2000; Larson and Narain, 2001).

Central command delivery of education's response to HIV is not going to be much help. Success will come where local communities are empowered to take action on AIDS 'around the corner and down the street' because HIV/AIDS is so deeply embedded in the customs and beliefs of each locality, and because NGOs, CBOs, homebased care programmes, individuals and volunteer and faith-based support schemes are already making a difference in alleviating distress (Larson and Narain, 2001; Save the Children UK, 2001b). Governments must work *in support* of communities, and national management

strategies, especially in the social sectors, must reflect this balance (Inter-Agency Working Group, 2000). This will involve helping NGOs develop a diverse range of skills and resources (Khmer HIV/AIDS NGO Alliance, 2001). Khana, in Cambodia, is working to strengthen NGO capacity and strategic alliances among NGOs and public sector stakeholders. The International HIV/AIDS Alliance is also dedicated to supporting community action on HIV/AIDS in developing countries, principally by assisting community groups to improve the quality of their work (International HIV/AIDS Alliance, 2001; World Bank, 2000b).

#### 4.6.a Research, Information Sharing and Analysis

**Setting the research agenda.** Time has been lost in framing HIV and education, and identifying its principal research themes. There is as yet no set of research principles, for example that HIV/AIDS research should be systematic and driven by demand rather than by the preference of individual academics, officials and agency staff; prioritised; part of a coherent and comprehensive education research agenda; networked; based on a set of common understandings and definitions; linked to education planning and reform; and focussed on potential leverage points for change within schools, institutions, systems, procedures and administrations. There are as yet few research partners (within post-secondary institutions, policy units, government departments, and the private sector), or resources allocated to non-curriculum HIV/AIDS and education issues.<sup>28</sup>

**Collecting and sharing information.** More information is needed in order to establish a coherent set of qualitative and quantitative data. It should also be possible to identify a set of benchmarks and crisis indicators – alarm bells which indicate trouble – which can be monitored over time. Such data needs to be complemented by anecdotal evidence, observation and lessons from experience collected from practitioners and others, systematically and regularly (Harris and Schubert, 2000; Botswana Ministry of Education, December 2000; Kelly, 2001b; personal communications). Much more information specific to education is needed on rates of prevalence, achievement, costs, education and training requirements to meet labour market requirements, psychosocial needs of affected learners, and how existing knowledge and value systems complicate life skills teaching for example.

**Using information.** Even more important, information must be analysed and shared if it is to contribute to understanding of how the pandemic threatens the education sector. It is necessary to be able to evaluate potential strategies and programmes, as well as implementation procedures and practical success stories. Only in this way will it be possible to be creative and flexible in providing education in increasingly complex environments, to increasingly complex cohorts of learners (Kelly, 2000a). IIEP's programme of information-sharing, action research and capacity building seeks to disseminate information about new studies, interventions, promising practices, tools and programmes and to provide planners and policymakers with advice on study design (Association for the Development of Education in Africa, 2001).

<sup>28</sup> Personal communication from Caryl Hartell, University of Pretoria Faculty of Education; and from the Vice Chancellor, University of Botswana.

***Management Appropriate to Crisis.*** Education systems, even in high prevalence countries like Botswana and South Africa, may not yet have had to deal with large-scale disruption except in small pockets. The pressure that will ultimately be put on the sector in such countries is likely to be on a scale with which bureaucracies are inexperienced. Bureaucratic response capacity itself has to be improved (Crouch, 2001a).

It is clearly not possible to manage the HIV crisis given present managerial capacity in many bureaucracies where there are still not enough adequately mandated, full-time, HIV/AIDS-focused planners and strategists, managers and evaluators. Fighting the pandemic is clearly not a part-time assignment for individuals dotted around government or agency bureaucracies, but a full-time assignment until such time as the situation stabilises. It is also clear that ministries and agencies cannot simply continue to react to the crisis, but must anticipate its consequences, and be far more proactive in harnessing resources to counteract it.

***Policy and Strategic Planning.*** Complex working arrangements will need to be coordinated within a framework of common understanding about the nature of the pandemic, and its potential impact on the sector. Policy which is determined in a consultative way needs to be interpreted for educators and officials responsible for implementing it, in the form of guidelines and guidance notes, regulations and codes of conduct, so that local, national and regional efforts are focused and purposeful.

***Resource Allocations.*** There has been some movement towards making funding arrangements for HIV/AIDS in education more efficient, more appropriate to the kind of partnership arrangements envisaged here. But more is required by both ministries of finance, and by international agency partners. On both sides, structures and procedures inhibit movement of funds to local programmes which could make a difference. The argument has been won that adequate provision for local and national *nongovernment* partners must now be made through government or nongovernment funding mechanisms. World Bank experience on social sector support, joint funding mechanisms being designed by bilaterals for SWAp purposes, and the use of fundholders by agencies all provide useful guidelines from which to learn and on which to act.

***Monitoring Achievements.*** Impact assessment researchers recognise the limitations of relying on mathematical models, and recommend monitoring key indicators that can be used to track the progress of the pandemic including educator absenteeism, deaths among staff, and in particular among teachers, rates of enrolment into schools, particularly differences in enrolment between boys and girls, numbers of orphans in schools, and drop-out rates from learning institutions (Johnson, 2000).

## 5. Conclusion

HIV/AIDS lurks in communities and families, in the most intimate, private moments of human relationships. It is a creature of culture and circumstances, local perceptions and

behaviours, custom and religious belief. That means it is virtually impossible to generalise about good practice: what works to break the power of HIV/AIDS in one place may not work in another.

There are perhaps four ways to categorise good practice in the education sector, according to whether the intervention is aimed at

- containing the virus
- providing social support for affected educators and learners
- protecting education quality and
- creating a foundation for action.

Radical, humanitarian interventions in these areas – tackling STDs, providing condoms, establishing home based care and school feeding schemes, and training peer health teams for all institutions for starters – can save lives in the short-term, while pilots are being tried, governments are mobilising and allocating resources, the capacity of NGOs is strengthened, planning kicks in, and behaviour change programmes start up.

Global experience suggests there are a number of longer-term generic tools that can make a difference with regard to HIV and education, save lives, and protect education quality.

The first tool is honesty. It is essential to stop pretending progress is being made against AIDS. This is an overwhelming disaster and so far little has been done to confront it effectively. It is essential to analyse, diagnose, and then manage properly. It is absolutely essential to enhance crisis management capacity in and out of government, with appropriate senior executives, resources and mandates, and to design interventions appropriate to the management capacity of the sector. That probably means keeping them simple while strengthening the capacity of sector nongovernment partners.

Second, working together, making use of all available resources – and especially the skills of girls and women – is the best route to take. All poverty reduction plans must factor HIV/AIDS into their schema (it is not clear that this is being done) so that HIV/AIDS can be addressed within the context of poverty that drives it. Governments, though increasingly well-intentioned, are largely characterised by inertia. There are thousands of examples of good, very good and potentially good practice at community level, but these are generally on a small scale, ad hoc and underfunded. In theory governments are committed to cooperating with NGOs.

In practice however, it is not clear how partners at national and local level are being strengthened and resourced so that they can support governments' strategies. At local level, NGOs, CBOs and faith-based organisations are making a difference in the lives of women and children. They provide support to teachers and heads as counsellors. They train children and teachers in peer counselling. They teach lessons of safe sex, work in communities to defuse violence, and care for the abused and violated. They are at the coalface. They are doing the job. Their contribution is not just considerable, it is fundamental – however fragmented it may be. Strengthening education's response now de-

depends on how the programmes of nongovernment partners are integrated into the sector's strategic planning and resource allocations, and whether or not they can be taken to scale.

Governments clearly have a role to play in coordinating and strengthening local responses, creating policy and establishing a regulatory framework, delivering health and social welfare services appropriate to community requirements, as well as shifting school and clinic programmes to cope with changing demands, and ensuring that sufficient funds are mobilised and channelled to those who can make best use of them. Ultimately however, governments must work *in support* of communities, and national management strategies must reflect this balance.

No one underestimates the difficulties of creating mechanisms, structures and processes that can achieve this. There are few models from which to learn. Ministries of education have struggled for years to decentralise decision-making and executive responsibility. Now that lives depend on decentralising responsibilities to communities and schools, perhaps they will make faster headway in this regard.

Third, it is only by monitoring the success of interventions, and evaluating whether they can be replicated or generalised that governments and agencies can be held accountable for taking effective action, against agreed performance benchmarks wherever possible. There is as yet no clear perception that the potential of HIV and AIDS to create havoc for education requires immediate intensive and extensive response throughout the education sector. But that is what is required. The challenge of millions of AIDS orphans in several regions by 2010 may serve to concentrate a global sense of responsibility to learners and educators.

Finally, it is possible that HIV/AIDS is, for many countries, the most significant issue in education today, and probably the biggest challenge to development. The need to confront the pandemic responsibly will require a fundamental re-think of development principles and procedures, and the relationships between governments and their funding partners. HIV/AIDS is rooted in poverty, and until poverty is reduced, little progress will be made in limiting its transmission or coping with its consequences. A development, rather than an AIDS-specific focus is essential now.

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